REHABILITATION LITERATURE

July-August 1980

VOLUME 41/NO. 7-8

Our 40th Year

In this issue: Section 504 and Higher Education; Independent Living Models; New Standard for Accessibility

THE NATIONAL EASTER SEAL SOCIETY

Easter Seals

SERVING THE HANDICAPPED

Events and Comments

Revised Accessibility Standard Announced

A NATIONAL DESIGN STANDARD for making buildings accessible to persons who have physical disabilities is the latest standard to be developed by the American National Standards Institute (ANSI). The new standard, known as *ANSI A117.1 (1980): Specifications for Making Buildings and Facilities Accessible To and Usable By Physically Handicapped People*, represents the culmination of five years of research and testing, deliberations, meetings, and ballots, until a concensus document was produced by the over 50 organizations represented on the American National Standards Committee A117.

The original American National Standard A117.1, approved in 1961 and reaffirmed in 1971, gradually grew obsolete as the years recorded wider recognition and acceptance of the place of handicapped persons in the environment. The nation's design professionals called for more sophisticated and technical criteria to meet the problem of architectural and environmental barriers. The standard was developed under the secretariat of the President's Committee on Employment of the Handicapped and the National Easter Seal Society. They were joined in the revision project by the U.S. Department of Housing and Urban Development, which not only assumed cosponsorship, but also funded the cost of research and testing carried out by the School of Architecture at Syracuse University. Over 200 handicapped persons with varying types of disabilities participated in the testing process. Copies of the *ANSI A117.1 (1980)* are available for $5.00 from the American National Standards Institute, 1430 Broadway, New York, N.Y. 10018.

New Department of Education Officially Opens

TWO NEW FEDERAL departments have resulted from a structural reorganization of the U.S. Department of Health, Education, and Welfare (DHEW). Starting in June of this year, DHEW officially became the Department of Health and Human Services and a new Department of Education was established. Shirley Hufstedler was appointed as first Secretary of Education; she will assume control of six major divisions, each headed in turn by an Assistant Secretary. The new Office of Special Education and Rehabilitative Services merges the Bureau of Education for the Handicapped with the Rehabilitation Services Administration. In addition, the following agencies serving the handicapped will fall under the jurisdiction of the new department: the Architectural and Transportation Barriers Compliance Board, the Office for Handicapped Individuals, the National Institute of Handicapped Research, and the National Council for the Handicapped. Major programs to be administered by the Department of Education include P.L. 94-142, Title I programs serving handicapped children, and vocational rehabilitation programs.

Equipment Data Bank Begun By NARIC

A SIGNIFICANT new program—ABLEDATA—is underway at the National Rehabilitation Information Center (NARIC) in Washington, D.C. Working with the California Department of Rehabilitation and the Rehabilitation Engineering Demonstration Units, NARIC is initiating an online computerized data bank of equipment and devices for disabled people. For each aid or device described in the computerized data bank, information is provided on availability, cost, and use; evaluation and user feedback data is included where available. Selected index terms or descriptors from a specially developed controlled vocabulary are assigned to each record. The data bank will be operational by the end of August, 1980, with the first one thousand items on personal care, home management, and communication aids. During this initial period the system is being used on a test basis by the state of California's rehabilitation engineering information brokers. The full ABLEDATA data bank describing approximately 10,000 aids and devices for handicapped people is expected to be completed and internationally available via computer terminal within the year through the Bibliographic Retrieval Service (BRS). Printed byproducts, such as listings and catalogs, are also planned and a prepackaged set of manufacturers' and distributors' catalogs on microfiche, coordinated with the computerized system, will be available.

TASH Conference Scheduled for October

THE SEVENTH ANNUAL CONFERENCE of The Association of the Severely Handicapped (TASH) will convene Oct. 30-Nov. 1, 1980, in Los Angeles, Calif. "Goals and Strategies for the Eighties" is the theme of the conference, which will serve as a nationwide forum in the field of education and services for persons with severely/profoundly handicapping conditions. Professionals, parents, and advocates will congregate to share observations, expertise, and experiences. The program will include over 150 presentations. For further information, contact Beverly Kershaw, Conference Coordinator, TASH, 1600 W. Armory Way, Seattle, Wash. 98119.

AHCA To Establish National Center for the Aging

AS PART OF a comprehensive consumer education project to assist this nation's elderly population in locating appropriate health care services, the American Health Care Association (AHCA) will establish a National Center on Health Information for the Aging. The Center will be headquartered in AHCA offices at 1200 15th St., Washington, D.C. 20005. Information about nutrition, health tips, lists of daycare and other noninstitutional care settings, extended care facilities, and other general health topics will be available. Further details concerning the Center may be obtained by writing AHCA at the above address or by calling (202) 833-2050.

Resource Center on the Elderly Seeks Documents to Expand Data Base

THE Service Center for Aging Information (SCAN) requests gerontology researchers, educators, analysts, and practitioners to submit reports and studies that describe research or program experience. Reports should emphasize the social practice and social-behavioral science areas. SCAN is especially interested in studies, reports, and conference presentations that are not usually published or widely circulated. SCAN routinely acquires documents to expand and update its bibliographic data base. The clearinghouse system provides a central point from which gerontologists, human service practitioners, and researchers throughout the U.S. can be informed of the latest information in the field of gerontology. The system's Program Experience Exchange collects and disseminates information about innovative and model projects. SCAN encourages submittal of reports, manuals, and other information about these projects. The SCAN system is a component of the National Clearinghouse on Aging of the Administration on Aging. The system currently includes the Social Practice Resource Center and the Social-Behavioral Science Resource Center. Documents and inquiries can be submitted to: SCAN Resource Centers, Acquisitions/Dept N.R., P.O. Box 168, Silver Spring, Md. 20907; tel. (301) 565-4269 or (800) 638-2051.

Change of Address

FORMERLY LOCATED on the Gallaudet College campus, the new address for the National Center for a Barrier Free Environment is Suite 1006, 1140 Connecticut Ave., N.W., Washington, D.C. 20036; (202) 466-6896 (both voice and TTY).

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REHABILITATION LITERATURE

July-August 1980, Volume 41, No. 7-8

ISSN 0034-3579

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Subscription rate: $15.00 a year, United States; $15.00, plus $2.00 postage, Canada and other countries. Single copy, $3.00. Inquire for student rates.

Published bimonthly by the National Easter Seal Society, 2023 West Ogden Ave., Chicago, Ill. 60612. Printed at the Interstate Printers and Publishers, Inc., Danville, Ill. Second class postage paid at Chicago, Ill., and at additional mailing offices.

Address changes must be received by the 10th of the month to take effect the following publishing month.

The annual index, of authors only, is published at the end of the calendar year.

Rehabilitation Literature is an educational service of the National Easter Seal Society. Its purpose is explained further in the statement on the fourth cover of this issue.

—*The Editor*

Contributed articles in *Rehabilitation Literature* are indexed selectively in *Index Medicus, Excerpta Medica: Sect. 19, Psychological Abstracts, Hospital Literature Index, Social Work Research & Abstracts, dsh Abstracts, Blindness, Visual Impairment, Deaf-Blindness: Semiannual Listing of Current Literature, Chicorel Abstracts to Reading and Learning Disabilities, Exceptional Child Education Resources, Current Contents: Education,* and *Current Index to Journals in Education.*

Information on Back Issues

Subscribers should claim any missing issue within two months of the date of publication (overseas 5 months). We shall replace a missing issue if the loss is due to nondelivery on the part of the postal service, and if the issue is still in stock.

Rehabilitation Literature stocks issues only for the current year and previous three years. Earlier issues are not kept in print by the publisher. University Microfilms International, is the source of supply for microfilm and photocopies of any issue. A microfilm edition of Volumes 1-25 (Jan., 1940-Dec., 1964) may be ordered at a price of $55.00. Current subscribers to the regular printed edition may also subscribe to a microfilm edition that is distributed at the end of each volume year. For these services, address: University Microfilms International, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Reproducing Materials from Rehabilitation Literature

Article of the Month

Three Years Later: The Impact of Section 504 Regulations on Higher Education

GAIL G. FONOSCH, Ph.D.

SECTION 504 of the Rehabilitation Act of 1973 provides a legal mechanism for removing barriers to higher education. As the Section 504 regulations have been in effect for approximately three years, it is an appropriate time to assess the impact of these provisions on colleges and universities. Courts continue to interpret Section 504; financial burdens arising from compliance remain; institutions face a myriad of unique situations when extending educational opportunity to students with disabilities. Many college and university communities lack experience, and possibly genuine interest, in transforming campuses into barrier-free environments. The three-year time span provides an opportunity to examine the views of the federal and state governments, institutions, students, and the courts for purposes of formulating future directions for colleges and universities.

Rehabilitation professionals need to encourage university personnel to extend equal educational opportunity to disabled citizens. Walker and Pomeranz[24] developed a model where rehabilitation counselors worked closely with college counselors. This type of cooperative effort has the potential for hastening the transformation to barrier-free universities.

The regulations for implementing Section 504 of the Rehabilitation Act of 1973 state: "No qualified handicapped* person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance."[9] Compliance with this mandate requires colleges and universities to demonstrate how their programs and activities are accessible to students with disabilities. Although educational institutions must follow a plan to meet the requirements of Section 504, successful integration of disabled students into campus

About the Author . . .

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*The definition of *handicapped individual* for the purposes of Section 504 is any person who *a)* has a physical or mental impairment that substantially limits one or more of such person's major life activities, *b)* has a record of such impairment, or *c)* is regarded as having such an impairment.[22]

communities is not guaranteed by good intentions. This dilemma was expressed by Clarence J. Brown of the U.S. House of Representatives: "Clearly, we have a moral obligation to provide opportunities to the handicapped that are as equal as possible to those enjoyed by other Americans. . . . So it is not at all difficult to determine what is right and what is legally required. The difficulty comes in translating the moral obligation and legal requirements into reality."[3]

Section 504 Regulations

The Section 504 mandate was a sweeping statement of equality. Delineation of this legislation left little doubt that these regulations would have a major impact on institutions of higher education. The major provisions affecting postsecondary education will be summarized.

Admission. Qualified handicapped individuals may not be denied admission because of a handicapping condition. Quotas for numbers of handicapped students admitted cannot be applied, nor may tests that discriminate against those with certain conditions be administered. Although information regarding a limiting condition may be requested on admission forms, provision of this information is voluntary rather than mandatory. The intent of this section is to guarantee disabled persons equal chance to be admitted to colleges and universities, but it falls short of being an "affirmative action" measure.

General Treatment of Students. Qualified handicapped students cannot be subjected to discrimination or excluded from participating in any academic, research, occupational training, housing, health, insurance, counseling, financial aid, physical education, athletics, recreation, transportation, other extracurricular, or other postsecondary program or activity.[9] This provision going beyond curricular activities is intended to assure full participation in the academic community; for example, housing facilities equivalent to those provided for nonhandicapped students must be available (at the same cost), accessible, and convenient to disabled students.

Academic Requirements. Modifications in academic requirements are required to ensure no discrimination due to a student's limiting condition. Rules that may have a discriminatory effect (such as the prohibition of tape recorders in classrooms) cannot be imposed. Auxiliary aids such as taped texts, interpreters, or adapted equipment must be provided in cases where the lack of auxiliary aids will hinder participation in educational programs. Adjustments are required in cases where examination procedures may be disadvantageous to persons with disabilities.

Whereas the handicapped population look upon these regulations with optimism and a feeling of achievement, institutions of higher education have not viewed Section 504 with the same sense of elation. The legislative provisions were specific with a timetable to compliance attached. Deadlines made it imperative that institutions begin immediately outlining methods for compliance: The 504 regulations were signed on April 28, 1977, became effective June 3, 1977, and a self-evaluation of the capability of the college or university to serve students with disabilities was required to be available for inspection by the Department of Health, Education, and Welfare (HEW) personnel by June 3, 1978.

Proponents of Section 504 point out that the key to the regulations is "program accessibility," and not the elimination of all architectural barriers that would cost an incredible amount of money (HEW has estimated a price tag for compliance at $2.4 billion).[20] Biehl[2] explains "program accessibility" to mean "equivalent" (or, equally effective) experiences and outcomes rather than "identical" measures. Substitutions can be made if reasonable, although opportunities should occur in the most integrated settings possible. Providing separate programs is prohibited unless necessary to achieve equal opportunity.

Structural changes need be made only if other alternatives, such as reassignment of classrooms, are not feasible. In situations where structural changes are needed, the deadline for compliance was June 2, 1980; however, all buildings constructed after June 3, 1977, were required to be accessible. While the 1980 deadline was not the prime concern three years ago, many institutions are now faced with noncompliance due to the lack of reliable funding sources for architectural modifications. Wulfsberg and Petersen, in a study conducted for the U.S. Office of Civil Rights, reported: "Just over 40 percent of the total assignable space is currently accessible to the mobility impaired . . . an average of over 75 percent of an institution's assignable space will have to be accessible to the handicapped before program accessibility is achieved."[26] This government report estimates a $561 million pricetag for the June 1980 compliance with $245 million needed for modification of private institutions. These figures only include changes for mobility impaired persons, excluding the needs of sensory impaired individuals!

Section 504 has provided the impetus for opening college doors. The provision is essentially a civil rights statute written in antidiscriminatory language paralleling that appearing in Section 601 of the Civil Rights Act of 1964. The mandate was designed to remedy discriminatory conditions where individuals with disabilities were not afforded equal opportunity in educational activities. Postsecondary institutions were required to modify academic requirements so as to not discriminate, based on handicap, against

"otherwise qualified" students. Modifications could include changes in length of time for completion of degree requirements, substitutions of specific required courses, or adaptations in the manner in which specific courses are conducted. However, the *Guide to the Section 504 Self-evaluation for Colleges and Universities* states: "If a requirement is shown essential to a program and a handicapped person cannot fulfill it, then the person is not *qualified* within the definition of this term. Section 504 is not intended to dilute the quality of education offered, and contains no requirements that essential program requirements be modified or waived."[2]

Of the various cases in the courts testing the precise meaning of Section 504, the Supreme Court agreed to review Southeastern Community College v. Davis as the first test of Section 504. Ms. Davis, a licensed practical nurse, was refused admission to a registered nursing program because of a severe hearing impairment. The U.S. District Court concluded that refusal was primarily based on Ms. Davis's projected inability to be licensed as a Registered Nurse after graduation. The court interpreted "otherwise qualified" to mean that Ms. Davis could not perform because of her disability rather than being able to perform because of her abilities.

In March, 1978, the U.S. Court of Appeals reversed the decision of the U.S. District Court by stating the disability could not be examined as the criterion for determining if Ms. Davis was "otherwise qualified" for admission. Program qualification should be based on academic and technical standards necessary for performance in the program.[8] The Court of Appeals reprimanded the college for being unprepared (from a faculty viewpoint) to adequately train and supervise Ms. Davis. The court reminded Southeastern of its legal responsibility and recommended modification be made to equalize educational opportunities to compensate for Ms. Davis's limitation.[5]

The Supreme Court sided with the U.S. District Court, stating an otherwise qualified person is one who is able to meet all of a program's requirements in spite of a handicap. The court felt disabled persons can be required to meet physical requirements of technical training programs, such as a nursing curriculum, in order to avoid lowering standards of such a program. Essentially, Ms. Davis was judged not qualified to enter the professional training program and Southeastern's unwillingness to make major adjustments in its nursing program did not constitute discrimination.[19]

The Supreme Court's interpretation of Section 504 somewhat defines the parameters of the law, but the gray area between discrimination and equal opportunity will remain. Alfred H. DeGraff, director of Disabled Student Services, Boston University, said he anticipated three possible reactions from colleges and universities: some would ignore the decision, some would "slow down" changes, and others would use it as an excuse for noncompliance.[23] The Southeastern Community College v. Davis decision presents a challenge to all who support the intent of Section 504 to go beyond the regulations in efforts to create universities and colleges where the atmosphere is conducive to attitudinal change. Implications of the Davis decision were examined by nearly 200 people at a symposium in November, 1979. Urgency was placed on destroying misconceptions and stereotypic portrayal of disabled persons and, at the same time, expanding the notion of a person's functional abilities to include personal strengths, background, creativity, and resources available to meet "legitimate physical qualifications" of training programs.[7]

In addition to extending equal opportunity, the legal mechanism stresses that educational activities should operate in the most integrated setting possible. Laski states, "Section 504 of the Rehabilitation Act is the centerpiece for the definition of the rights of disabled people in higher education and the integration imperative is central to Section 504."[13] Segregated service delivery systems tend to isolate disabled persons from the societal mainstream, putting them at a disadvantage for learning coping skills necessary to compete in education and employment on an equal basis with able-bodied individuals. A segregated, versus integrated, approach also hinders the reduction of a "handicapping" (a barrier introduced by environmental or societal condition) attitude by the nondisabled population. The thrust of Section 504 also is to normalize conditions allowing full participation by all students in all regular campus activities. University policies should be avoided if they extend beyond facilitating education, thus providing special treatment.

The Role of the Federal Government

The federal intervention into educational policymaking emanated from the idea that all citizens have a right to education. This precept is firmly established for those under legal age through court cases involving handicapped children. The Education for All Handicapped Children Act of 1975 (P.L. 94-142) dictated handicapped persons (ages 3 to 21) be provided a free appropriate public education in the most integrated setting possible. Although the right to higher education is not as firmly established as the right to basic education, court cases have set a precedent for equality in access to higher education.[14]

The federal government has become an increasingly strong voice in higher education within the last two decades. While institutions of higher education benefit from federal involvement through the availa-

bility of financial resources, such as funds for research grants and student loans, the federal government has progressively become involved in educational policy decisions. As institutions have become more dependent upon federal funds, funding has become increasingly contingent upon undertaking (or refraining from undertaking) "a whole array of actions which are required or forbidden by federal legislation."[25]

The wedge of withholding federal monies has been used to encourage social justice through legislation such as Section 504 of the Rehabilitation Act. Costs for complying with federal regulations and administering programs have skyrocketed within the last decade, placing a financial burden on colleges and universities.[21] While direct appropriation of federal funds to implement Section 504 are lacking, requiring institutions to provide program accessibility can hurt financially; for example, regulations indicate auxiliary aids must be provided if necessary for accessibility. A deaf school teacher, who was required to enroll in courses to update a teaching credential, exercised her rights by requesting that the college she was attending provide and pay for an interpreter.[11] The institution's refusal was based on cost—the tuition for the course was $210 while the cost to provide an interpreter was $528.*

The role of the federal government in relation to Section 504 is to ensure full implementation of the law. HEW Secretary Califano directed the Office of Civil Rights to monitor compliance. The HEATH (Higher Education and the Handicapped) project was created and grants were made under the auspices of this project to facilitate compliance.[4] The Architectural and Transportation Barriers Compliance Board plays a regulatory role by assuring federally funded facilities are accessible.

The State Viewpoint

Since Section 504 does not provide for federal funding, institutions turned to state legislatures for appropriations to effect program accessibility. The University of Missouri estimated the cost of structural changes at $10 million for its four campuses and intended to seek funds from the legislature.[11] The U.S. Department of Health, Education, and Welfare contends, based on cost benefit analysis, that money spent for equality of education for the handicapped "would be more than made up for by revenues gained and by savings on welfare benefits and lessening costs of special education programs that would be done away with in mainstreaming."[20] However, this position may be hard to sell to state legislators.

Some states have outlined goals encouraging enrollment of students with disabilities. The Master Plan for Higher Education in Connecticut recommends designation of a person to assist disabled students, a special media center, reduction of architectural and attitudinal barriers, low- or no-cost services (such as special parking), and an integration imperative.[6]

The Position of Colleges and Universities

Over the last decade some colleges and universities have made special efforts to provide equal educational experiences for handicapped individuals, but college admissions policies and procedures (or lack thereof) for accommodating students with special needs exemplified the general attitude of personnel in higher education. Mahan reported that in a survey of approximately 1,000 four-year colleges and universities, 18 percent rejected the blind, 27 percent refused admittance to students in wheelchairs, and 22 percent rejected deaf students. Although approximately 75 percent of the institutions would accept handicapped students, only about 25 percent provided special facilities and services.[16] Since Mahan's study, compliance with Section 504 has provided motivation for colleges and universities to examine their admissions policies.

Assuring equal opportunity can be complex. For example, admissions tests are required to be administered to disabled students in a manner avoiding unfair distortion of results. Winterbottom contended some disabled students may be able to take a test under substantially equivalent conditions but "there are many others for whom those conditions must be so extensively altered as to raise serious questions about comparability of resulting scores."[25]

Newman observed that higher education, on the whole, has had little or no experience with disabled students and has not faced the necessity to learn about their educational needs.[18] Section 504 has required colleges and universities to investigate methods of meeting educational needs of those unable to learn in the conventional manner. While estimated costs of modifications and the timetable for compliance have caused a feeling of pressure and panic among institutions, it may also have provided the necessary incentive to begin changes immediately after the regulations were signed into law. Transition plans emanating from the self-evaluation studies have given universities written policies and procedures to

*The U.S. District Court judge ruled in the teacher's favor. A higher court reversed the decision, granting a summary judgment that ended the college's duty to provide further interpreter services. The higher court never dealt with the problem based on Section 504: "The Court dealt finally with the plaintiff's claim that the college had violated the Rehabilitation Act of 1973. It refused to consider the merits of the claim because the plaintiff had failed to exhaust her administrative remedies. The court noted that regulations which provide administrative procedures have not been promulgated pursuant to Section 504 of the act."[1]

follow when accessibility problems arise. Potential problems involving disabled students can now be prevented, anticipated, examined in an orderly manner, and solved without undue confusion.

Three years have elapsed since Section 504 regulations went into effect. University communities are more aware of citizens with disabilities, but now is the time for university administrators, faculty members, staff, and students to examine whether campuses are minimally meeting Section 504 regulations or whether a conscious effort is being made to equalize opportunities and integrate persons with disabilities into the campus environment. The most comprehensive examination of services for college students with limiting conditions was made at a conference entitled "The Disabled Student on American Campuses: Services and the State of the Art." This group recommended practices related to establishing service programs, improving architectural accessibility, modifying attitudes of the campus community, financing, evaluating services, and achieving normalization.[17] The report should be required reading for every administrator who has responsibility for implementing Section 504.

College and university communities should view Section 504 as an opportunity for achieving equality in education, a principle to which educators are committed. Institutions of higher education can use the mandate as a way of applying pressure on governing boards and state legislatures to implement needed changes (a staff coordinator for handicapped student services is a necessity, not a frill). Structural changes on campuses, such as laboratory modifications, provide long-term architectural changes needed for achieving accessible educational programming. Meeting the special needs of students with limiting conditions can be challenging and educational for faculty and students; for example, attendant care programs can benefit disabled students, aspiring nursing and physical therapy students, and faculty members involved in health education.

The Student Viewpoint

The number of disabled students attending college has increased in the last decade, and the trend is likely to continue. In past years, approximately 9 percent of totally disabled persons have attended college as opposed to 30 percent of persons who are not disabled.[12] The low demand for higher education by persons with disabilities has been created by a number of conditions that are, it is hoped, being corrected. Past barriers include *1)* lack of accessible postsecondary institutions, *2)* unequal educational opportunities at the primary and secondary education levels (poor preparation for higher education), *3)* attitudes of educators and rehabilitation personnel, and *4)* lack of auxiliary aids facilitating learning.

Although it is too soon to observe results, many educators hope "mainstreaming" will adequately prepare disabled students for success in college. With improved preparation, more disabled students will "expect" to attend college rather than make a difficult decision concerning the issue. As educators have the opportunity to interact with an increasing number of students with disabilities, their attitudes can be channeled in a positive direction.[10]

College attendance is consistent with rehabilitation goals. From an economic standpoint, it is beneficial for the human services effort if handicapped persons are optimally trained to compete for many professional positions, emphasizing mental rather than physical ability.[16] Lonnquist studied employment records of disabled college graduates and dropouts and recommended, based on results, that "college academic potential should be given priority by rehabilitation counselors and severely disabled clients in the career planning process."[15]

The student with a disability interested in pursuing a college degree needs a higher motivation level than the nonhandicapped student. Architectural and attitudinal barriers can be overwhelming; the day-to-day occurrences accumulate until students with special needs question why they are enduring such inconveniences. Section 504 can provide some relief. Changes will not be made overnight, but institutions are now becoming more aware of barriers faced by handicapped students.

Simultaneously, disabled students should assume partial responsibility for successful implementation of the regulations. The college or university cannot require students to declare the nature and extent of disabilities, but such information may be useful in successful matriculation. If students inform the university of their disabilities at the time of admission, facilitating preparations can be made. Currently enrolled students can also play a role by informing administrators and staff of problems that are facing them, such as a shortage of parking places or discriminatory practices in the taking of tests.

The Realities

Seven years have passed since the Rehabilitation Act of 1973 was enacted; three years have elapsed since Section 504 regulations have been in force. As the dust settles, certain positions are emerging.

The Supreme Court, as well as lower courts, have begun to define the meaning of Section 504. The Davis v. Southeastern Community College case reaffirms that the intent of Section 504 is providing equal opportunity rather than affirmative action measures.

The decision should not adversely affect college students in nontechnical programs or those who creatively devise methods for meeting physical requirements. However, the decision is a warning to career counselors and students to realistically appraise career alternatives and to provide assistance to educators regarding modifications that will equalize educational experiences for disabled students.

The question of costs is still an issue. Buildings are gradually being modified, and needs are being met when they arise; but many problems still have inadequate solutions because of cost factors. Campus transportation often must be individually arranged between a two-campus university because regular buses are not accessible—a necessary but expensive transportation arrangement.

Section 504 has created attention toward handicapped students enrolled in university programs. Now is the time to capitalize on this initial focus and work toward creating an environment that reflects the spirit of the law. Rehabilitation professionals can assist in creating barrier-free colleges, particularly at institutions relatively unprepared to receive students with special needs. Campus personnel need assistance with architectural modifications (dormitory facilities), attitude change (staff in-service), classroom modifications (changes in instructors' teaching methods), and auxiliary aids (appropriate devices for recording lectures). Although it may be the responsibility of university personnel to elicit help from rehabilitation professionals, colleges/universities may not take the first step. The following fictitious, but plausible, examples are designed to stimulate creative problem solving as well as to encourage participation by all to ensure equal access to educational programs.

Example One. An instructor arranged a number of field study experiences for students majoring in child development. When a student using a wheelchair was sent for an orientation interview, she was refused the opportunity to volunteer in the facility. The student was told that she could not reach the second floor (even though classes were held on the first floor) and that she should try to gain experience elsewhere. The field study facility was not university property but did receive federal funds. What should be done?

Example Two. A number of students on a commuter campus were dependent on electric wheelchairs for campus mobility, but transportation arrangements for getting to and from campus precluded transporting the heavy electric wheelchairs. A storage facility was requested so students could leave the chairs on campus overnight. The facility provided was little larger than a closet, had only one electrical outlet (a necessity for charging batteries), and placement/removal of the chairs was difficult even for able-bodied persons. When the disabled students complained, however, they were told no other facility was available. What are alternatives?

Example Three. A student with cerebral palsy, majoring in journalism, was severely restricted in physical movements and communicated with a headstick. The curriculum for a journalism major required students to complete speech and photography courses and to demonstrate a minimum proficiency in typing. What auxiliary aids could be provided so the student would be able to participate in the courses? What would be feasible classroom assignments? Should any of the requirements be waived or substituted?

Example Four. A university department instituted a new requirement that all majors within the department register for and attend a special workshop before they could be eligible for student teaching assignments. Written notices of the change appeared in the campus newspaper and department newsletter. Posters were placed on all bulletin boards in the building. A blind student missed the workshop because he was not notified of the new requirement, and he was informed that he could not "student teach" during the next semester. What should be done? How could the situation have been avoided? How can all communications be extended to visually impaired students?

Example Five. Graduate Record Exam (GRE) scores were required for all students applying for graduate work within a particular school within the university. A student applying to this school had an undergraduate grade point average of 3.3 and excellent recommendations. The student had a neuromuscular condition that affected coordination and stamina. Completing the GRE would require special administration and twice the administration time (approximately six hours) as for other students. Should the GRE requirement be waived in this case? in all cases? What could be alternative requirements to the GRE? If the student takes the exam, is the score comparable with the norms?

These examples illustrate unique problems that can arise. Few disabled students will have the same limitations. One student may not be able to communicate verbally, another student may not be able to derive intended benefits from visuals, a third student may not be able to take notes. Institutions of higher education must continue to prepare for such challenges.

The creation of optimum college environments demands attention from university administrators, faculty, staff, and students, as well as from persons outside the university. The implementation of Section 504 must be a realistic and cooperative effort. Section 504 can be used to develop campus policies and services designed to facilitate and equalize education for

disabled students. The regulations do not provide for any special privileges, just the opportunity to receive the same educational services as the rest of the student body. The costs and responsibilities must be shared. Everyone from the student to the chancellor to the rehabilitation professional has a part to play in the successful implementation of Section 504. When we all share the costs, we will all share the benefits.

ACKNOWLEDGMENT

The author would like to thank Dr. Lois Schwab, Professor, Human Development and Family, University of Nebraska, for her assistance in writing this article.

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Independent Living Models

LEX FRIEDEN

Introduction

AN INDEPENDENT LIVING PROGRAM has been defined as a community based program having substantial consumer involvement that provides directly or coordinates indirectly through referral those services necessary to assist severely disabled individuals to increase self-determination and to minimize unnecessary dependence on others. Services provided or coordinated include housing, attendant care, readers and/or interpreters, and information about goods and services relevant to independent living. Other services that may either be provided or coordinated by an independent living program include transportation, peer counseling, advocacy or political action, independent living skills training, equipment maintenance and repair, and social or recreational services.[1]

Let us examine this definition more closely. There seem to be three major elements which constitute the substance of this definition. They are: community based, consumer involvement, and service provision. Community based implies that the programs are designed to serve the needs of a population in one particular community as opposed to a region, state, or nation. Community based as it applies to this definition also means that programs are rooted in the community which they serve to the extent that they are dependent upon the people and resources in that community for direction and subsistence. Consumer involvement implies that these programs depend upon people who receive their services, people who have in the past received services, or people who may at some time in the future receive services to provide leadership and assistance by serving on boards of directors, advisory committees, and by working as paid or volunteer staff persons in the program. Consumer involvement in this case insures that programs do not lose touch with the needs of their clients, and it means that they will maintain a sort of grass roots, down-to-earth character and richness. Service provision indicates that these programs are not simply social clubs or political action groups. They are in the business of enabling severely disabled people to live comparatively independent lives in their own communities by providing whatever services are necessary for this to happen. In many instances these services relate to basic needs like housing, transportation, and attendant care. However, in some cases these services relate to more career oriented goals like education and work.

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An expanded version of this article will be included as part of a forthcoming publication entitled Independent Living Service Centers, *to be published as an Institute on Rehabilitation Issues document by the Arkansas Rehabilitation Research and Training Center, Hot Springs, Ark., in December of this year.*

Research for this article was supported in part by the National Institute of Handicapped Research, U.S. Dept. of Health, Education, and Welfare, under grant #22P-59106/6-01. For further information or technical assistance related to independent living, contact the author at: Independent Living Research Utilization Project, Texas Institute for Rehabilitation and Research, 1333 Moursund, Houston, Tex. 77030.

In order to gain a better understanding of the possible structures and functions of independent living programs, let us look at three types of programs identified by the Independent Living Research Utilization (ILRU)* project in an extensive 1978 survey. After polling more than 450 programs that claimed to be providing services for independent living, ILRU iden-

[1]Frieden, Lex; Richards, Laurel; Cole, Jean; and Bailey, David. "A Glossary for Independent Living." ILRU Sourcebook: *A Technical Assistance Manual on Independent Living.* Houston, Tex.: TIRR (Institute for Rehabilitation and Research), 1979.

*ILRU is a federally funded independent living program technical assistance project. Located at the Texas Institute for Rehabilitation and Research (TIRR) in Houston, Texas, ILRU conducts research, training, and consultation, and produces written and audiovisual materials related to independent living of severely disabled people.

tified 35 programs that were actually community based, had substantial consumer involvement, and provided services to assist severely disabled people to increase self-determination and minimize unnecessary dependence on other people. Of those 35 programs, only 12 met the definition of an independent living center as originally characterized by the Center for Independent Living in Berkeley, California, as it is generally understood by the leaders in the independent living movement around the country, and as codified in California law. The definition of an independent living center in this strict sense is a nonresidential, community based, nonprofit program which is controlled by the disabled consumers it serves, and which provides services directly or coordinates indirectly through referral services those services that are designed to assist severely disabled individuals to increase personal self-determination and to minimize unnecessary dependence upon others.

The pure definition of an independent living center includes a description of a minimum set of services that must be provided by such a center. These are housing assistance, attendant care, readers and/or interpreters, peer counseling, financial and legal advocacy, and community awareness and barrier-removal programs. One can see that this definition is somewhat restrictive and certainly excludes programs of a residential or transitional nature that are generally considered to be part of the independent living movement. Therefore, the term "independent living program" evolved to include two other distinct types of programs. These are independent living residential programs and independent living transitional programs.*

An independent living residential program is a live-in program that provides directly or coordinates through referral shared attendant services and transportation. Other related services may also be provided by these programs. An independent living transitional program is one that facilitates the movement of severely disabled people from comparatively dependent living situations to comparatively independent living situations. The primary service provided by these programs is skill training in such areas as attendant management, financial management, consumer affairs, mobility, educational/vocational opportunities, medical needs, living arrangements, social skills, time management, functional skills, sexuality, and so forth. Transitional programs are usually goal oriented and/or time linked. It is important to keep in mind that both of these types of programs must also be community based, have substantial consumer involvement, and increase personal self-determination and minimize unnecessary dependence on others.

Thus, we have three types of independent living programs: centers, residential programs, and transitional programs. Each of these are similar to the extent that they are community based, have consumer involvement, and provide services designed to facilitate independent living by severely disabled people. However, each of them is different to the extent that they provide either ongoing or transitional services, that they are either residential or nonresidential, and that they are either controlled by consumers or merely provide opportunities for substantial consumer involvement. These fundamental differences between programs may seem somewhat subtle and unimportant to the uninitiated observer. But to those who understand the nuances of the independent living movement, these differences are extremely significant. In fact, debates related to the importance of these differences between independent living devotees often arouse emotions and lead to temperamental outbursts.

The differences are not difficult to explain. Some people believe that independent living programs must be directed by and controlled by consumers in order to be viable. Other people believe that consumer involvement on a lesser scale is sufficient. Some people believe that residential programs are institutional, segregated, and do not provide an opportunity for optimal normalization in the community. Other people believe that these programs are suitable alternatives to institutionalization for severely disabled people, that they are one step on a continuum of independence, and that they are not necessarily segregated. Some people believe that transitional programs are simply residential programs in disguise, that they are too much like traditional rehabilitation programs, and that they do little to insure the long-term support of severely disabled people in their communities. Other people believe that transitional programs are far different from residential programs in that they force participants to move into the community after a specified period of time or after the participants have met certain goals. They believe that transitional programs are much more cost effective than other sorts of independent living programs and that they enable severely disabled persons to live independently in their communities without the need for ongoing services other than those provided for the general population.

*The term *independent living program* used here is analogous to the term *independent living center* as described in Title VII of Public Law 95-602 (The Rehabilitation Act Amendment of 1978). *Independent living program* was chosen for use here because it is a generic term that subsumes several different types of programs, including one called a *center for independent living*. Since independent living center, as conceived in the early 1970's, has a very specific and somewhat limiting definition, it is understood that a broader definition like that of *independent living program* was intended by the fathers of the independent living legislation when they referred to *centers for independent living*.

These differences of opinion should not discourage the adoption of any one type of program, but they should lead to questions that may help determine which type of program is most appropriate to meet the needs of certain groups of severely disabled people in particular communities. It may be and in fact has been the case in some instances that all three types of programs are needed in a given community. Instead of competing with one another for prominence, these three types of programs should complement each other in a practical approach.

Variable Dimensions of Independent Living Programs

Besides the basic differences between programs described above, several other variable dimensions of programs can be identified. These dimensions may be useful in describing programs and in determining how those programs fit into any given community. The dimensions used by ILRU in its 1978 program survey and described by Pflueger in her monograph *Independent Living*[2] are: service setting, service delivery method, helping style, vocational emphasis, goal orientation, and disability type served. In addition to these, several other dimensions may be important. They are: program sponsor, management structure, geographical setting, and primary funding source.

Service setting relates to whether a program is residential or nonresidential, like a store-front operation. Service delivery method relates to whether services are provided directly by the program or indirectly through referral to other agencies. Helping style relates to the extent to which consumers are involved in the operation of the program. Vocational emphasis relates to whether or not vocational goals are prerequisites for participation in the program. Goal orientation relates to whether the program is transitional or ongoing. Disability types served relates to whether the program focuses on people with a particular type of severe disability or whether the program provides services for people with many different disability types. Program sponsor relates to whether the program is sponsored by an existing health service, social service, or rehabilitation service agency in the community, or whether it is a comparatively new and independent entity. Management structure relates to the amount of control that the board of directors of the organization has compared to the control maintained by the executive director, or to the power of the director compared to that of the staff. Geographical type relates to whether the program serves a primarily urban area with an extremely dense population, or whether the program serves a rural area with a comparatively scattered population. Primary funding source relates to whether the program is supported mostly by fees paid for services rendered or by grants and donations. It is important to recognize that these features are not exclusive and that they simply constitute dimensions across which programs may vary. Also, the descriptions given above for these dimensions are not complete, but they are sufficient to allow for constructive discussion. With this in mind, let us compare some of the existing independent living programs in the United States according to the definitions and dimensions listed above.

Existing Program Models

Although the Center for Independent Living in Berkeley, California, has most often been cited as the epitome of an independent living program, we have chosen here to examine two other lesser known programs with equally outstanding characteristics. To begin with, let us examine the Ann Arbor Center for Independent Living (CIL) in Michigan and the Community Service Center for the Disabled (CSCD) in San Diego, California.

Both the Ann Arbor CIL and CSCD are located in highly populated urban areas. They each serve over 500 clients per year drawn from all major disability types. They each report that their services are equally distributed among male and female clients and that they have at least a 25 percent representation of nonwhite persons among their clientele. Their staffs are each composed of more than 50 percent disabled persons and they each provide both professional and peer counseling services. Their primary services relate to advocacy, community consultation, and community education, although they both provide referral to housing, attendants, and transportation. Both programs utilize multiple funding sources—including federal, state, and foundation grants—as well as individual and group donations. They both depend on funding from state agencies as their primary source of income and their annual budgets both exceed $100,000. In spite of substantial funding, both programs list inadequate funding among their major problem areas. Both the Ann Arbor CIL and CSCD in San Diego are independent living centers in the truest sense of the word.

The ILRU project is presently in the process of updating its 1978 survey of independent living programs. Data obtained thus far seem to indicate that the number of independent living programs in the United States has nearly doubled during the two years since the original survey was done. There are now more than 20 programs in California alone. There are at least five programs each in Massachusetts and Texas, and at least three programs each in New

[2]Pflueger, Susan Stoddard. *Emerging Issues in Rehabilitation: Independent Living.* Washington, D.C.: Institute for Research Utilization, 1977.

York, Kansas, Michigan, and Washington. By far, most of the existing programs are located in urban areas. In fact, only three truly rural programs have been identified. In the past, many programs were located adjacent to university campuses. However, more of the newer programs seem to be locating away from campuses in order to better serve the community at large. Residential and nonresidential programs seem to be equally represented among existing programs. In fact, several programs provide comprehensive services in both residential and nonresidential settings.

It is clear that nonresidential programs serve more persons on an annual basis than residential programs. In fact, nonresidential programs average serving more than 500 persons per year, while residential programs average serving fewer than 50 persons annually. More than two-thirds of the existing programs serve persons with different types of disabilities. Of those serving a single disability type, spinal cord injury is the type most often served. There are twice as many independent living programs with an ongoing orientation as there are transitional programs. In fact, very few of the recently established programs are transitional. With respect to vocational emphasis, the programs are almost evenly divided. About half of them have a strong vocational focus while the other half have only an incidental focus on vocational issues.

About half of the existing programs have a staff consisting mainly of handicapped individuals, and the other half are staffed by a majority of nonhandicapped persons. It should be noted, however, that those programs which are not staffed mainly by handicapped people generally are directed or managed by handicapped individuals. Most of the programs provide both direct services and referrals to other agencies. A few of the older programs provide only direct services with no referrals. However, most of the recently organized programs place a tremendous emphasis on information and referral type services. This seems to reflect a growing concern for better utilization of existing services in the community. It also reflects a growing emphasis on advocacy, which leads to the expansion of existing social service and health service programs in the community to include severely disabled persons among their clientele.

The most frequently cited service delivered by existing independent living programs is residential service. The next most frequently cited primary services are peer counseling and independent living skills training. Other services frequently cited as primary are attendant care, advocacy, financial aid counseling, transportation, social and recreational activities, and mobility training. Most existing programs are recently organized, private, nonprofit entities that are governed by a corporate board of directors who in turn employ an executive director to manage day-to-day program activities. A few programs are affiliated with existing rehabilitation agencies, such as comprehensive rehabilitation centers, voluntary social service agencies like Goodwill and Easter Seals, and state vocational rehabilitation agencies. These programs are generally managed by a project director who is employed by the sponsoring agency and who reports to an advisory committee that includes strong consumer representation.

Almost half of the existing programs rely on four or more sources of income to support their programs. The older programs seem to rely more on direct or third party income for services rendered while the newer programs rely more on grants from federal, state, and local governments. Donations by individuals and corporations seem to be a secondary source of funding for most programs, and foundation grants are of incidental note at this point. Almost two-thirds of the existing programs depend on funds from state rehabilitation agencies as their primary source of support. Although nearly as many programs use federal funding as one source of income, very few of them depend on that as a primary source. About one-fourth of all existing programs have only one source of funding. On the other hand, nearly one-fourth of the programs utilize at least five sources of income and, with one exception, each of these programs serves more than 500 persons annually.

As one might suspect, most of the older programs—those established in or before 1976—are the biggest programs. Also, as one might suspect, the programs serving the most people generally have the largest budgets and serve the largest communities. In many respects, the older programs may be described by the adjective "multi." They are usually multiservice, multidisability, multifunded, multifocused, multidimensional, and multifaceted.

An Hypothetical Program Model

Information gathered about the successes and failures of existing programs may be useful in planning new programs. If one asked what kind of independent living program was best, the answer given by most experts in the area would be that it depends on the needs of disabled people in any given community, on the availability of existing community resources, on the physical and social makeup of the community, and on the goals of the program itself. Nonetheless, some generalities can be stated.

It appears without a doubt that judicious incorporation of the major tenets of the independent living movement lead to successful programming. That is, provisions must be made for the substantial involvement of consumers in program planning, manage-

ment, operation, and monitoring. Programs should be as community based as possible. The services that they provide should be directly related to the needs of the community they serve. They should directly provide a set of core services not available to disabled persons elsewhere in the community, and they should coordinate and provide referral to existing services in the community. They should provide a combination of ongoing and transitional services. These transitional services are generally called independent living skills training and may be provided in a temporary residential setting.

Programs should establish straightforward management policies modeled after other successful community based social service programs. They should maintain sound fiscal management and adopt effective accounting procedures. They should obtain consultation and assistance from existing programs and other sources of technical assistance, and they should establish built-in program evaluation and outcome evaluation methods. They should develop multiple sources of funding, and they should be accountable to both funding sources and their own clientele. They should develop strong supportive relationships with existing local and state rehabilitation agencies, as well as the private sector in their own communities. They should struggle to avoid compromising idealistic principles in the face of pragmatic concerns. Finally, they should strive to be inventive.

Future Trends

We have explored several different prototypic models of independent living, reviewed the major similarities and differences between programs, discussed some philosophical bases of the independent living movement, briefly examined a few existing programs, looked at the present status of independent living program development, and stated several generalities relating to program development and operation. At this point, we shall attempt to glimpse into the future by examining recent patterns and trends in the development of independent living programs.

It appears as though the present trend to establish new programs will continue for the next two to five years until each state has on the order of five to 30 independent living programs. This means that by 1985, there may be as many as 300 to 500 programs in the United States. Based on the fact that there are now about 65 active programs in the United States with budgets averaging about $100,000 per year each, it appears as though about $5.5 million is being spent on independent living programs today. About $2 million of this is from federal appropriations through Title VII. Furthermore, given the fact that 10 million additional dollars will be spent this year (FY 80) from Title VII appropriations, with most of this used to establish new programs, it is not beyond imagination that funding would be available in 1985 to support the anticipated 300 to 500 programs.

Again, judging by recent trends and the prevailing feelings of experts in the area of independent living, one may predict that future programs will emphasize consumer control, be community based, and avoid providing residential services. With additional funding, one may also predict the establishment of several programs in the same metropolitan area. These programs will be of several different types—some transitional, some ongoing. Also, they may focus on different primary disability types. For example, in a city with several programs, one program may provide services primarily for mentally retarded adults, another program may provide services primarily for mobility impaired individuals, and still another program may provide services primarily for persons with communication or visual disorders.

With a growing movement toward independent living by severely disabled people, there will be a greater demand for integrated barrier-free accommodations. More public attention and political clout will be focused on the elimination of work disincentives, the provision of barrier-free public transportation, and the provision of community wide attendant care, reader, and the interpreter referral programs.

With the rapid expansion and proliferation of independent living programs, more programs will fail due to overexpansion and mismanagement. It is possible that this will lead to an effort by the federal government to impose strict controls on independent living program funding, program standardization, or perhaps even licensing requirements. This rapid program development may also lead to the evolution of a type of independent living specialist or professional independent living program staff person. If these changes come to pass, the likelihood of institutionalization is inevitable, and the independent living movement will undoubtedly wind up a part of the nursing home establishment, the MHMR establishment, or something analogous to those.

In conclusion, let us look once more at the present state of development of independent living programs. Right now, in the United States, nearly 8,000 severely disabled people are living more independently than they were three years ago. These are persons who have been and are being served by independent living programs. At the present growth rate, by the year 1985 as many as half a million severely disabled people may be living comparatively independent lives, integrated throughout our communities as a result of services provided by independent living programs.

Special Report

Will the New Standard for Accessibility Curb the Proliferation of Design Requirements?

RITA McGAUGHEY

FOR SEVERAL DECADES NOW, considerable efforts have focused on the environmental barriers that handicap a growing number of persons from participating in the mainstream of their communities. The social and legislative changes that occurred as a result of these efforts are now legion. The Architectural Barriers Act passed by the Congress in 1968 was the first federal law that mandated accessibility in public buildings. The Architectural and Transportation Barriers Compliance Board (ATBCB), which was established under the 1973 Rehabilitation Act, serves as a monitoring force to the 1968 Law. A variety of other laws also testify to the public's acknowledgment that *all* citizens have rights to seek housing, education, and employment opportunities of their choices. In the private sector, the gains made in expanding a barrier-free environment can be measured in the growing demand for technical information from architects, builders, designers, and manufacturers. Awards formerly granted to those programs that alerted the public to the problems of inaccessibility are now reserved for actual models that incorporate accessibility features in the design of buildings and facilities.

Does all of this reflect the notion that we've eliminated the problem of inaccessibility by meeting the awareness challenge? Obviously the answer to that must be an emphatic *no*. As could be expected, the diverse efforts of the past decade resulted in the proliferation of a wide variety of design requirements that unfortunately left the architect and builder more bewildered than enlightened. It is one thing to learn what are the design requirements for making buildings accessible to persons with handicaps. It is something else again to cull through the vast array of provisions for accessibility that are encompassed in codes, laws, and regulations at every level of government.

Uniform design criteria for making buildings accessible to persons with handicaps was the prime aim of the project that resulted in the first Standard for Accessibility to be approved by the American National Standards Institute (ANSI) in 1961. The idea of developing an ANSI Standard originated two years earlier with the President's Committee on Employment of the Handicapped and the National Easter Seal Society. This professional tool, it was felt, would have more credibility among designers, legislators, and code administrators than any other type of privately developed or governmentally developed set of specifications. This credibility results primarily from the consensus process that is required for an ANSI Standard. In 1961 a consensus was reached on the first ballot from a Review Committee that was composed of some 50 representatives of the design, construction, and manufacturing industries, consumers, advocates, and regulatory agencies.

The need to expand the original ANSI A117.1 (1961) Standard became evident in the early 1970's when more and more housing programs were undertaken with public funds (the scope of the first standard covered public buildings only). Again a Review Committee of 54 representatives was established and research was initiated under a grant from the U.S. Department of Housing and Urban Development (HUD) to update and expand the 1961 standard. This time it took three ballots before reaching the consensus needed to gain the ANSI approval. The debates, confrontations, and compromises that characterized the three-year period of the ballot process give a vivid picture of the mounting interest, concern, and complexities surrounding issues related to making buildings accessible to persons with handicaps.

While the ANSI approval of A117.1 (1980) has given us a new "tool" for accessibility, its effectiveness cannot yet be measured until we look at how

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uniformly it will be applied by administrative bodies across the country. At the federal level, we have already seen new rulemaking procedures by federal agencies that could result in different versions of ANSI A117.1 (1980). To achieve some semblance of uniformity and consistency in these federal regulations, a set of minimum guidelines and requirements have been proposed by the Architectural and Transportation Barriers Compliance Board. A provision of the 1978 Amendment to the Rehabilitation Act authorizes the ATBCB to develop the guidelines for use by the four standard-setting agencies: General Services Administration, Postal Service, Department of Defense, and HUD. With few exceptions the technical specifications contained in the ATBCB's guidelines parallel those of ANSI A117.1 (1980). The guidelines actually take the ANSI specifications a step further by defining the quotas that are required by these regulatory agencies when applying the design requirements in federally funded buildings and facilities.

The task of specifying quotas for these requirements was purposely left up to administrative authorities by the developers of ANSI A117.1 (1980). Limiting the scope of the ANSI Standard to the "how-to" approach was deemed appropriate since local situations (including political pressures and other forces) are unique to each administrative authority. A considerable task has therefore been left up to these authorities when adopting the standard in codes, laws, and regulations.

Debates over this distinction between a standard and a regulation underscored most of the opposition to early drafts of the ANSI Standard. The language contained in the final standard that was approved by ANSI early this year reflects the compromise that was reached.

For example, although the installation of "at least one" accessibility feature of a particular type is all that's called for in the ANSI Standard, an accompanying provision recommends a "reasonable number" of that item. It is left to administrative authorities to specify these reasonable numbers or to establish a procedure for determining them based upon such factors as: *1)* population to be served, *2)* availability to occupants, employers, customers and visitors, *3)* distances and time required to use the accessible elements, and *4)* provisions of equal opportunity and treatment under law.

Chairman of the ANSI Secretariat for A117.1 (1980), Timothy J. Nugent, was more specific in the recommendations he made on behalf of the Secretariat to the ATBCB. The Secretariat recommends that an administrative authority compile a supplement separate from ANSI A117.1 (1980) giving specific applications, quotas, and numbers when developing their regulations for accessibility. This recommendation is based upon the need to preserve the integrity of the standard by separating numerical requirements from the technical "how-to" information contained in ANSI A117.1 (1980).

An unexpected boost to the efforts to gain uniformity in design criteria came through the Office of Management and Budget (OMB) early in 1980. In a memo from OMB Director, James T. McIntyre, executive directors of the U.S. governmental agencies were advised that "voluntary standards that serve the agencies' purposes and are consistent with applicable laws and regulations should be adopted, in whole or in part, and used by federal agencies in the interests of greater economy and efficiency."

The economics of making buildings accessible to persons with handicaps is directly related to how consistently the new ANSI Standard is applied in new construction as well as the remodeling of existing structures. It is also a prime force in motivating industry to come up with the new building technology that can make barrier-free design the norm for the entire built environment. Uniformity in design criteria for accessibility was the number one recommendation that came from the representatives of business and industry who participated in a 1979 series of Conferences on Corporate Response to Accessibility conducted by the National Easter Seal Society for the Architectural and Transportation Barriers Compliance Board. On the whole, the attitude of business as reflected at the conferences indicated a wait-and-see attitude. Plainly, industry needs to be convinced that regulations can reach a level of consistency and uniformity before it can be persuaded to make the retooling investments needed for the new technology called for in barrier-free design.

As a follow-up to the 1979 Conferences on Corporate Response to Accessibility, the National Easter Seal Society is currently sponsoring a Traveling Show Project that is reaching code officials, designers, and others at their own meetings to save them travel, time, and money. Designed to promote and interpret the new ANSI Standard for Accessibility, the traveling show is reaching such groups as the National Conference on State Building Codes and Standards, National Fire Protection Association, Building Owners and Managers Association, Southern Building Code Conferences, American Physical Therapy Association, National League of Cities, Doors and Hardware Institute, American Library Association, and the American Society of Landscape Architects. The project is already showing results. The Board for the Coordination of Model Codes (BCMC), established under the Council of American Building Officials, will consider the issue of uniformity in accessibility provisions at its 1980 summer meeting in Colorado. This endorse-

ment from BCMC is expected to carry considerable weight in influencing the major model codes of this country to adopt uniform provisions for making buildings and facilities accessible to persons with handicaps.

The thrust for uniformity in design criteria for making buildings accessible to persons with handicaps is especially timely when viewed from the spectrum of the growing number of regulations that affect the built environment. It wasn't long ago that no less than 44 agencies claimed to have standards development authorities in setting criteria for energy conservation (under the recently developed Department of Energy, these have all been consolidated). The movement to coordinate building codes is another example of a response to conflict arising from the proliferation of regulations.

Reactions to the public notices by those federal agencies proposing separate standards for accessibility signal the support for a uniform design requirement as defined in ANSI A117.1. Again, we will wait and see.

Design for Accessibility, the program session sponsored by the National Easter Seal Society, addresses the environmental needs of persons with disabling conditions and resources for serving these needs. The program gives special emphasis to the national standard for designing accessible buildings and facilities. The standard, ANSI A117.1(1980), covers all basic elements of the built environment from site development through internal building circulation and includes criteria for accessible dwelling units.

In addition to seeking widespread acceptance of the standard, the program aims at gaining uniformity in its interpretation and application. Achieving uniformity in design criteria is essential for eliminating the barriers that now prevent millions of persons from participating in the mainstream of their communities.

The following organizations have scheduled ***Design for Accessibility*** in their 1980 convention programs:

Association of Physical Plant Administrators (Southeastern Region)	Oct. 13	Raleigh, N.C.
Association of Physical Plant Administrators (Central States Region)	Oct. 18	Little Rock, Ark.
National Recreation and Park Association	Oct. 19	Phoenix, Ariz.
Southern Building Code Congress	Oct. 27	Memphis, Tenn.
504 Technical Assistance Conference	Oct. 30	Baltimore, Md.
National Association of Realtors	Nov. 6-8	Anaheim, Calif.
American Society of Landscape Architects	Nov. 24	Denver, Colo.
Association of Student Chapters American Institute of Architects	Nov. 28	Philadelphia, Pa.
National League of Cities	Dec. 2	Atlanta, Ga.
Building Owners and Managers Association	Dec. 6	Washington, D.C.
National Conference of State Legislatures	Dec. 17	Washington, D.C.
National Association of Housing and Redevelopment	Dec. 9	New Orleans, La.

Cleft Type, Age, and Sex Differences in Teen-Agers' Ratings of Their Own Behavior, Self-Esteem, and Attitude Toward Clefting

PHILIP STARR, ACSW

Problem

THERE IS A GROWING RECOGNITION that adolescence can no longer be viewed as a homogeneous age period.[3] Simmons, Rosenberg, and Rosenberg[6] reported that early adolescents had greater fluctuations in their self-image ratings than did older adolescents. Clifford and Brantley[2] reported that older subjects (15 to 20 years) had significantly higher scores on measures of parental pride than younger adolescents (11 to 14 years).

Furthermore, Clifford and Brantley[2] reported significant sex differences in the self-ratings by adolescents; females had more positive scores on parental emotion (perception of parental feelings) and lower scores on parental apprehension (parental concern) than males. Richman[5] reported on the teachers' ratings of the behavior of teen-agers. Sex differences were noted with males rated as displaying more conduct disorders (aggression) than females. Within the patient group, Richman reported that males received significantly lower composite achievement scores than did the females.

On behavior and achievement measures, Richman[5] also reported that there were no significant differences between the teen-agers with cleft lip and palate (CLP) and teen-agers with cleft palate only (CPO). Starr[8] reported similar findings in his study of teen-agers' ratings of themselves.

Therefore, the purpose of this study was to assess how the variables of age, sex, and cleft type are associated with teen-agers' ratings of their own behavior, self-esteem, and attitude toward clefting. Furthermore, it was to assess what interactions, if any, exist between these variables and the teen-agers' self-ratings.

Sample and Data Collection

The sample consisted of 94 teen-agers who were patients at the H. K. Cooper Institute in Lancaster, Pa. There were 54 (40 males and 14 females) with CLP and 40 (21 males and 19 females) with CPO.

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The data were collected at the time of the teen-agers' regular clinic appointments. The measuring instruments employed were the Missouri Children's Behavior Checklist, a Self-Esteem Scale, and an Attitude Toward Clefting Scale. The Missouri Children's Behavior Checklist, developed by Sines and others,[7] is a set of 70 descriptions of children's behavior rated on a "Yes" or "No" basis. Each item refers to a concrete behavioral situation and does not call for subjective judgments about behavior. The completion of the Checklist results in six summed scores in the areas of aggression, sociability, inhibition, activity level, somatization, and sleep disturbance.

The Self-Esteem Scale, developed by Simmons, Rosenberg, and Rosenberg,[6] is a six-item scale that assesses the subject's general overall feeling toward

About the Article . . .

A STUDY was undertaken of the behavior, self-esteem, and attitude toward clefting of 94 teen-agers who were patients at the H. K. Cooper Institute. The measuring instruments employed consisted of the Missouri Children's Behavior Checklist, Self-Esteem Scale, and the Attitude Toward Clefting Scale. The results indicated that there were no statistically significant differences by the cleft types for the three measures. The younger (13 and 14) teen-agers were more aggressive, more active, and had more somatic complaints than did the older (15 to 18) teen-agers. The only difference between the males and the females was that the males were more aggressive. Implications of these findings are presented.

self. On each item, the participants indicate whether they have had feelings similar to those described. Each response is scored as either favorable or unfavorable; the scoring range for the scale is from zero to six with the higher score indicating a more favorable self-esteem.

The Attitude Toward Clefting Scale is a modification of the Acceptance of Disability Scale developed by Linkowski.[4] We modified this 50-item inventory for patients with cleft lip and/or palate (CL/P) by substituting the term *cleft condition* for the more generalized concept of disability used by Linkowski. Each item has a six point Likert-type response of agreement - disagreement. The score for each teen-ager's attitude toward clefting could range from 50 to 300. The higher the subject's score, the more accepting the teen-ager was of his or her cleft condition.

Results

The first data comparison was between the teen-agers with CLP and those with CPO. There were no statistically significant differences between the two groups on the three measures employed in this study.

The second data analysis compared the 50 subjects who were 13 and 14 years old with the 40 subjects who were between 15 and 18 years of age. The findings presented in Table I indicate that the older subjects rated themselves as significantly less aggressive, less active, and having less somatic complaints than did the younger subjects. The findings for patients with CPO (13 and 14 versus 15 to 18) were the same as those for all the subjects. Whereas, the findings for patients with CLP indicated that the older subjects rated themselves as having significantly higher attitude toward clefting and lower activity than younger subjects with this cleft type.

The third data analysis compared the 61 male subjects with the 33 female subjects. The only significant difference was that males rated themselves as more aggressive than females. The findings for patients with CLP (males versus females) were the same as those for all the subjects. The findings for patients with CPO indicated that there were no sex differences.

The fourth data analysis examined the interaction between age and cleft type. For the patients with CPO, the 18 older patients rated themselves as significantly less aggressive, less active, and having less somatic complaints than the 22 younger subjects. These findings are the same as for all the patients. For the patients with CLP, the 26 older patients rated themselves as having a higher attitude toward clefting and being less active than the 28 younger patients with CLP.

The fifth comparison examined the interaction between sex and cleft type. For the patients with CLP, the only difference was that the 40 males were more aggressive than the 14 females. For the patients with CPO there were no statistically significant differences between the 21 males and the 19 females.

The sixth comparison examined the interaction between age and sex. For the male patients, the 31 older males rated themselves as less aggressive, less inhibited, and less active in relation to the 30 younger males. For the female patients, the 13 older females rated themselves as being less aggressive than the 30 younger females.

Data analysis of the interaction of age, sex, and cleft type was not undertaken. The reason was that

TABLE I—*Age Differences in Teen-agers' Ratings of Their Behavior, Self-Esteem, and Attitude Toward Clefting*

	CL/P				*CPO*				*Total*			
	13 & 14 N=28		*15 to 18 N=26*		*13 & 14 N=22*		*15 to 18 N=18*		*13 & 14 N=50*		*15 to 18 N=44*	
Variables	$\bar{x}$	σ	$\bar{x}$	σ	$\bar{x}$	σ	$\bar{x}$	σ	$\bar{x}$	σ	$\bar{x}$	σ
1. Aggression	7.1	4.0	5.8	3.4	8.7	3.4	5.1	3.7**	7.8	3.8	5.5	3.6**
2. Inhibition	4.6	2.5	3.9	2.8	5.1	2.5	4.1	2.2	4.8	2.5	4.0	2.6
3. Somatization	2.6	1.4	2.6	1.9	3.4	1.9	1.8	1.1***	3.0	1.7	2.3	1.7*
4. Sociability	7.3	1.6	7.3	1.6	7.0	1.6	7.6	1.1	7.2	1.6	7.4	1.5
5. Activity Level	5.4	1.8	4.4	1.5*	5.4	2.1	3.6	1.6**	5.4	2.0	4.1	1.6***
6. Sleep Disturbance	2.5	1.4	2.6	1.9	2.8	1.8	2.6	1.5	2.6	1.6	2.6	1.8
7. Self-Esteem	2.8	1.7	3.2	1.6	2.8	1.8	3.7	1.3	2.8	1.7	3.4	1.5
8. Attitude Toward Clefting	228.2	34.0	249.6	30.3**	247.1	31.9	251.7	27.5	236.5	32.5	252.7	29.3

*Significant at .05 level
**Significant at .01 level
***Significant at .001 level

the sample size became so small that data analysis was not feasible.[1]

Implications

The first implication of these results is that no significant relationship between cleft type *per se* and self-esteem, behavioral functioning, or attitude toward clefting was found. This finding supports the premise that a physical anomaly *per se* is not a factor in explaining how a teen-ager rates his or her behavior, self-esteem, or attitude toward clefting.

The second implication of these results is that adolescence is not a homogeneous age period. Our findings support the premise that early adolescence (13 and 14 years) is different from late adolescence (15 to 18 years). The early teen-agers were significantly more aggressive, more active, and had more somatic complaints than the older teen-agers.

The final implication is that the sex differences for teen-agers with CL/P were similar to that of the general population. Males rate themselves as being more aggressive than females.[9]

Of the three variables studied, age was the most potent variable in differentiating between segments of the teen-age sample. Therefore, from a rehabilitative perspective, patients in their early teen years should be singled out for special attention.

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Special Report

The Sheltered Workshop As a Community Recycling Center

MICHAEL D. WESOLOWSKI, Ph.D., and GERALD L. BACZA, Ed.D.

MANY SHELTERED WORKSHOPS do not provide actual work. Sheltered workshops often exist to provide a place for handicapped individuals to spend their day engaging in arts and crafts activities that are unsalable. Many sheltered workshops have greenhouses that grow and sell plants and herbs for little more than it costs to buy seed. Most workshops do business on a contract by contract basis where a contract is awarded to the workshop to produce a product for a limited period of time. When a contract of this type is awarded to a workshop, most of the workers are pulled from their regular jobs to work on the contract until it is finished. This is an extremely inefficient way to run a business and a haphazard means of providing training to sheltered workers. Brown, Wright, and Hitchings* have provided some helpful guidelines for sheltered workshops when procuring work contracts.

Those sheltered workshops administered by persons possessing sufficient skills in marketing and business administration to run a workshop in a lucrative manner are fortunate. One of the basic rules of marketing is that a business must produce a product that the public will buy and not produce a product and hope that the public will buy it. This necessitates the need for research into market areas prior to manufacturing a product or providing a service. Typically, the administrator must make a choice as to whether to run a lucrative business or to provide education and training to the workers with state and federal subsidies. Rarely are the two functions done simultaneously. Ideally, the production of a product or service by sheltered workers would also provide training for workers.

The need exists for an everpresent, readily accessible market for the services of a sheltered workshop. This type of market for services could be obtained through waste recycling. Recyclable wastes such as paper, metal, and glass are always available, and waste recycling could provide a marketable service for sheltered workshop employees while providing useful training. These services would make the community more aware of the sheltered workshop as a viable community resource. Recycling endeavors of sheltered workshops would necessitate the workshop becoming intricately related to the community in that all wastes must be obtained from and sold to the community where the workshop exists. This would seem to make the community aware of the workshop as a community resource. Even sheltered workshops that have contracted to provide services or manufactured goods at a sizable profit could benefit from providing recycling services by involving the community in these endeavors.

The present study attempted to investigate the extent to which sheltered workshops in the United States are engaged in recycling, the amount of profit accrued to recycling, the types of materials most frequently recycled, and the market values of various recyclable materials in different regions.

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Preparation of this paper was supported by the Rehabilitation Services Administration through the West Virginia Rehabilitation Research and Training Center.
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Participants

The Wage and Hour Division of the U.S. Department of Labor supplied a list of 3,057 rehabilitation workshops in 41 states and the District of Columbia.

*Brown, L. F.; Wright, E.; and Hitchings, W. Guidelines for Procuring Work Contracts for Sheltered Workshop Clients. *Career Development for Exceptional Individuals.* 1978. 1:88-96.

About the Article . . .

SHELTERED WORKSHOPS need an everpresent, readily accessible market for their services. Waste recycling would appear to provide such a market for sheltered workers' services as well as promoting community involvement and awareness. The present study surveyed 3,057 sheltered workshops in 41 states and the District of Columbia in an attempt to find out approximately how many workshops are engaged in recycling activities, profits gained through recycling, the types of materials recycled, and the market values of various recyclable materials in different regions of the country. Results showed that 307 of the workshops responding did recycling. Some showed profits, some incurred losses, but all said that recycling served as an excellent source of training for sheltered workers.

Of the 3,057 questionnaires sent out, responses were obtained from 788 (25.8%) of the workshops.

Method

Questionnaire

A cover letter explaining the purpose of the survey accompanied each questionnaire. The questionnaire asked questions primarily concerned with profits from recycling, materials recycled, and methods used to collect and process materials. Follow-up letters to prompt returns were not used; however, any returns giving unusual or unclear answers were followed-up by phone calls.

Results

Of the 788 total responses received, 307 sheltered workshops indicated that they did recycling. Each material (paper, metal, and glass) was analyzed for a mean selling price, a range, and standard deviation. A list was compiled of the other unique items that sheltered workshops recycled.

Analysis of Sheltered Workshops Recycling Paper

Of the total 307 sheltered workshops reporting that they recycled, 157 indicated they recycled paper. Of this 157, a mean selling price for paper to be recycled was $2.23 per 100 pounds. There was a standard deviation of 4.82 and a range of 0 for a low to $45.00 per 100 pounds for a high. The high price of $45.00 for 100 pounds of paper was for computer paper.

Sheltered Workshops Recycling Metal

Of the total 307 sheltered workshops recycling, 127 indicated that they were recycling some sort of metal. A total of 10 different kinds of metal were recycled. A summary of the number of workshops recycling each metal, the mean selling price per 100 pounds, the standard deviation, and range of prices are listed in Table I.

Sheltered Workshops Recycling Glass

Of the total 307 sheltered workshops recycling, only 35 indicated that they did recycling of this material. This low number might reflect the danger involved in handling glass. It must be sorted by color and crushed before many companies will buy the glass. A mean selling price of $1.06 per 100 pounds was reported with a standard deviation of 1.15. A range for glass resale was 0 for a low and $5.00 per 100 pounds for a high price.

TABLE I—*Metals Recycled by Sheltered Workshops*

Type of Metal	*# of Workshops Recycling*	*Mean Price per 100 lbs.*	*Standard Deviation*	*Range Low/High*
1 Steel	31	$ 2.00	4.10	00/20.00
2 Aluminum	76	8.06	8.43	00/25.00
3 Copper	23	12.17	16.23	00/50.00
4 Brass	14	12.54	14.31	00/40.00
5 Tin	10	2.10	4.92	00/16.00
6 Gold	2	No Profit	—	—
7 Silver	2	30.00	—	—
8 Bimetal	6	.69	.46	.10/1.38
9 Bronze	1	.00	—	—
10 Zinc	3	7.67	9.29	.01/18.00

Sheltered Workshops Recycling Other Materials

Many workshops indicated other materials that were recycled besides paper, metal, and glass. Many cotton and fiber materials were recycled throughout the southern portion of the United States. Recycling corrugated cardboard and computer cards realized a profit for many sheltered workshops. Also, some workshops recycled rubber through tires and other products. The following list shows some of the other interesting items recycled:

—plastics
—clothing
—lumber
—electrical meters and appliances
—kaowool
—yarn and thread
—furniture
—wreath easels
—pallets
—thread cones
—pop cartons
—batteries
—telephone parts
—mardi gras beads
—coat hangers
—bicycles
—bailer twine
—plastic gloves
—nuts and bolts
—paper clips
—steel drums
—skids
—foam rubber
—polyester
—beer cases
—printing plates
—photographic chemicals
—sawdust
—fluorescent lamps

Copy of Report Requested

Of the total 307 responding "yes" to the recycling question, 277 indicated they wanted a copy of the final report. Along with the 373 requesting a copy of the report from the "no" responses, this yields a total of 650 workshops requesting a report from 788 responses. This is 82 percent of the total respondents requesting more information about recycling. The results of this study should provide added insight into the area of recycling for sheltered workshops.

Individual State Analysis

Further data analysis was done on an individual state basis. These data were analyzed to see if some regions of the United States or individual states recycled certain materials over others.

The best geographical area for recycling activity occurred around the Great Lakes. The states of Minnesota, Michigan, Illinois, Indiana, and Ohio did recycling with paper, metal, and glass. The Great Lakes might be used as a means of transportation for these materials. Michigan has a mandatory deposit on all beverage containers of soda and beer. This deposit has reduced this kind of litter but has raised storage problems for the local businessmen who have to return money for the containers to the customers.

The southern states do more recycling of textile materials than the northern states. This recycling effort could be influenced by the cotton crops and local textile industries.

Discussion

This study surveyed 3,057 sheltered workshops in 41 states and the District of Columbia as to their waste recycling activities; 788 (25.8%) of the workshops responded to the survey. Of these respondents, 307 workshops indicated that they were engaged in some waste recycling.

Paper was recycled in 157 workshops with an average selling price of $2.23 per 100 pounds and a range of 0 to $45.00 per 100 pounds. The large fluctuations in the prices are due to the fact that many types of paper are recycled, including computer paper, newsprint, and cardboard. Also, paper products are used for insulation material where there is a large seasonal and geographic difference in market value.

Metal was recycled by 127 workshops with 10 different metals being recycled. The average selling price depended on the type of metal with bimetals yielding the lowest price ($.69/100 lbs.) and silver giving the highest price ($30.00/100 lbs.).

Glass was recycled by 35 workshops with an average market value of $1.06 per 100 lbs. and a range of 0 to $5.00 per 100 lbs. The fact that glass must be sorted by color and crushed before it is sold make it a precarious and possibly harmful material for many sheltered workers to handle.

Numerous materials other than paper, metals, and glass were found to be recycled by workshops. Of these materials, corrugated cardboard, computer cards, and tires appeared most prevalent and profitable.

Whether or not a workshop gained a profit as a result of its waste recycling activities, all workshops that did recycling reported that recycling provided good training for their clients. Although several workshops have made a very lucrative business through recycling and have received great amounts of publicity, others say that they have lost thousands of dollars. One workshop reported that after contracting with Reynold's Aluminum to recycle aluminum cans, its storage bins began to collect garbage and rats. This workshop had to call the local junk dealer to haul away the cans and then clear out the rats. In spite of its accrued rodent problem, this workshop contended that the recycling project may have succeeded if better planning and "leadership" could have been obtained.

With emphasis on conservation of energy, it would appear that recycling would be a good business venture. However, as with any business, planning is essential to the success of a recycling operation. Since it takes a great volume of any material for recycling to make money, a business has to plan to collect, store,

process, and ship tremendous quantities of materials. Publicity is crucial to make the community aware of a recycling center if such volume is to be obtained.

The authors found that some regions had bimetal cans while other areas had all aluminum cans. It would be profitable to recycle soda and beer cans if the cans distributed in that region were aluminum and sell for an average of $8.06/100 lbs. or about 1¢ per can, as opposed to an area that distributed bimetal cans worth an average of $.69/100 lbs. No reasons could be found for using these different metal cans in different regions of the country. In addition, when recycling aluminum, one should consider that aluminum siding could add sharply to the poundage. Sheltered workshops could contract with local construction and aluminum siding companies to recycle scrap aluminum.

It was also advised by several workshops that one of the first steps in developing any recycling effort is to contract all local businesses to assess the need to recycle any material, or how these businesses could benefit from a recycling program.

Overall, the authors found that aluminum, corrugated cardboard, and tires were probably the most profitable materials to recycle. Of course, as stated previously, a location where bimetal cans are distributed could be deleterious to aluminum recycling. Also, the workshop should be near a place to sell the materials, otherwise shipping cost might diminish profits. Any sheltered workshop considering a program in recycling should look closely at market values, material availability, transportation, and storage costs.

The authors wish to thank Art Rorn of the Wage and Hour Division of the U.S. Department of Labor for his help, and R. T. Walls for his support and encouragement. Appreciation is also due to G. Rutter of the Indiana County Recycling Center and J. DeJohn of Owens Illinois Glass Company for information.

Survey on Sheltered Workshop Recycling Efforts

_____ Yes _____ No 1. Are you doing any recycling?

_____ Yes _____ No 2. Do you recycle paper?
What profits can be expected per 100 lbs.?
_____

_____ Yes _____ No 3. Do you recycle metal?
What kind? _____
What are your profits per 100 lbs. for each metal?
_____
_____

_____ Yes _____ No 4. Do you recycle glass?
What profits can be expected per 100 lbs.?
_____

_____ Yes _____ No 5. Do you recycle anything else?
If yes, what? _____
_____

6. Please comment on the system you use to pick-up, process, and deliver your materials _____
_____
_____

_____ Yes _____ No 7. Do you want a copy of the final report?

_____ Yes _____ No 8. Overall, are you satisfied with your recycling program? How? _____
_____

EVENTS AND COMMENTS—
Continued from inside front cover

Directory of Federal Programs for the Elderly Now Available

THE 1980 *Chartbook of Federal Programs in Aging* is an annotated directory of 164 federal programs relating to aging research, training, and services. It points out the interrelationship of one federal agency to another and provides guidance on what kinds of projects are most likely to be funded by the Administration. Three main sections of the directory support the main body of 164 program charts in 23 major agencies: *1)* departmental and functional indexes of major and related federal programs, *2)* a listing of about 200 related programs that were not included in the charts because they are either indirectly related to aging or funding ceased for that particular program, and *3)* appendixes that include additional federal agency and congressional contacts, selected national clearinghouses, federal libraries, regional office contacts, summaries of Office of Management and Budget circulars, lists of Administration on Aging and National Institutes of Health grant and contract categories, state units on aging, and HUD field offices. The *Chartbook* costs $19, prepaid, and may be obtained by contacting 1980 Chartbook, Care Reports, Inc., 4865 Cordell Ave., Washington, D.C. 20014; tel. (301) 986-1607.

Information on Elderly Assistance Programs Sought

THE INSTITUTE ON AGING at Portland State University is seeking information on programs designed to assist older people who have recently experienced stressful events, such as widowhood, forced relocation, criminal victimization, and so forth. Of particular interest are programs that are especially innovative or effective. Also sought are assistance efforts that are more informal and possibly unfunded. It is likely that many innovative and effective programs are unknown nationally. The Institute on Aging hopes to identify these programs so that they can serve as models for implementation in other areas. Persons knowing of such programs or who would like details about the project, please contact Richard Schulz at the Institute on Aging, Portland State University, P.O. Box 751, Portland, Ore. 97207; tel. (503) 229-3801.

Change of Address

EFFECTIVE in June of this year, the American Alliance for Health, Physical Education, Recreation, and Dance (AAHPERD) will be headquartered at 1900 Association Drive, Reston, Va. 22091; tel. (703) 476-3400. AAHPERD's former address was: 1201 16th St., N.W., Washington, D.C. 20036.

Directory of National Information Providers Is Revised

THE SECOND EDITION of the *Directory of National Information Sources on Handicapping Conditions and Related Sources* has been compiled by the Clearinghouse on the Handicapped, U.S. Office for Handicapped Individuals. This directory documents at the national level major information sources existing for handicapped persons and those working on their behalf. Abstracts on 285 information and direct service providers (advocacy, consumer, voluntary health organizations) are presented and grouped into various categories, including: blindness/visual impairment, camping, career counseling, cerebral palsy, cleft palate, clothing, deaf-blind, deafness/hearing disorders, developmental disabilities, education, employment, equipment and aids, independent living, learning disabilities, legislation, mental retardation, neurological disorders, prosthetics, recreation, rehabilitation engineering, rehabilitation facilities, research, severely disabled, sex education, sheltered workshops, spinal cord injury, statistics, therapies, transportation and travel, and vocational education and counseling. Further information on this document *(DHEW Pubn. No. OHDS 80-22007)* may be obtained from the Clearinghouse on the Handicapped, Office for Handicapped Individuals, Special Education and Rehabilitation Services, Washington, D.C. 20201; tel. (202) 245-1961.

Learning Disabled Adults Form National Network

ORGANIZED AND FORMED at the annual meeting of the President's Committee on Employment of the Handicapped this past May, the National Network of Learning Disabled Adults (NNLDA) plans to strengthen communication among learning disabled people. Goals include keeping learning disabled adults apprised of new developments and opportunities and creating a greater awareness of their needs. It is the intention of the Network to bring learning disabled adults together in their home communities to share common problems and solutions. Further information may be obtained by contacting NNLDA, P.O. Box 541, Tulsa, Okla. 74112.

Cancer Rehabilitation Forum Planned for November

A NATIONAL FORUM on "Comprehensive Cancer Rehabilitation and Its Vocational Implications" will convene Nov. 13-15, 1980, in Williamsburg, Va. Sponsored by the Virginia Department of Rehabilitative Services and the Department of Continuing Medical Education and Cancer Rehabilitation Program of the Medical College of Virginia, Virginia Commonwealth University, the 2½-day conference is designed to provide access to multidisciplinary discussion and dissemination of information concerning current problems and issues in the rehabilitation of individuals with cancer-related disabilities. Special emphasis will be placed on conditions that influence employability, including advances in medical treatment, psychosocial effects of catastrophic illness, the assessment of vocational potential, and barriers to employment. Participants will review topics pertinent to the comprehensive rehabilitation of the person with cancer, be introduced to current rehabilitation models, determine the applicability of the individual rehabilitation models to specific organizational situations, identify policy limitations and attitudinal constraints that affect vocational rehabilitation, and generate ideas for new and more effective rehabilitation methods. The forum is limited to 175 persons and a balance among disciplines will be maintained. Further information on the program and registration may be obtained by contacting Kathy E. Johnson, Continuing Medical Education, MCV Station, Box 48, Richmond, Va. 23298; tel. (804) 786-0494.

Seminar To Examine Disabled As Volunteers

THE PENNSYLVANIA Easter Seal Society will conduct a general training seminar, Sept. 18, 1980 for volunteer coordinators at the Sheraton Valley Forge, Valley Forge, Pa. This seminar, aimed at using disabled persons as volunteers, will be presented in cooperation with the Pennsylvania State University, College of Human Development, and the Community College of Allegheny County. Using the theme, "The Untapped Resource," the sessions will familiarize volunteer coordinators with the competencies and abilities of disabled persons so that they can be given volunteer opportunities in organizations. The coordinators will be given ideas on how to update skills in recruiting, interviewing, placement, and program planning to meet the needs of disabled volunteers and to identify community resources for recruiting and information on accommodation techniques. The faculty will include: Winifred L. Brown, administrative director, and Joan Simon, associate director, Mayor's Voluntary Action Center of New York City; Harriet Naylor, director, Volunteer Development, Department of Health and Human Services, Washington, D.C.; William Staas, Jr., M.D., president and medical director of Magee Memorial Rehabilitation Center, Philadelphia, Pa.; Harold H. Wilke, D.D., director, The Healing Community; and Marlene Wilson, president, Volunteer Management Associates, Hartford, Conn. Follow-up workshops, to be held regionally throughout the state, will provide individual consultation on program development, recruiting, and placement. More information and registration forms may be obtained by contacting Patricia McGrath, The Pennsylvania Easter Seal Society, P.O. Box 497, Middletown, Pa. 17057; tel. (717) 939-7801.

Newsletters To Focus on Rehabilitation Management

TWO NEW MONTHLY publications for management of rehabilitation and social service agencies have been announced recently. A newsletter entitled *Personnel Practices & Labor Relations*, for nonprofit organizations, started publication in February while the second, *The Nonprofit Board*, is scheduled for circulation sometime in August.

The personnel newsletter in its early issues has brought rehabilitation and social service directors up to date on the new regulations of the National Labor Relations Board, affecting all nonprofit agencies. These new regulations essentially open the doors to unionization of nonprofit facilities under the protection of the NLRB through the organizing process. The publication has also featured "How-To" articles on subjects such as "How to Develop An Effective Grievance Structure," "Department of Labor Rules Need Watching," "Is The Employee Exempt or Non-Exempt," plus articles on the Fair Labor Standards Act, developing an agency employee handbook, the issue of compensatory time versus overtime, and special DOL rules for residential facilities. Purpose of the publication is two-fold: equip agency management with the new skills needed in working under NLRB rules and acquaint agency management with what is happening in the way of union activity in nonprofit organizations.

The second publication features an advance charter issue focused on the board of directors. It is intended for distribution by the executive director each month to each board member. The monthly newsletter will attempt to assist boards of directors in establishing policies and procedures and describe how to work effectively with management staff of an agency, how to differentiate policy and administration, how to develop accountability statements for both board and executive director, and how to develop a simple financial reporting system that all board members can understand.

Sample copies of *Personnel Practices & Labor Relations* and *The Nonprofit Board* are available free of charge from Fred McDonald Management Consultants for Nonprofit Organizations, 200 N. Wheeling Rd., Prospect Heights, Ill. 60070.

Film/Reading Materials On Vocational Education Programming Now Available

PRODUCED UNDER CONTRACT to the U.S. Department of Education, two half-hour films and accompanying texts that consider mainstreaming and post-secondary vocational education for handicapped students have recently been released. The film entitled "Working On Working" and its companion book present methods for mainstreaming handicapped students in secondary vocational education programs. Stressing attitude formation, the film and text document innovative programs and administrators in a wide variety of situations and settings.

"Taking On Tomorrow," the second film/book presentation, offers a look at recent changes in the movement toward employability for handicapped students through vocational programs at community colleges, junior colleges, and vocational-technical institutions. The film focuses on a post-secondary school's vocational education program and its special services, accessible facilities, and flexible teaching methods. The text provides first-person descriptions of programs in development all over the country. Both the film and text address key issues concerning policy-making, planning, funding, staffing, and communicating.

The films "Working On Working" (#A02631) and "Taking On Tomorrow" (#A02904) are available for purchase at $185, for rental at $12.50 (3 days), and for preview prior to purchase for qualified buyers from the National Audio Visual Center (GSA), Order Section, Washington, D.C. 20409; tel. (301) 763-1891.

The companion books, *Working On Working* ($5.50) and *Taking On Tomorrow* ($2.35), are available from: Dissemination and Utilization for Vocational Education, The National Center for Research in Vocational Education, Ohio State University, 1960 Kenny Rd., Columbus, Ohio 43210.

Revised Handicapped Funding Directory Published

RESEARCH GRANT GUIDES has announced the publication of the revised and updated 1980-81 edition of *Handicapped Funding Directory*, a resource of information for planners and fund seekers for the handicapped. This 1980-81 edition lists over 400 foundations, associations, and government agencies for handicapped programs and services. In addition, the directory includes articles on how to obtain a grant, what a reviewer looks for in an application, names and addresses of state agency directors, and a bibliography of grant funding publications. The cost of the directory is $16.50 per copy (including postage and handling). It is available in paperback from Research Grant Guides, P.O. Box 357, Oceanside, N.Y. 11572.

Health Education Journal Issued

Health Education Quarterly, now published by Human Sciences Press, is an official publication of the Society for Public Health Education. Formerly called *Health Education Monographs*, this journal will explore a wide range of practical and theoretical topics, including recent advances in alcohol and related substance-abuse education, occupational health and safety programs, community health service concerns, and specialized programs for the elderly and minorities. All manuscripts and other editorial correspondence should be addressed to the editor: Dr. Marshall H. Becker, Dept. of Health Behavior and Education, University of Michigan, 1420 Washington Heights, Ann Arbor, Mich. 48109. Providing a practical aid to health care administrators, public health educators, and related policy-makers, this journal will be published quarterly, at an annual subscription rate of $42 for institutions and $20 for individuals. Inquiries regarding subscriptions should be sent to the publisher: Human Sciences Press, 72 Fifth Ave., New York, N.Y. 10011.

Audiovisual Training Program Examines Work Needs of Rehab Clients

A REHABILITATION CLIENT'S failure to sustain employment may have little to do with actual job skills. The wide range of secondary problems that can interfere with job performance is the focus of the latest training program developed by the ICD Research Utilization Laboratory in New York. "Work Related Needs: An Introduction," a 20-minute audiovisual presentation, addresses such diverse problem areas as inappropriate on-the-job conduct, architectural and transportation barriers, personal difficulties related to financial situation, and household management or off-the-job lifestyle. While the program may be of interest to anyone involved in service delivery to the disabled, it is expected to be the most helpful to rehabilitation counselors and students of counseling, who may need to prepare themselves for dealing with such obstacles. Although the program provides no solutions, it is meant to trigger discussion and exchange and to encourage vocational rehabilitation personnel to consider the range of potential employment barriers. Because of rapid counselor turnover, rehabilitation agencies and facilities may find the program especially useful for new counselor orientation or as an in-service training pool. In the university or training setting, the program can readily be incorporated into the rehabilitation counselor curriculum.

"Work Related Needs: An Introduction" may be presented by anyone with access to a slide projector and cassette player. Useful tips on presentation alternatives are included in a Trainer's Guide. Attractively designed Trainee Booklets summarize and expand upon the material covered in the slide program. Complete kits containing 129 slides, cassette tape, script, Trainer's Guide, 10 Trainee Booklets, and an evaluation questionnaire, are available for $75 postpaid from Information Center Orders, Research Utilization Laboratory, ICD Rehabilitation and Research Center, 340 E. 24th St., New York, N.Y. 10010. Because of federal grant support, one copy of "Work Related Needs: An Introduction" is available at no charge to directors of staff development and training in state vocational rehabilitation agencies.

(Continued on page 198)

A Teacher's Guide to Management of Physically Handicapped Students

JUNE B. MULLINS

Published by Charles C Thomas, Publ., 301-327 E. Lawrence Ave., Springfield, Ill. 62717. 1979. 432 p. illus. $21.50.

Reviewed by WILLIAM R. GEARHEART, Ed.D.

UNLIKE THE TITLES of some current texts, *A Teacher's Guide to Management of Physically Handicapped Students* is properly descriptive of this volume. Authored by an experienced educator in this field, it provides basic information about various physical disabilities, plus many practical suggestions for classroom teachers. This book presents what would be expected (as reflected by the title) and also includes three chapters not ordinarily found in books about the physically handicapped. Whether these chapters should be included in such a text may be open to debate; however, they are included, and for many readers they will be welcome additions.

The three chapters just mentioned are Chapter 14—Down's Syndrome; Chapter 25—Visual Disorders; and Chapter 26—Disorders of the Ear and Hearing. This reviewer's first reaction was, "What are these topics doing in a text on the physically handicapped?" Although hearing and visual disorders *are* physical disorders, they are not usually included in texts on the physically handicapped. And, although a case may be made for inclusion of Down's syndrome in the section on systemic disorders (along with heart problems, lung disease, diabetes, and hemophilia), it certainly is not usually categorized in this manner by special educators.

After further reflection, and conversations with professors who train teachers of the physically handicapped, it was concluded that with the large number of multihandicapped students in special educational programs today and the incidence of hearing and visual disabilities among such students, these two chapters might be appropriate. As for the chapter on Down's syndrome, a similar rationale for inclusion may be made, but seems to the reviewer to be less clear-cut; perhaps it should be simply considered a bonus.

About the Reviewer . . .

Dr. Gearheart is a professor of special education and director of the Training Program For Special Education Administrators at the University of Northern Colorado. He has served on a number of national advisory panels to such groups as the U.S. Bureau of Education for the Handicapped, and has directed an extensive educational program for handicapped Navajo students. Dr. Gearheart has served as consulting editor for the Journal of Learning Disabilities *and has authored or coauthored 10 professional texts in the area of special education.*
Address: School of Special Education and Rehabilitation, University of Northern Colorado, Greeley, Colo. 80639.

Mullins notes that her text was written to fill a gap between "texts concerned with educational assessment, prescription, clinical teaching, and behavior management" and "medically oriented texts that describe disease entities." She initiates her efforts through a discussion of the philosophical framework of special education, which is probably as effective as possible in the brief space allotted. Since many teachers in training who might use this text will have had other general course work background on this topic, and special educators in the field should be aware of this framework, this discussion is probably sufficient for these two groups. It may be too brief to be sufficient for many others (physicians, related health professionals, or other interested laypersons). Other chapters in section one provide an ecological discussion of handicap, a consideration of the total rehabilitation team (emphasizing the teacher's role), and a discussion of genetic mechanisms. Each is well presented. Given the many additional topics left to be discussed in the major sections of this text, this first section is a balanced, succinct presentation. As with the first chapter, it may be assumed that some of these topics will be discussed in greater length in other course work (in university training programs) and that many inservice educators and health care professionals will already know a great deal about these areas of concern.

The majority of this text is composed of chapters dealing with various areas of physical disability, including: Amputations, Arthritis, Cleft, Undersized Persons, Spinal Curvatures, Spinal Cord Damage, Spina Bifida, Cerebral Palsy, Epilepsy, Heart Problems, Lung Disease, Diabetes, Hemophilia, Allergic Reactions, Ulcers and Colitis, Cancer, Anemias, Cystic Fibrosis, and Muscular Dystrophy.

In all, this text includes 26 chapters with an average of about 15 pages per chapter. Considering the complexity of the various topics under consideration, Mullins has done an excellent task of providing considerable information in a minimum amount of space. Many of the chapters include information about classifications (within the topic under consideration) and simplified diagrams to explain anatomical and educational considerations. Review guides—including key terms, discussion questions, and the like—will be of value when this text is used in a college class. Two appendices, one on various resources and the other on organizations serving the handicapped, appear to be up-to-date and comprehensive.

Chapters on cerebral palsy, hearing impairments, and visual impairments are among the longer chapters with those on skeletal and muscle problems the shorter. Mullins utilized the assistance of a number of colleagues in reviewing various chapters, and this reviewer would not presume to be able to comment on the technical accuracy of details of various areas of physical disability, but within the limits of reviewer knowledge, the basic information appears to be sound. The style of presentation of information tends toward the informal, which is quite appropriate considering the intended audience of teachers of the physically handicapped. If pressed to find a reason to comment negatively, it might be noted that the flow and sequence of information from chapter to chapter could be somewhat smoother, but this presentation would have been most difficult given the variety of topics to be covered. This does not, however, detract from the overall usefulness of this text.

In summary, Mullins has written a text that provides a clearly outlined overview of the major types of physical handicaps (as they are normally recognized) and educational suggestions for the management of students with physical disabilities. Her inclusion of the sensory disorders is unique among texts on physical handicaps, but is a welcome addition. It appears that this text will be of interest and value in training programs for teachers of multihandicapped children and to health care professionals in general.

Other Books Reviewed

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Communication Breakdown of Brain Injured Adults

By: **Helen Broida, Ph.D.**

1979. xv, 136 p. College-Hill Press, P.O. Box 35728, Houston, Tex. 77035. $14.95.

BECAUSE LANGUAGE THERAPY for brain injured patients continues for a longer period of time than other forms of treatment, families of these patients often seek the advice of speech pathologists on crucial and immediate problems related to management. Drawing on over 20 years of experience as a speech pathologist and counselor of families, the author thoroughly answers questions about communicative disorders frequently asked by family members and health care teams.

Synthesizing material from a variety of sources in a succinct and nontechnical manner, the volume presents general information about causes of brain damage and the nature of aphasia, and specific details about the speech problems of persons with aphasia and how they understand the speech of others, read, write, use gestures, and perform mathematical calcu-

lations. Among the main characteristics of brain injury discussed are that treatment requires cooperation and active participation on the part of the affected person, the injury often intensifies premorbid emotional patterns, intellectual assessment should be made after the closest possible contact with the patient has been established, and therapy should aim to help the patient regain the ability to communicate in situations of everyday life. Some of the practical questions addressed are: How can persons with aphasia be helped to "find" the word they want to say? Should faulty pronunciation and other errors be corrected? Should the use of gestures be encouraged? Is the sense of time affected by aphasia?

The communicative disorders of apraxia and dysarthria are also considered. A featured section is devoted to the adjustments and therapeutic role of families of brain injured patients, including discussions on the sexuality of these patients and modifying homes to accommodate them. A glossary of terms supplements this useful text.

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Depression in Children and Adolescents

Edited by: **Alfred French**, M.D., and **Irving Berlin**, M.D.

1979. 298 p. Human Sciences Press, 72 Fifth Ave., New York, N.Y. 10011. $19.95.

THE EPIGENETIC VIEW of child development and evidence that childhood is not always "a time of innocence and happiness" have led to psychiatric studies of the phenomenon of depression among children and adolescents. From a variety of historical, developmental, and clinical perspectives, the editors and 10 other authorities in various mental health disciplines discuss research on the etiology and treatment of depression, and evaluate the relationship between this psychological problem and family dynamics. Psychotherapeutic techniques that can be used with physically handicapped, abused, and self-destructive children are exemplified through numerous case histories.

One article is devoted to the psychological stress experienced by a 4-year-old boy with Guillain-Barré syndrome. The child was able to use puppets in play therapy to express anger and revenge and to fantasize about the outcome of events, indicating a healthy emotional response to his illness. The topics of other articles are a longitudinal study of two self-destructive boys, psychobiological and psychodynamic theories of childhood depression, the effects of child abuse, individual therapy sessions, and the implications of child development processes for the treatment of depression in adolescence. A comprehensive annotated bibliography of clinical and theoretical literature on this new area of child psychiatry is included.

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The Diabetic At Work and Play. Second Edition

By: **Buris R. Boshell**, M.D.

1979. xi, 186 p. figs. Charles C Thomas, Publ., 301-327 E. Lawrence Ave., Springfield, Ill. 62717. $12.75.

TO AVOID serious complications, persons with diabetes must be made aware of the signs and symptoms of the disease, its implications for everyday activities, and basic methods of treatment. This book provides such information and emphasizes the importance of effective communication between patients and physicians in controlling diabetes.

Opening sections review the history of treating diabetes, incidence and statistics, and the goals of management. The benefits of the availability of insulin point out the progress that has been made in this area. The significance of diet and exercise is explained in the context of general nutrition; included are exchange lists indicating how many servings of particular foods are advisable. The nature and types of insulin and guidelines for injecting it are described, and the use of oral drugs (sulfonylureas and biguanides) in diabetes is considered. Testing urine samples for glucose and acetone and interpreting the results are also explained.

Recommendations are made for personal hygiene, preventing complications (especially those pertaining to the eye and foot), and preparing for pregnancy, employment, and travel. The special features and addresses of camps for children with diabetes and the functions of the American Diabetes Association are presented. Recent research in the management of diabetes, such as pancreas and islet cell transplants, somatostatin, and new forms of insulin, are summarized. Among the seven appendixes are a bibliography and a glossary of terms.

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Effective Methods for Correcting Articulatory Defects

By: **Cameron W. Garbutt**, Ph.D., and **John O. Anderson**, Ph.D.

1980. vi, 218 p. paper. Interstate Printers & Publ., 19-27 N. Jackson St., Danville, Ill. 61832. $7.95.

IN ADDITION to describing traditional approaches to speech correction—such as auditory, tactile, and kinesthetic stimulation—this guidebook for speech therapists features several innovative techniques. These methods include the use of a long or double consonant (when the word ends in the same consonant that initiates the following word, as in "big goat"), assimilation (a sound changing under the influence of nearby sounds), and successive approxima-

tion (teaching a sound through the motor performance used with a related sound).

Tests for evaluating the client's articulation of phonemes and blends are presented. Numerous exercises provide practice in consonantal blends, differentiating between voiced and voiceless pairs, and building sentences for mastery of the sound in rapid speech. The drills employ nonsense words, true words, and syllables that were selected on the basis of research on eliciting correct articulation of the phoneme and common occurrence of phonemes in words. To allow for detailed explanation and greater number of exercises for each consonant, the book focuses on the 10 consonants that are most frequently articulated improperly. The symbols of the International Phonetic Alphabet are used to indicate the syllables and nonsense words in the exercises, and key words and diacritical marks are used to show readers not familiar with this alphabet how to pronounce the sound.

Also included are sections on using the exercises to correct the speech problems associated with hearing impairment, cerebral palsy, brain damage, and cleft palate. A unique chapter is devoted to the articulatory problems of blacks and Spanish-Americans, including vowels that are troublesome for them. A bibliography completes the text.

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Genetic Diseases and Developmental Disabilities: Aspects of Detection and Prevention

Edited by: **Tamah L. Sadick** and **Siegfried M. Pueschel**

1979. xvii, 134 p. figs., tabs. Westview Press, 5500 Central Ave., Boulder, Colo. 80301. $12.50.

DRAMATIC PROGRESS has been made in human and medical genetics during the past two decades, with innovative technologies in cytogenetics and biochemical genetics aiding in the detection and prevention of many genetic disorders and developmental disabilities. To explain the implications of these advances to practitioners and the general public, renowned physicians and geneticists discuss developments in their respective fields in this volume.

The first section of the text is concerned with prevention of congenital defects through homozygote and heterozygote screening. New methods of prenatal diagnosis are discussed in the second section, including brief consideration of the ethical, legal, and psychosocial issues related to their use. The final part of the book is focused on applying genetic knowledge to improve genotypes and promote physical and emotional health.

The articles are: Overview: Genetics and Preventive Medicine, by Barton Childs, p. 7-10.—Genetic Screening: The Heterozygote Experience, by Charles R. Scriver, p. 13-30.—Screening of Newborn Infants, by Robert Guthrie, p. 31-44.—Screening for Alpha-1-antitrypsin Deficiency, by Richard C. Talamo, p. 45-49.—Carrier Detection in Duchenne Muscular Dystrophy and Implications for Genetic Counseling in X-linked Disease, by Marie-Louise E. Lubs and others, p. 51-62.—Prenatal Diagnosis of Chromosomal Disorders, by Siegfried M. Pueschel, p. 65-73.—Prenatal Detection of Neural Tube Defects, by Aubrey Milunsky and Tamah L. Sadick, p. 75-87.—Prenatal Diagnosis by Fetoscopy and Fetal Blood Sampling Including Initial Attempts to Diagnose Duchenne Muscular Dystrophy, by Maurice J. Mahoney and John C. Hobbins, p. 89-100.—Prenatal Diagnosis of the Hemoglobinopathies, by David G. Nathan, Blanche P. Alter, and Maurice J. Mahoney, p. 101-108.—A Place for Genetics in Health Education and Vice-Versa, by Barton Childs, p. 111-134.

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Gross Motor Management of Severely Multiply Impaired Students: Volume 1—Evaluation Guide; Volume 2—Curriculum Model

By: **Beverly A. Fraser, Genevieve Galka,** and **Robert N. Hensinger,** M.D.

1980. 2 vols. figs. paper. University Park Press, 233 E. Redwood St., Baltimore, Md. 21202. $22.75 (Vol. 1); $19.95 (Vol. 2).

SUCCESSFUL educational development in all children depends in part on the acquisition of basic motor skills. Severely multiply impaired children require individual treatment plans based on thorough and accurate assessment of motor problems. This two-volume set provides an evaluation tool and a school curriculum model for gross motor management in such children. Volume I, the *Evaluation Guide*, provides an overview of orthopedic management, including evaluation and treatment concerns in specific areas such as spinal deformities, and problems involving the hips, knees, and feet. Coordination of efforts among all the child's caregivers—physician, therapists, teachers, and parents—is seen as essential to management. Three comprehensive therapy evaluation guides are provided for use by the physician and therapist: a normal range of motion guide depicts range of motion of joints in a normal person, a developmental reflex guide describes reflex and reaction activity in normal young children and indicates how reflexes influence gross motor skills, and the developmental gross motor guide describes, in sequence, the expected development of body motion and skills in normal children from birth to age three. Assessment, utilizing these tools, determines the components of a child's individual education plan. The first volume concludes with a chapter on equipment appropriate for use with severely handicapped students

For Your Reference Collection

"TRAINEES ARE INDIVIDUALS! While it is true that mentally retarded people typically share some developmental deficiencies, they differ as much in personality, attitudes, habits, and individual potential as do the nonretarded." This statement is taken from the third edition of *Handbook for Job Placement of Mentally Retarded Workers* by Jacobs, Larsen, and Smith—all three senior research scientists at the American Institute for Research at Palo Alto, California. The promotion of employment opportunities for mentally retarded citizens is the purpose of this handbook. It can also serve as a guide to those "whose goal is the integration of the mentally retarded individual into the competitive work world."

Handbook for Job Placement of Mentally Retarded Workers: Training, Opportunities, and Career Areas. Third Edition

By: **Angeline M. Jacobs, Judith K. Larsen,** and **Claudette A. Smith**

1979. xvii, 326 p. Garland STPM Press, 545 Madison Ave., New York, N.Y. 10022. $27.50.

Formerly entitled *Guide to Jobs for the Mentally Retarded*, this book will provide valuable information for directors and counselors of work activity centers for individuals with limited intellectual ability. Those involved in job retraining of individuals with any type of developmental disabilities, as well as retraining programs such as those under the Comprehensive Employment and Training Act, will also find this handbook helpful. The third in a series, the text lists descriptions of 158 jobs that retarded workers have proven their ability to perform. The first edition, published in 1960, listed only 131 such descriptions.

The authors have divided this book into six chapters. An introduction gives the background and a description of the book, tells how to use it, and cites a sample case study. How the book is used will depend on the need of the individual using it. For instance, it may be used as a training resource or in actually placing clients in jobs.

A section entitled "The Mentally Retarded Worker" supplies an overall view of mental retardation. Here, the authors cite the percentage of the population affected by mental retardation and list some of the more than 200 known medical causes of the disability. Also indicated are the four levels of mental retardation that range from mild to profound and the IQ scores associated with each level (ranging from a high of 55-69 to a low of 24 or below). Characteristics, job opportunities, and training programs are also discussed.

The purpose of prevocational evaluation and training is then outlined. The authors state that it is during the prevocational training period that

at home, in school, and while traveling; described and pictured are more than 80 commercially available products that the authors have evaluated for use by children with various problems.

Volume II, the *Curriculum Model*, presents activities that have been used with severely multiply impaired students to improve gross motor behavior. Following physician evaluation and prescription for physical therapy, goals and performance objectives are established; a plan for each child can thus be developed by choosing activities designed to achieve the goals. Selection of appropriate activities and equipment is facilitated by cross-referencing between the two volumes. The section on therapy techniques includes activities on positioning, range of motion, relaxation, stimulation, and postural drainage (positions to drain and clear mucus secretion). Gross motor activities included are those which promote head control, rolling, sitting, creeping, kneeling, and standing. Descriptions of each activity include procedures, methods of monitoring progress, indications, contraindications, and precautions.

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The Handicapped Librarian: A Study in Barriers

By: **G. Garry Warren,** Ph.D.

1979. 155 p. tabs. Scarecrow Press, P.O. Box 656, Metuchen, N.J. 08840. $7.50.

SEVERAL BOOKS on providing library services to handicapped persons have been published recently, yet the employment opportunities and working conditions for disabled persons in the field of librarianship have not been closely examined. To improve personnel relations in libraries and to supply handicapped persons considering employment in this field with relevant facts and assessments, this book presents the results of a survey of 87 library directors and 42 handicapped librarians.

Jobs for handicapped persons in libraries are considered in the context of recent legislation on equal employment opportunities, and literature pertinent to this study is reviewed. Another section describes the methods of collecting and analyzing data from directors of libraries (with at least 20 staff persons) on

the trainee is helped to overcome some of the limitations that have prevented him from obtaining job training and employment in the past. Covered in this section are: selecting the program levels for a client, assessment of a client's capabilities, and content of the prevocational programs. Applying the client's ability to the skills needed to perform a certain job is explained. Twenty examples are given on a basic skills chart that defines skills and provides practical applications of them. One example on this chart is the skill of counting money and making change.

A discussion of the procedures for placing clients in the employment setting tells counselors how to locate jobs and employers, prepare a job profile, match the client with the job, and teach the employer how to redesign a job to make it suitable for the client. Also described is the follow-up, which serves to answer any additional questions the employer may have and determine whether the client can perform the job, needs additional training, or should be trained for another type of employment.

Over half of the text is devoted to the subject of job profiles. This topic is divided into three sections. The first is concerned with "those characteristics of the individual that are assumed to be minimum requirements for employment," including neatness and the ability to communicate and cooperate with others. In section two, 158 job profiles are listed in six groups: merchandising, office, service, agriculture/fishing/forestry, skilled trades, and processing and manufacturing. The last section states the type of organizations that might have employment positions for trainees, ranging from advertising firms to zoos.

In general, *Handbook* is well written and contains a wealth of valuable information. Concern for and confidence in the value of mentally retarded workers is demonstrated by the authors in the following statement: "If the training program is properly planned and administrated, mentally retarded adults have shown the ability to learn work skills to a degree equal to that of nonretarded workers."

An individual need not be a professional to benefit from this book. The material is so completely and comprehensively presented that all readers are sure to gain insight into the abilities of mentally retarded persons.

—*Alfred D. Leis*

The reviewer is a freelance writer who was born with cerebral palsy and is active in a number of committees and organizations for handicapped persons. In 1976, he served as chairman of the Sheridan County, Wyoming, White House Conference on Handicapped Individuals.

numbers of handicapped staff and awareness of their special needs, and from handicapped librarians (identified by the directors) on personal background and education, present position, and attitudes toward this position and the library profession in general.

One out of every five disabled librarians surveyed stated that they had been denied positions solely on the basis of handicap, with incidents of discrimination almost twice that figure among hearing-impaired librarians. The study also showed that, contrary to the opinion that handicapped professionals are only capable of working in the technical services, disabled librarians hold directorships and public service jobs. Other findings were that some handicapped librarians cannot attend continuing education activities because of their disability or inaccessible buildings, these librarians are optimistic and confident persons who are content with their careers, attitudes toward disability are as important as physical barriers in determining hiring and advancement in this field, and accommodating the physical needs of handicapped librarians involve minor expenditures. Tabular data and direct quotations from study participants appear throughout the text, and the 2 questionnaires used to gather information are appended.

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Hearing and Hearing Impairment

Edited by: **Larry J. Bradford**, Ph.D., and **William G. Hardy**, Ph.D.

1979. xvi, 653 p. figs. tabs. Grune & Stratton, 111 Fifth Ave., New York, N.Y. 10003. $43.50.

CONTAINING CONTRIBUTIONS from over 50 authors, this book is designed to promote an integration of various approaches, procedures, and techniques that are used to aid persons with hearing impairment, and to generate new inquiry in the field. The text consists of six major sections. The first part traces the historical backgrounds of the several professions concerned with hearing problems. A number of theories on impaired and unimpaired hearing, language, and speech (emphasizing instrumentation) are presented in the second part, and methods used by

teachers and directors of rehabilitative programs are described in the third. The fourth section covers behavioral problems and psychological adjustments associated with hearing impairment, and the fifth surveys the types of social, recreational, legal, religious, and vocational services available to persons with this disability. The final section is focused on the delivery systems (both functioning and planned for the future) that can improve the quality of life for hearing impaired persons.

Partial contents are: History of Education for the Hearing Impaired, by Richard W. Flint, p. 19-39.—New Developments in Surgery for Hearing Impairment, by Fred H. Linthicum, Jr., p. 75-91.—The Clinical Management of Otologic Disorders, by Werner D. Chasin, p. 93-108.—Language and Psycholinguistics, by Robert N. St. Clair, p. 145-154.—Residential Centers for the Hearing Impaired and the Community, by William N. Craig, p. 275-286.—Aural Rehabilitation for the Aging, by James R. Maurer, p. 319-338.—Multiply Handicapped Hearing-Impaired Children, by Jerome D. Schein, p. 357-363.—Psychosocial Problems Associated with Childhood Hearing Impairment, by Roger D. Freeman, p. 405-415.—The Mental Health Program for the Deaf of St. Elizabeth's Hospital, by Doris Lee Dickens, p. 467-473.—Hearing Impairment and the Family, by Robert W. Hutner, p. 489-495.—Law and the Deaf, by Sy DuBow, p. 511-514.—U.S. Service Delivery Systems for the Hearing Impaired, by Michael Marge, p. 575-585.—The Impact of Laws and Regulations on Services for the Hearing Impaired, by Robert M. McLauchlin, p. 607-620. All the articles are thoroughly referenced.

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Humanistic Teaching for Exceptional Children: An Introduction to Special Education

Edited by: **William C. Morse**

1979. viii, 332 p. figs., tabs. paper. Syracuse University Press, 1101 E. Water St., Syracuse, N.Y. 13210. $18.00, cloth. $8.95, paper.

DEVELOPING AN UNDERSTANDING of each special child as a human being enables educators to help each child most effectively and achieve the real goal of special education. Called "life streaming," the goal is defined as "the plan which will maximize the ability to lead as normal a life as special education can provide." To enhance the reader's receptivity to recommendations of the various contributing specialists, the editor prefaces the volume with a discussion of several fundamental issues in special education. Placing the person before the handicap—seeing the child's specialness apart from any physical or mental condition—is the recurrent theme. This outlook will insure proper educational placement and programming for each individual. Special problems created by a society such as ours, specifically problems related to risk factors and educational considerations, are detailed, since awareness of these forces is seen as a key to understanding many of our special children.

The bulk of the text is comprised of chapters written by experts in various fields who were chosen in part because of their humanistic concerns and their direct experiences with children. Each field is introduced through actual case studies of children whose progress has been followed through adulthood. Educational programming that has proven effective is detailed and implications for future educational planning are offered.

Included are: Mental Retardation, by Raymond N. Elliott, Jr., p. 22-55.—Socioemotional Impairment, by William C. Morse and Harold Coopchik, p. 56-87.—Learning Disabilities, by John G. Frauenheim and John R. Heckerl, p. 88-118.—Gifted and Talented Children, by Donald J. Treffinger, p. 120-148.—Preschool Language Disabilities, by Lawrence J. Turton, p. 150-176.—Vision Problems, by Geraldine T. Scholl, p. 178-202.—Impaired Hearing, by Sophie L. French, p. 204-239.—Physical Handicaps, p. 240-267, and Cerebral Palsy, p. 269-299, by William M. Cruickshank and Lawrence J. Lewandowski.

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The Interdisciplinary Health Care Team: A Handbook

By: **Alex J. Ducanis**, Ph.D., and **Anne K. Golin**, Ph.D.

1979. x, 201 p. Aspen Systems Corp., 20010 Century Blvd., Germantown, Md. 20767. $21.50.

TO CLARIFY their approach to a relatively new topic, the authors define the interdisciplinary team as "a functioning unit, composed of individuals with varied specialized training, who coordinate their activities to provide services to a client or a group of clients." Although interdisciplinary teams are becoming popular in a variety of health and human service settings, problems in the teams' operations have become evident, mainly due to misunderstanding of the implications of this form of care. This book endeavors to alleviate some of those functional problems by integrating research findings from psychology, sociology, and management in order to formulate a conceptual framework for interdisciplinary teams.

Medicine, nursing, social work, psychology, education, physical and occupational therapy, and counseling are among the professions usually represented on the health care team, and the similarities, differences, and areas of common concern among them can cause conflicts. Therefore, opening sections discuss the nature of professionalism and ways of improving interprofessional relationships, including a scale for de-

For Your Information

LEARNING DISABILITIES are referred to as a "family affair" in the title of this book because as soon as a child's problems with learning become apparent to family members, they "must make many practical adjustments—and even more emotional ones—that reflect the goals and values of the family as a group, as well as the needs of its individual members." To help parents make these accommodations and to allow teachers to appreciate the situations of these families, this straightforward volume offers sensible recommendations for managing children with learning difficulties at home, in school, and in outside relationships. Replete with concise clinical sketches drawn from the author's work with these children, the book clarifies basic concepts in an informal, empathetic manner.

Learning Disabilities: A Family Affair

By: **Betty B. Osman**

1979. viii, 225 p. Random House, 201 E. 50th St., New York, N.Y. 10022. $8.95.

The author's emphasis on each child's individuality is reflected in her use of the term learning differences, which also avoids the stigma associated with disability. Confusing diagnostic labels are ignored in favor of a summary of factors that may cause a learning problem, such as intelligence, sensory deficits, brain injury, emotions, and inadequate teaching. The examples of particular families are then cited to demonstrate the process of recognizing and accepting children's learning differences and honestly explaining them to the child, and ways that parents and siblings can help a child with these difficulties feel accepted in spite of their understandable anger, anxiety, frustration, and fatigue. Since children and adolescents with learning differences often have trouble making friends because of inability to interpret the subtleties of social interaction or rejection by peers, approaches to use when talking to children about this topic—such as specifying requirements of a successful relationship, evaluation of a child's readiness for a social activity, and advice on manners and conversation—are suggested.

The types of educational options available to children with special needs—teacher conferences, repeating grades, psychological evaluations, resource rooms, and tutors—and the rationale for each of them are illustrated by the experiences of one boy's progress from kindergarten through high school. Effective methods for assisting children with homework are described, and the advisibility of having parents rather than tutors provide this assistance is considered. In a section on when and how to use community resources, the major treatments for learning problems—optometric training, perceptual-motor programs, psychotherapy, behavior modification, medication, megavitamins, and experimental diets—are objectively and succinctly reviewed. The importance of the family's involvement and realistic expectations are stressed in planning for college and adult life. Appended material includes information on diagnostic tests, planning an individualized education plan, and income tax deductions for handicapped children.

—*S.J.T.*

termining professionals' perceptions of themselves and other professionals. The client's or patient's role in the team, either as a source of information or as a participant in making decisions, and the context in which the team operates—influenced by the size and type of sponsoring organization, its policies for referral and treatment, channels for communication, and administrative structure—are then considered.

A protocol for observing team conferences is presented to help focus and negotiate divergent goals of the organization, professionals, and clients and to coordinate such activities as diagnosis, treatment, decisions on cases, and evaluation. Concepts derived from the dynamics of small groups—such as norms, conformity, status and power, cohesiveness, and coalitions—are related to how the interdisciplinary team performs its work. Measuring a team's effectiveness and modifying its activities according to the results of evaluation are also covered. The future of the interdisciplinary health care team is addressed in two concluding sections on preparing professionals to work cooperatively and overcoming obstacles to teamwork, such as differing professional codes of ethics, increased specialization, the sponsoring agency's lack of commitment, and technical language. This well organized text also contains references.

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Laryngectomee Rehabilitation

Edited by: **Robert L. Keith** and **Frederic L. Darley**, Ph.D.

For Your Professional Reading

SINCE the U.S. is rapidly becoming a country of high population density and heavily industrialized areas, a consideration of how older, more complex European countries with these same conditions have responded to attendant social problems can be instructive. In the area of American rehabilitation services—which are already changing in regards to more inclusive eligibility, greater social support, mass delivery systems, and new theories of counseling—an in-depth comparison with European practices would appear to be particularly useful for U.S. rehabilitation professionals responsible for planning. To supply these persons with accurate and challenging information on which to base constructive changes and to promote a reevaluation of this society's attitudes toward handicapped persons, this book discusses the roles and functions of rehabilitation counselors (or their equivalents) in Great Britain, Sweden, The Netherlands, France, and Yugoslavia, as well as the relevant social policies and benefits of these countries. Conducted in 1971 and consisting of visitations to rehabilitation facilities, over 100 interviews, and analyses of data unavailable in official government bulletins, the study investigated five aspects of rehabilitation in these countries: *1)* emphasis of professional contacts, *2)* training programs for rehabilitation professionals and their relationship to job requirements and service delivery, *3)* differentiations of roles and functions and use of support personnel, *4)* the influence of a culture's traditional counseling and human behavior theories on the professional's work, and *5)* the use of group interactions instead of the traditional counselor-client relationship.

As a basis for analyzing the data on European countries, the current situation and division of responsibilities among rehabilitation counselors in the U.S. is summarized in an introductory section, which also details the methods and procedures used in the study. The main portion of the text is devoted to the findings in each of the five countries arranged according to development of concepts, allowing for a comparison of such topics as general structure of rehabilitation, methods of vocational therapy, types of social work performed, and specific services for the blind. Some of the main features of these countries and their services, and the reasons why they were selected for the study, are: Great Britain—advanced industrialization, the position of the Disablement Resettlement Officer (who maintains a 3 percent employment quota for disabled persons), and a concept of professional functioning that has influenced other European systems; Sweden—an

European Rehabilitation: Service Providers and Programs

By: **G. D. Carnes**, Ph.D.

1979. xiii, 305 p. tabs. University Centers for International Rehabilitation, D-204 W. Fee Hall, Michigan State Univ., East Lansing, Mich. 48824. $5.95.

1979. 533 p. figs. College-Hill Press, P.O. Box 35728, Houston, Tex. 77035. $24.50.

THE FIFTH Laryngectomee Rehabilitation Seminar was held on June 10-15, 1979, at the Mayo Clinic in Rochester, Minn. This collection organizes the significant contributions of seminar participants to the rehabilitation of persons with laryngectomies. Both historical reviews and reports on current research are presented. Slides used at the conference and referred to in the papers are represented by numbered figures, and references are included.

Partial contents are: The Artificial Larynx: Types and Modifications, by Eric D. Blom, p. 63-85.—Intermediate Stage of Teaching Alaryngeal Speech, by Melvin Hyman, p. 117-134.—Therapy Techniques for Heterogenous and Homogeneous Groups, by Richard W. Holland, p. 205-215.—Pre- and Postoperative Anatomic/Physiologic Observation in Laryngectomy, by Daniel E. Martin, p. 277-297.—Laryngeal Transplantation and Reinnervation, by Bruce W. Pearson, p. 335-343.—Development of the Feminine Voice and Refinement of Esophageal Voice, by James C. Shanks, p. 367-378.—Factors in the Choice of Treatment of Patients with Laryngeal Cancers, by Bryan Neel, III, and Lawrence W. DeSanto, p. 403-407.—Physical and Occupational Therapy for the Patient with Laryngectomy: Why and What For? by Ann H. Schutt, p. 409-421.—Special Problems of the Alaryngeal Speaker, by Marshall J. Duguay, p. 423-444.—Nursing Care of the Laryngectomee Outside the Hospital Environment, by Nancy Morozink, p. 445-457.—Factors That May Interfere with Acquiring Esophageal Speech, by Shirley J. Salmon, p. 501-512.—Extras in Rehabilitation: Smelling, Swimming, and Compensating for Changes after Laryngectomy, by P. Helbert Damsté, p. 513-519.—The Effects of Restricting Parameters of the

extensive social welfare system and respect for individual rights; The Netherlands—high population density, a sophisticated sheltered workshop program, and progressive social policies; France—a fragmented rehabilitation program that requires a psychological examination for all clients; and Yugoslavia—the only country in which the term "rehabilitation counselor" is mentioned in the literature, which also refers to American grants and documents the effects of an eastern culture.

Because social policies and benefits for disabled persons directly affect the rehabilitation professional's work and because the policies of the target countries varied significantly from those of the U.S., this topic is given special attention. Some form of compulsory health insurance with coverage for rehabilitation, subsidies for housing and transportation, special provisions for the elderly, adaptive equipment, tax relief for handicapped persons, and financial assistance for industries that employ these persons are provided by all five countries; their systems of sheltered workshops and income maintenance are considered in relation to those of U.S. Among the conclusions drawn in this area are that only benefits for severely disabled war veterans in the U.S. approach those generally available for all disabled persons in Europe, and that although these European benefits contribute to "a more secure and meaningful life," they can also serve as deterrents to economic independence.

The author addresses the implications of these two conclusions and other findings of the study, and offers his opinions on how U.S. services should be reformed. Among the major findings of the study are that previous literature had conveyed "distorted views" of European rehabilitation, European educational institutions for professional workers maintain high standards, stereotyping and discrimination toward handicapped persons exist in the 5 countries but these persons are also recognized as a minority group with equal rights, and duties typically performed by U.S. rehabilitation counselors were distributed in these countries among many professional groups, whose vital importance is consistently recognized. Commenting on the demands for increased social benefits for disabled persons in this country, the author writes: "Simply providing the hard services, workshops, and centers is not enough; if we are to profit from the European experience, there is a vital requirement for even better trained workers with a knowledge of personality dynamics, abnormal motivations, and professional skills to address crippling emotional problems and remotivate clients."

This valuable comparative study, which should help practitioners gain new insights into this country's system for delivering services and devise ways of improving it, also contains a concise summary, 20 conclusions, and examples of training programs for rehabilitation workers in Great Britain, Sweden, and Yugoslavia.

—S.J.T.

Speech Excitation Function of an Electronic Larynx: A Pilot Study, by Dan Kelley, p. 521-533.

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Living with Multiple Sclerosis

By: **Elizabeth Forsythe**

1979. 140 p. paper. Faber and Faber, 99 Main St., Salem, N.H. 03079. $11.95, cloth. $6.95, paper.

A UNIQUE PERSPECTIVE on living with multiple sclerosis is provided by a physician who learned, while a wife and mother of three, that she had the disease. Following a recounting of some of her experiences, Dr. Forsythe provides, in layman's terms, facts about multiple sclerosis, including its progression and forms of treatment. Myths that abound because of difficulty with diagnosis and mystery regarding etiology are discussed. The variability of the condition among affected persons precludes blanket answers to questions readers may have, but tentative solutions to common problems are offered; opinions, when given, are clearly identified.

An individual with multiple sclerosis is helped in taking a candid yet positive look at the psychological effects of the condition. Many practical suggestions are given on adjusting to various limitations, but a positive philosophical outlook, while probably ineffective in controlling the disease itself, is proclaimed as an effective method of maximizing mental and physical powers. Acceptance, which differs from submission, is seen as an ongoing process, and Dr. Forsythe admits that she continually works at achieving her goal, which she feels should be everyone's—becoming a whole person despite disabilities.

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Medicaid Eligibility: Problems and Solutions—An Urban Systems Research Report

By: **Marilyn P. Rymer** and others

1979. xi, 345 p. tabs. Westview Press, 5500 Central Ave., Boulder, Colo. 80301. $24.00.

ALTHOUGH Medicaid programs—which are administered by the individual states and jointly funded by federal and state governments—have extended health care services to underprivileged persons, the process of becoming eligible for these services has been criticized for its complicated regulations and varying standards. Conducted for the Health Care Financing Administration of the Department of Health, Education, and Welfare, the project reported in this book attempted to document inequities, ineffective incentives, and administrative problems in Medicaid eligibility systems; to develop alternative policy and administrative reforms for this system; and to estimate the costs of these reforms. To obtain information from a source that is often overlooked, a major thrust of the research was focused on the opinions and ideas of program managers in nine states.

Current requirements for Medicaid eligibility and state options are reviewed in an introductory section, which includes tables indicating state decisions and relevant statistics. Issues pertaining to equity and incentive—such as financial criteria, group and categorical definitions, interstate variation, and program operation—are then analyzed. Among the most critical administrative problems that are examined are noncompliance with federal policies among the states, impracticality of some provisions, the lack of data in state programs, and deficiencies in the internal operations of these programs.

Based on general conclusions on Medicaid's 10 years in operation, the following approaches to reform are presented: an administrative reform package (which can be implemented without legislative amendments or major regulatory changes), technical reforms, major federal standardization of programs, and increased flexibility of state programs. These suggested changes can be instituted within the existing Medicaid program and do not require a system of national health insurance.

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Planning for Services to Handicapped Persons: Community, Education, Health

Edited by: **Phyllis R. Magrab**, Ph.D., and **Jerry O. Elder**

1979. xiii, 254 p. Paul H. Brookes, Publ., P.O. Box 10624, Baltimore, Md. 21204. $14.50.

DURING THE 1970's, legislation and court decisions granted equal services and due process of law to disabled persons, yet lack of planning for the provisions of these new services has resulted in piecemeal, duplicative, and disorganized systems of delivery. Considering the coordination of health and social services for handicapped persons to be the "challenge of the Eighties," this book scrutinizes a number of service delivery systems in order to establish a foundation for planning.

Because the needs and problems of disabled persons transcend the traditional boundaries of social, educational, health, and vocational rehabilitation systems, the relationships between these areas are discussed. Some of the major problems addressed in this collection of articles are identification of the handicapped population, the focus of existing programs on institutions rather than local communities, overlapping federal legislation and programs, multiple sources of funding, independent planning organizations, and different models of service delivery developed by specific disciplines. Ways of resolving these problems, including a workbook for determining needs of a community and meeting them through coordination and funding, are suggested in the concluding articles.

Contents are: Community Service Planning, by Anderson Pollard, Howard Hall, and Charles Keeran, p. 1-39.—Educational Planning, by Ronald Wiegerink and John Pelosi, p. 41-76.—Perspectives on Planning for Prevention of Mental Retardation, by Andrew E. Lorincz, p. 77-90.—Community Health Planning, by Herbert J. Cohen, p. 91-120.—Health Planning for Handicapped Persons in Residential Settings, by Philip Ziring, p. 121-135.—Rehabilitation Planning, by William Kiernan, p. 137-171.—Advocacy, by Marianne Bennett and Robert P. McNeill, p. 173-191.—Coordination of Service Delivery Systems, by Jerry O. Elder, p. 193-209.—Case Study for Planning Coordinated Services, by Elynor Kazuk, Lorna Greene, and Phyllis R. Magrab, p. 211-245.

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Sex Education for Physically Handicapped Youth

By: **C. Edmund Hopper** and **William A. Allen**

1980. xiii, 130 p. figs. paper. Charles C Thomas, Publ., 301-327 E. Lawrence Ave., Springfield, Ill. 62717. $8.75.

ADOLESCENCE is a difficult time of life for most persons because of the many physical changes that take place and the confusing choices that must be made in social life, education, and careers. Since handicapped children usually enter puberty with poor self-images and feelings of insecurity, the typical problems of adolescence are more complicated for them. To assure physically handicapped adolescents that they can enjoy friendships with the opposite sex and achieve sexual fulfillment, this book addresses sexuality openly and sensitively.

Addressing handicapped youth informally and using language they will readily understand, the au-

thors suggest ways of maintaining a positive self-image in spite of disabilities. The opinions and feelings of handicapped adolescents on such topics as where sex education should be taught, reactions to growing up, and premarital sex are then presented. Advice is offered on ways of getting acquainted with persons of the opposite sex and enjoying sex. Sexual fantasies, masturbation, contraception, pregnancy, genetic counseling, homosexuality, and venereal disease are also covered. Other sections describe alternative lifestyles and community, state, and national resources that help handicapped youth gain access to activities and services.

As disabled students are mainstreamed into regular classrooms, they require comprehensive information on sexuality so that they can comfortably relate with their peers. A substantial amount of this information is provided in this volume.

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Skillstreaming the Adolescent: A Structured Learning Approach to Teaching Prosocial Skills

By: **Arnold P. Goldstein,** Ph.D., and others

1980. ix, 220 p. paper. Research Press, 2612 N. Mattis Ave., Champaign, Ill. 61820. $6.95.

ADOLESCENTS with behavioral problems of aggression, withdrawal, and immaturity often must develop appropriate ways of responding to the educational environment and confidence in their ability to learn before they can benefit from traditional methods of instruction. To assist youngsters in dealing with these problems both in the least restrictive school setting and in the community, teachers are presented with a system of structured learning that teaches adolescents social and planning skills, alternatives to aggression, and ways of understanding feelings and coping with stress. Since a program must account for individual variation in order to be successful, the descriptions of this system are supplemented with information about the selection and grouping of adolescents.

Four procedures used in skill training—modeling, role playing, performance feedback, and transfer of training—are described, including ways of maximizing their effectiveness, examples of their applications, and supporting research. Organizing and conducting structured learning groups are then discussed, followed by a detailed examination of selecting and grouping of students according to combined homogeneous and heterogeneous methods, behavioral assessment, and use of specific checklists, charts, and records.

The structured learning curriculum consists of behavioral steps and suggestions for teaching 50 skills. Transcripts of initial teaching sessions demonstrate the concepts of modeling and role playing. Examples of behavior that may disrupt the structured learning group and methods of management (behavior modification, instructional techniques, and maintaining a positive teacher-student relationship) are also provided. An annotated bibliography of evaluations of programs employing structured learning and additional references complete the text.

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Vocational Curriculum for Developmentally Disabled Persons

By: **Paul Wehman,** Ph.D., and **Phillip J. McLaughlin,** Ed.D.

1980. xxi, 229 p. figs, tabs. paper. University Park Press, 233 E. Redwood St., Baltimore, Md. 21202. $12.95.

ONE REASON why developmentally disabled workers usually perform simple, unrewarding tasks is that many vocational education teachers and practitioners in rehabilitation centers are unaware of ways to train these workers for more complex jobs. As a basis for the inservice instruction of these professionals, this volume presents a curriculum of work skills and explains the contexts in which it can be implemented. This approach assumes "that developmentally disabled persons are capable of productive sheltered work or successful competitive employment."

Establishing a sheltered workshop and utilizing behavioral assessment and instructional techniques in this setting are discussed and illustrated by five case studies. Developmentally disabled persons' potential for competitive employment is demonstrated by three additional case studies, which are preceded by methods of facilitating entry into this type of employment (selection of jobs and employers and assessment of workers' behavior). The importance of vocational evaluation techniques—clinical assessment, laboratory work samples, situational assessment, work tryouts—in determining a client's aptitude, ability, and interests is emphasized.

The latter half of the text consists of a logical sequence of work skills that has been field tested with moderately and severely developmentally disabled students in a public school program. Over 100 skills are grouped according to seven categories: fine motor, domestic, food service, home industry, horticulture, janitorial, and clerical. For each skill the curriculum states an instructional objective, prerequisite skills and materials, a detailed task analysis, and teaching procedures. The curriculum can also be used with mildly handicapped clients. An annotated bibliography on vocational programming for developmentally disabled persons is included.

EVENTS AND COMMENTS—Continued from page 185

Language Laboratory To Prepare Specialists for Work with Deaf Adults

SAN FRANCISCO STATE UNIVERSITY has been awarded a Rehabilitation Services Administration Experimental and Innovative Training Grant for the purpose of setting up a language laboratory that will train specialists to teach language related to independent living skills to deaf adults. Training will include a comprehensive individualized competency based curriculum with provision of direct services to deaf adults, field experiences, lab practice, and training with sign language. The laboratory will begin in September of this year and is open to both full and part-time students, with day, evening, and summer sessions planned. All applicants must meet the university's admission requirements and possess a bachelor's degree. Preference will be given to applicants who will complete this program in conjunction with a master's degree and/or Communication Handicapped Credential; possess a master's degree in rehabilitation counseling or are certified rehabilitation counselors; are currently employed as an independent living skills specialist with the deaf; or demonstrate specific competence to be employed in this capacity. Hearing and hearing impaired persons with interest and experience in working with deaf persons are urged to apply. For applications and information regarding program requirements, address inquiries to: Alice Nemon, Department of Counseling, San Francisco State University, 1600 Holloway Ave., San Francisco, Calif. 94132; tel. (415) 469-2005.

Audiovisual Lectures in Rehabilitation Issued by Northwestern University

A SERIES of "Lectures in Rehabilitation" have been made available by Northwestern University and the Rehabilitation Institute of Chicago. The audiovisual presentations include: *1)* "Overview of Rehabilitation Medicine," by Jacqueline Wertsch, M.D., 35 minutes, color; *2)* "Nursing Care of the Handicapped in the Acute Hospital Setting," by Linda Best Chalmers, R.N., 25 minutes, color; *3)* "Assistive Devices for the Rehabilitation Patient," by Sheridan Trail-Sorensen, OTR, 30 minutes, color; *4)* "Consumer Concerns in the Acute Hospital Setting," by Margaret Pfrommer and Don A. Olson, Ph.D., 20 minutes, color; *5)* "Medical Management of Spinal Cord Injury," by John Toerge, D.O., 55 minutes, color; *6)* "Management Problems of the Spinal Cord Injured," by Catherine Geibel, R.N., 25 minutes, black and white. The presentations are ¾ inch video cassettes and may be rented for $20 or purchased for $60; rental may be applied toward purchase. For further information or to order, contact: Ellie Wydeven, Research Dissemination, Rehabilitation Institute of Chicago, 345 E. Superior, Chicago, Ill. 60611.

Guide for Handicapped Riders Published

THE Canadian Riding for Rehabilitation Society has announced that *Riding for Rehabilitation: A Guide for Handicapped Riders and Their Instructors*, by Joseph Bauer, is now available. The 127-page publication deals with the technical problems that confront a handicapped rider as well as those encountered by instructors and their assistants. The detailed description of equipment and methods employed by the author and a number of European organizations prominent in the field of riding are documented with 84 illustrations. *Riding for Rehabilitation: A Guide for Handicapped Riders and Their Instructors* is available for $14.75 from CanRide, 209 Deloraine Ave., Toronto, Ontario, Canada M5M 2B2.

Listing of Services for Adults with Learning Disabilities

THE FIRST EDITION of the *Listing of Services for the Postsecondary LD Adult*, published by Academic Therapy Publications (ATP), has just been released. This listing, compiled in order to meet the new awareness of the need for services for adults with learning disabilities, will serve as a companion volume to the biannual *Directory of Educational Facilities for the Learning Disabled*, also published by Academic Therapy. More than 2,000 individuals and facilities were contacted for information for the listing, which includes facilities (and the precise services offered), colleges with programs for the LD student, self-help groups, relevant publications, and miscellaneous items of interest. Facilities and colleges are listed alphabetically within states. The listing has been designed to be used by adults with learning disabilities, parents, counselors, teachers, rehabilitation personnel, guidance specialists, and members of the Association for Children and Adults with Learning Disabilities at the local, state, and national level. ATP plans to upgrade the publication at regular intervals. Concerned and knowledgeable individuals are urged to submit new information on facilities for the adult with learning disabilities throughout the year so that each succeeding edition of the listing can be more comprehensive.

The booklet is available at no charge to anyone requesting a single copy. Additional copies are available in groups of 10 for $2.00 handling charges. Write: Academic Therapy Publications, 20 Commercial Blvd., Novato, Calif. 94947.

Booklet for Parents of Children With Genetic Disorders Offered

TWELVE MILLION AMERICANS have some type of genetic condition. Each year, 210,000 babies are born with genetic disorders or birth defects. *Learning Together: A Guide for Families With Genetic Disorders*, by Debra Haffner, is a new publication of the Health Services Administration, U.S. Public Health Service. This booklet is a guide on how to organize a parent support group, providing practical information and tips on health, education, laws, and resources that may be helpful to families with handicapped members. It is designed for parents and health professionals working with handicapped people to provide background on the role of mutual aid groups as an important adjunct to the medical delivery system. Copies of this publication *(Pubn. No. HSA 80-5131)* may be obtained from the National Clearinghouse for Human Genetic Diseases, 1776 E. Jefferson St., Rockville, Md. 20852.

Airport Guide Now in Braille

A BRAILLE VERSION of the comprehensive guide, *Services and Facilities for the Handicapped at Kennedy International, La Guardia, and Newark International Airports*, has been published by the Port Authority of New York and New Jersey. The publication offers a wealth of information about the facilities and services available to handicapped travelers at these airports. For complimentary copies, contact: Port Authority of New York and New Jersey, Aviation Public Services Division, One World Trade Center, Room 65 North, New York, N.Y. 10048.

Library of Congress Publishes Reference Work for Blind Musicians

Dictionary of Braille Music Signs, the only reference work of its kind for blind musicians using braille music notation, has just been published by the National Library Service for the Blind and Physically Handicapped (NLS/BPH) of the Library of Congress. The book, 210 pages in large print, was prepared by Bettye Krolick, a music braillist and consultant. It contains definitions of more than 400 music signs and about 100 literary abbreviations, and there are explanatory sections on the history of the braille music code and fundamentals of braille music notation. Signs defined include those used in current transcription and obsolete signs that appear in older music. The dictionary can be used by braille music readers to determine meanings of unfamiliar braille symbols. Each page of the print edition lists corresponding pages of a companion braille edition. In this way, sighted teachers and blind students can easily locate the same information.

The *Dictionary of Braille Music Signs* is available free of charge to blind musicians and music students. It will also be provided for music teachers, libraries, and schools serving blind music students. Interested persons should write to the Music Section, National Library Service for the Blind and Physically Handicapped, Washington, D.C. 20542.

This section serves as an index to current publications reviewed, digested, or abstracted in this issue. The subject headings are those under which the same references are cataloged in the Library of the National Easter Seal Society. The author index for each issue will be found on the inside back cover. The annual index, of authors only, is published at the end of the calendar year.

ACCESSIBILITY

See p. 174.

ADOLESCENCE

See 249.

ADOLESCENCE—SPECIAL EDUCATION

See 250.

AGING

252. **Kulys, Regina** *(Jane Addams College of Social Work, Univ. of Illinois at Chicago Circle, P.O. Box 4348, Chicago, Ill. 60680)*

Older people and their "responsible others," by Regina Kulys and Sheldon S. Tobin. *Social Work.* Mar., 1980. 25:2:138-145.

To determine if elderly persons know someone on whom they can depend in a crisis, 249 elderly persons (with a mean age of 78 years) were asked to name a person who would be responsible for them and their affairs if they were hospitalized (referred to as "responsible other"). The study also investigated the quality of the relationship between the elderly persons and their designated caretakers. All but 6 of the respondents named a responsible caretaker. Although the majority of persons surveyed were genuinely satisfied with their relationship with their caretaker, for half the participants this was not the person "closest" to them. Also, at least 10% of the designated caretakers did not give practical assistance or share ideas and concerns, indicating that practitioners should identify elderly persons without family and friends and strengthen their interpersonal relationships before a crisis occurs. Tabular data are discussed and 10 references are included.

AGING—INSTITUTIONS

253. **Kaufman, Allan**

Social policy and long-term care of the aged. *Social Work.* Mar., 1980. 25:2:133-137.

Long-term care is defined as treatment and services over an extended period of time—offered in an institution or other setting—for a chronic, irreversible condition. Issues involved in providing long-term care for elderly persons and their implications for social policy are discussed. A presentation of statistics on elderly persons requiring long-term care is followed by a critique of the federal government's policy of administering this care through its medical system. This policy is said to force the institutionalization of elderly persons who require long-term care but lack family support, sufficient funds, or the ability to negotiate for services in a community setting, and to foster dependence on residential treatment. Research is cited indicating that most elderly persons maintain close relationships with their children even though they may live apart from them, and that government policies on long-term care for the elderly can either substitute for or enhance the family's strengths. Among the recommendations made for developing quality long-term care for elderly persons are alternatives to institutionalization, specialized geriatric medicine for rehabilitation and prevention of chronic illness, and formulation of a comprehensive federal policy in this area that encourages families to care for their older members. 13 references.

Social Work is published by the National Association of Social Workers, 1425 H St., N.W., Suite 600, Washington, D.C. 20005.

254. **Meissner, Judith E.** *(Dept. of Nursing, Bucks Co. Community College, Swamp Rd., Newtown, Pa. 18940)*

Assessing a geriatric patient's need for institutional care. *Nursing 80.* Mar., 1980. 10:3:86-87.

Presented is a functional rating scale that nurses can use to determine if an elderly patient requires institutional care after hospitalization. The scale contains 7 groups of items. The first 2 groups assess general physical and mental functions, including eyesight, hearing, and orientation to time, person, and place. The remaining sections aid in evaluating patients' ability to function independently and their financial situation, the accessibility of their living quarters, and the availability of help from family, friends, and community services. Guidelines for using the scale are explained, and consultation with the patient's friends or family is recommended to obtain accurate scores.

Based on research performed by the scale's authors, 3 categories of patients are indicated: those who can live by themselves at home, those who would benefit from some form of supervision (in a boarding home or apartment project for elderly persons), and those requiring care in a nursing home, a hospice, or a psychiatric facility. This scale provides patients and families with a specific measurement on which to base decisions about post-discharge care.

AGING—MEDICAL TREATMENT

255. **Florence, David R.**

Adjustment to long-term care. *Nursing Homes.* Jan.-Feb., 1980. 29:1:18-19.

Prospective nursing home residents and their families often view placement in these institutions as the least attractive alternative to independent living, partly because research has found that nursing homes foster depression and dependence and provide only a minimum of activities. These misgivings about treatment, along with the shock of relocation and apprehension about health status, frequently cause problems in adjusting to these residences. This article

discusses the psychosocial needs of nursing home residents and their families so that their staffs can improve the quality of care. Physical capabilities, mental state, previous living environment, family visiting patterns, and self-concept are said to be among the main characteristics that affect a resident's ability to adapt to the new environment regardless of the quality of nursing care, which is also addressed. Since the family's reaction to placement influences the adjustment of the patient, the common feelings of families in this situation are described, along with 2 aspects of helpful family participation—concern for the resident and support for the staff. The importance of preplacement counseling in promoting a successful adjustment is stressed.

Nursing Homes is published by Heldref Publications, 4000 Albemarle St., N.W., Washington, D.C. 20016.

AMYOTROPHIC LATERAL SCLEROSIS

256. Weiner, Leslie P. *(Dept. of Neurol., McKibben 142, Univ. of Southern Calif., 2025 Zonal Ave., Los Angeles, Calif. 90033)*

Possible role of androgen receptors in amyotrophic lateral sclerosis. *Arch. Neurol.* Mar., 1980. 37:3:129-131.

Amyotrophic lateral sclerosis (ALS) is one of many motor neuron diseases of unknown etiology. Based on the finding that androgen receptors have been detected in both cranial nerve and spinal motor neurons, this article hypothesizes that ALS may be a disease in which androgen receptors in motor neurons are lost or not functioning. The hypotheses is suggested by the male-to-female ratio of the incidence of the disease, age of onset, and the sparing of neurons of cranial nerves III, IV, and VI that coincidentally lack androgen receptors. It is suggested that the loss of androgen receptors results in a variety of insults, including axonal damage. Investigations for testing this hypothesis, focused on correlating central nervous system androgen receptors with the processes of aging and repair, are recommended. 21 references.

APHASIA

See 235.

ARTHRITIS

257. Sheppeard, H.

Intra-articular osmic acid in rheumatoid arthritis: Five years' experience, by H. Sheppeard and D. J. Ward. *Rheumatol. & Rehab.* Feb., 1980. 19:1:25-29.

Two hundred and one patients with rheumatoid arthritis (in 305 knees) received intra-articular osmic acid in one or both knees. Assessment was based on relief of pain, warmth, tenderness, size and presence of effusion, degree of synovial thickening, and range of pain-free movement. Satisfactory results were obtained in 61% of all knees treated after one year, in 46% after 3 years, and in 22% after 5 years. Considering only those knees with no or minimal joint damage, favorable results were obtained at higher percentages—74% at one year, 63% at 3 years, and 38% at 5 years. The procedure was well tolerated and only 2 patients, who developed acute effusions on the day of injection, experienced post-injection pain. Other side effects are discussed. The physiology of this form of treatment is explained, and tabular data and 19 references are included.

Rheumatology and Rehabilitation is published by the British Association of Rheumatology and Rehabilitation, 2 The Green, Woodford Green, Essex IG8 0NF England.

ATTITUDES

See 301.

AUDIOLOGY

258. Billings, Bradley L.

Report writing in audiology: A handbook for students and clinicians, by Bradley L. Billings and Henry D. Schmitz. Danville, Ill., Interstate Printers & Publ., 1980. x, 46 p. paper.

Reports written by students in the field of audiology are usually quite lengthy and detailed because, in addition to transmitting information, they are used by supervisors to evaluate clinical activities. Since the purpose of a professional audiologic report is to summarize concisely but thoroughly the results of the evaluation that was conducted and their implications, professional reports are shorter than those written by students and are intended to be read in full by referral sources. To acquaint beginning audiologists with these differences in style and content, this handbook presents guidelines for writing useful and organized reports. Obtaining a case history that includes the reason for referral and methods of communication used is recommended as an aid to writing reports, and the value of easy-to-read forms (particularly an audiogram) is discussed. Examples of case histories and forms are provided. Four major sections of the report are described in detail: introduction, audiologic results, impressions, and recommendations. A practical feature of this text is the 15 sample reports illustrating the main concepts in a variety of common situations.

Copies of this publication are available for $3.95 from Interstate Printers & Publishers, 19-27 N. Jackson St., Danville, Ill. 61832.

BLIND—MENTAL HYGIENE

259. Needham, Walter E. *(Clinical Psychol., Eastern Blind Rehab. Cntr., Veterans Admin. Hosp., W. Spring St., West Haven, Conn. 06516)*

Irrational thinking and adjustment to loss of vision, by Walter E. Needham and Marjy N. Ehmer. *J. Visual Impairment & Blindness.* Feb., 1980. 74:2:57-61.

Some psychologists have hypothesized that the way in which persons think can directly influence the feelings that they experience and their general adjustments in life. Considering the implications of this theory, this article states that individual differences in coping with blindness seem to be related to a person's belief or disbelief in certain "irrational statements"

about this disability. The main irrational beliefs are that personal worth is dependent on physical adequacy, blind persons have a unique psychological make-up, personal happiness is always related to the extent of sight a visually impaired person retains, blindness adversely affects interpersonal relationships, and this disability will be cured by a new scientific discovery. Each of the statements is thoroughly discussed, and interventions in residential and nonresidential programs and psychotherapy that enable blind persons to evaluate misconceptions and develop realistic goals are described. 16 references.

BRAIN INJURIES

260. ***Developmental Medicine & Child Neurology.*** Supplement to 22:1.

Raised lead levels and impaired cognitive/behavioural functioning: A review of the evidence, by Michael Rutter.

Lead is known to be a neurotoxin and lead poisoning in children can cause encephalopathy, which often results in permanent neurological consequences and mental impairment. To determine the level of lead in the blood that may be detrimental to children, research findings on the effects of raised lead levels on children's cognitive and behavioral functioning are reviewed. Five types of studies are considered: clinical studies of children with high levels of lead, studies of mentally retarded children and those with behavioral problems, studies in which one variable was manipulated to determine its effect on another variable, investigations of children living near a lead smelter, and studies of dental lead in the general population. Although the findings are somewhat contradictory, the evidence suggests that persistently raised lead levels in blood in the range above 40μg/100ml may cause slight cognitive impairment (a reduction of 1 to 5 IQ points on average) and, less certainly, may increase the risk of behavioral problems. There are indications that there may also be psychological risks with lead levels below 40μg/100ml, but the available evidence on this point is inconclusive. Studies of other brain trauma are compared and suggestions are made for both practical implications and further research. 80 references.

Developmental Medicine and Child Neurology is published by Spastics International Medical Publications, 5A Netherhall Gardens, London, England NW3 5RN.

BURNS

261. **Becker, Bruce E.** *(Dept. of Phys. Med. & Rehab., Sacred Heart General Hosp., Eugene, Ore. 97440)*

Hypertrophic burn scarring: Control of chest deformities with a new device. *Arch. Phys. Med. & Rehab.* Apr., 1980. 61:4:187-189.

Kyphosis, restriction of the chest, and deteriorating body scar hypertrophy occurred in a 9-year-old boy after thermal injury, in spite of conventional therapy. To help alleviate these problems, a 2-piece polyethylene molded body jacket, which included a full neck and chin conformer and directly applied controlled pressure to the scar area, was constructed. Other features of this device were ease of application by one person, washability, and shoulder retraction with conformation to the complex topography of the anterior shoulders, anterior chest, and neck. The methods of constructing this jacket and 3 photographs of it are presented, and the boy's case history is summarized. Marked improvement in the appearance of the hypertrophic scar tissue began within 72 hours after the jacket was fitted; after wearing the device for shortly over 6 months, the child demonstrated full range of motion in his shoulder and neck, his chest expansion was typical for his age, and his stature was fully erect.

CEREBRAL PALSY

262. **Love, Russell J.** *(Vanderbilt Univ. School of Med., 21st Ave. South at Garland Ave., Nashville, Tenn. 37232)*

Speech performance, dysphagia and oral reflexes in cerebral palsy, by Russell J. Love, Evelyn L. Hagerman, and Elaine G. Taimi. *J. Speech & Hearing Disorders.* Feb., 1980. 45:1:59-75.

The adequacy of biting, sucking, chewing, and swallowing, as well as the presence or absence of 9 infantile oral reflexes, were assessed in 60 persons with cerebral palsy. The affect of the asymmetric tonic neck reflex (ATNR) and the Moro reflex on the infantile oral reflexes was also studied. A trend for persons with more adequate feeding skills to achieve greater overall speech proficiency and articulatory competency was noted. Fifteen participants demonstrated abnormal oral reflexes, which could not be elicited consistently; the effect of ATNR and Moro reflex on the oral reflexes appeared to be limited. Results generally reinforced the value of the prescription of improving feeding among persons with cerebral palsy, but the need to change abnormal oral reflexes received less support. The use of prespeech training or oral muscles to reduce possible future dysarthria is discussed in terms of the findings. Tabular data and 49 references are included.

CEREBRAL PALSY—PHYSICAL THERAPY

263. **Horgan, James S.** *(Behavioral Scientist, Dept. of Phys. Educ., College of Health, Phys. Educ., and Recreation, Univ. of Illinois, Chicago Circle Campus, P.O. Box 4348, Chicago, Ill. 60680)*

Reaction-time and movement-time of children with cerebral palsy: Under motivational reinforcement conditions. *Am. J. Phys. Med.* Feb., 1980. 59:1:22-29.

The purposes of this study were to determine the effect of motivational reinforcement (verbal praise) on the performance of a task measuring times of reaction and movement by children with spasticity from cerebral palsy, and whether this form of reinforcement could prevent the inhibition of the hyperactive reflex during the acquisition of a specific motor skill. Twenty boys and 16 girls with this disability were tested on the motor task under controlled conditions;

this task is fully described and illustrated by 2 photographs. Participants were matched and paired on the basis of this testing, and then grouped into experimental and control groups of 18 members each. The investigation consisted of initial and final week testing under controlled conditions, and 5 intervening weeks of behavioral treatment with the experimental group. Analyses showed that only the experimental group made significant improvement in their times of reaction and movement. Implications of the findings are discussed, and tabular data are included. 10 references.

CHILD CARE—INSTITUTIONS

264. Russo, Eva M.

Coping with disruptive behavior in group care, by Eva M. Russo and Ann W. Shyne. New York, Child Welfare League of America, 1980. 74 p. tabs. paper.

Treating aggressive children in group settings—whether they are referred to as delinquents, status offenders, or emotionally disturbed—necessitates an adequate number of staff who can respond to disruptive behavior with appropriate measures and limit the child's activities. As part of an effort to update standards for serving children in institutions and to determine the types of limitations commonly used by child care staff, this study analyzes responses to a survey from 144 facilities in the U.S. and Canada. The sample included 59 group homes, 16 child care institutions, and 69 residential treatment centers. Data are reported and discussed on characteristics of the facilities (staff, services provided, referral sources) and their populations (sex and age, race and ethnicity, intellectual and physical functioning, and behavioral classification), types of disruptive behavior exhibited, methods of coping with this behavior, and respondents' views on behavior management in their facilities.

Verbal abuse, loss of impulse control, absence without leave, and stealing were found to be the most pervasive forms of disruptive behavior. Discussion was by far the most frequently used method of dealing with these problems; restriction of privileges and separating a child from the group were other popular responses to usual misbehavior. Discharge was clearly the most frequently used form of responding to acute situations. The use of medications and secure confinement are discussed, and implications of the study for child care workers are stated. Excerpts from the survey questionnaire are appended.

Copies of this publication are available for $5.50 from the Child Welfare League of America, 67 Irving Pl., New York, N.Y. 10003.

CHILDREN—GROWTH AND DEVELOPMENT—MENTAL HYGIENE

See 236.

CLEFT PALATE

See p. 177.

CLOTHING

See 281.

COLLEGES AND UNIVERSITIES

See p. 162.

COLLEGES AND UNIVERSITIES—RECREATION

265. Mirell, Philip *(Div. of Rehab.-Educ. Services, Univ. of Illinois, Champaign, Ill. 61820)*

The disabled and recreational opportunities on campus, by Philip Mirell and Pat Barrett. *J. Phys. Educ. & Recreation.* Apr., 1980. 51:4:43-44.

Section 504 of the Rehabilitation Act of 1973 mandates equal opportunity for students with disabilities in athletic activities within federally assisted colleges or universities. Recreational professionals, according to the authors' interpretation of the legislation, must insure opportunity for participation by all students in a wide spectrum of recreational activities. Stated are several considerations that foster, as a prelude to planning, an understanding of the law's intent: heightened self-confidence often results from successful recreational participation, physical exercise and sensory feedback may be more important to handicapped students who lack prior environmental stimulation, myths about limitations of disabled students can be dispelled through social integration of all students, and lack of prior exposure to selection and acquisition of leisure skills by some students may dictate a different approach from that used with others who have acquired abilities. Integration of all students with similar interests, regardless of abilities, is a prime consideration in implementing the spirit of the law; segregated programs are viable only in certain instances. Adaptation should not be required of the participant, but should be made, when necessary, within the structure of the activity or the physical environment. Several recommendations for implementation are made and the recreational program of the University of Illinois at Champaign-Urbana is suggested as a model.

COLLEGES AND UNIVERSITIES—RECREATION—SURVEYS

266. Nesbitt, John A. *(Recreation Educ., Univ. of Iowa, Iowa City, Ia., 52242)*

Recreation services for students with handicapping conditions, by John A. Nesbitt, Bill C. Snyder, and Sharon Van Meter. *J. Phys. Educ. & Recreation.* Apr., 1980. 51:4:41-42.

Reported are responses to a questionnaire on campus recreation and disabled students completed by 31 colleges with members in the Association on Handicapped Student Service Programs in Postsecondary Education. Objective survey information reveals services covering a broad spectrum of recreational programming for hearing, visually, and physically handicapped students. A recounting of narrative information provided by coordinators of campus services in 14 of these institutions highlights special emphases in their particular setting. Concluding the article is a rationale for establishment of recreation education—whether in the form of scheduled classes, individual or group counseling—incorporating training in

advocacy and consumerism skills. An addendum enumerates and briefly discusses 10 points to consider in addressing recreational needs of collegians with disabilities; among the subjects mentioned are: consumer representation in planning, personnel, physical access, and recreational counseling and skills courses.

COMMUNICATIVE DISORDERS

See 235.

CONGENITAL DEFECTS

See 239.

CONGENITAL DEFECTS—DIAGNOSIS—PARENT PARTICIPATION

267. **Murray, Robert F., Jr.**

Special considerations for minority participation in prenatal diagnosis, by Robert F. Murray, Jr., and others. *JAMA.* Mar. 28, 1980. 243:12:1254-1256.

Parents who use information from prenatal diagnostic techniques (such as amniocentesis and fetoscopy) in family planning are often faced with serious ethical and moral decisions. Communicating with professionals and making these decisions may be more difficult for members of minority groups because of cultural background, educational and economic factors, general suspicion of governmental programs, and problems of access to diagnostic and therapeutic services. For professionals formulating ethical, social, and legal guidelines for prenatal diagnostic programs that will benefit minority groups, recommendations are presented in the areas of design, counseling, and access. Among the major proposals are that representatives of the minority group to be served by the program should be involved from the beginning in planning and development, counseling should be available before and after prenatal diagnosis and the risks of experimental techniques should be explained to parents, and persons should not be denied services if they cannot pay for them in full.

Reprints of this article are available from Tabitha M. Powledge, The Hastings Center, 360 Broadway, Hastings-on-Hudson, N.Y. 10706.

DEAF

See 242.

DEAF—SPECIAL EDUCATION—DESIGNS AND PLANS

268. ***British J. Audiology.*** Feb., 1980. Supplement No. 3. 1-24.

Design of educational facilities for deaf children.

Instead of presenting plans for a particular building, this booklet sets forth general guidelines for designing educational facilities for deaf children. The suggested method of design, which is outlined in an appended flow diagram, includes assignment of roles within a planning team, measurement of the level of environmental noise (particularly in the teaching areas), planning for controlling noise, obtaining space for audiometry and maintenance of equipment, and consideration of lighting and blackboard position, display areas, and amplification systems. Two tables contain subject headings to help architects organize plans in the areas of policy, operation, and design, and indexes of sound reduction of various types of partitions. Also appended are structured examples of the types of activities that occur in residential and day schools for the deaf, charts for measuring steady and variable noise, addresses of schools for the deaf recently built in the United Kingdom, and related references.

British Journal of Audiology is published by the Royal National Institute for the Deaf, in collaboration with the British Society for Audiology, 105 Gower St., London WC1E 6AH, England.

DEAF—SPECIAL EDUCATION—PROGRAMS

269. **Nober, E. Harris** *(Dept. of Communication Disorders, Univ. of Massachusetts, Amherst, Mass. 01003)*

Assessment of a higher education mainstreamed deaf program, by E. Harris Nober, Linda Nober, and Harry Murphy. *Volta Review.* Jan., 1980. 82:1:50-57.

In 1960, the California State University at Northridge began a program for deaf students enrolled in regular classes that offers notetaking services, interpreters, and vocational counseling. Centered on 64 deaf students enrolled in the program in 1975, this study compiled demographic, educational, and audiologic information about the students and asked instructors how they determined grades for deaf and hearing students and how they compared the skills of the 2 groups of students. Among these students, 72% stated that their deafness occurred before the age of 3, 83% said they regularly used hearing aids, and 88% and 91% were assisted by interpreters and notetakers, respectively.

Some of the concerns expressed by instructors regarding determination of grades for deaf students were the difference between students' potential and their performance, communication and emotional involvement between students and instructors, misinformation from interpreters, and the "morality" of the university's placing deaf students in regular classes with unprepared teachers. Seventy percent of the instructors stated that deaf students and hearing students receiving the same grade performed comparably on examinations. Reasons why the majority of deaf students were able to successfully complete their programs are suggested, and the importance of inservice resources for hearing students, instructors, and administrators is emphasized.

DEVELOPMENTAL DISABILITIES—PARENT EDUCATION

270. **Waisbren, Susan E.** *(Children's Hosp. Medical Cntr., Developmental Evaluation Clinic, 300 Longwood Ave., Boston, Mass. 02115)*

Parents' reactions after the birth of a developmentally disabled child. *Am. J. Mental Deficiency.* Jan., 1980. 84:4:345-351.

To gain an understanding of the ways parents react to the birth of a developmentally disabled child and to explore the effects of social and financial services on these parents, 30 families with a developmentally disabled child less than 1.5 years old were compared to 30 families with a nonhandicapped child of the same age. Half of the families lived in California and the other half lived in Denmark, which has a comprehensive national program for such families that includes cash subsidies, home counseling, day care, and free medical care. Results of interviews and questionnaires indicated that parents with a developmentally disabled child were very similar to other parents in most aspects of adjusting to a new baby, but that they expressed more negative feelings about themselves and their children. The public services of Denmark were not significantly more helpful to parents than services offered in the U.S., and the use of services correlated with positive adjustment in some areas and with negative adjustment in others. Several interpretations of this unexpected finding are discussed, and tabular data and 25 references are included.

DEVELOPMENTAL DISABILITIES—SOCIAL SERVICE

271. **O'Hara, David M.** *(Acting Dir., Social Services, John F. Kennedy Institute, 707 N. Broadway, Baltimore, Md. 21205)*

A family life cycle plan for delivering services to the developmentally handicapped, by David M. O'Hara, Harris Chaiklin, and Barbara S. Mosher. *Child Welfare.* Feb., 1980. 59:2:80-90.

Psychological services that address a family's life cycle take into account expectable crises in the lives of members and specific tasks that they must perform at certain ages, as well as variables in the social, psychological, and value structure. This article discusses ways in which social workers can use the family life cycle perspective to help families with developmentally disabled children. This focus on assisting the family considers the child's developmental stage in relation to the parents' aging; an example of a child entering young adulthood with parents between 40-60 years of age is provided, indicating the tasks, needs, problems, and services that are typical in this situation. Distinguishing between problems caused by social sources and those resulting from personal emotions is explained. An example of using this approach with a 20-year old girl with neuromuscular disease, who was poorly motivated, and her parents, who wanted her to develop greater independence, is provided. The importance of understanding the context of family life in serving developmentally disabled persons is emphasized. 22 references.

DIABETES

See 237.

DISEASES—PREVENTION

272. **U.S. Public Health Service. Office of the Assistant Secretary for Health**

Disease prevention & health promotion: Federal programs and prospects. Washington, D.C., The Service, 1980. v, 203 p. tabs. paper.

Composed of representatives of all agencies within the Department of Health, Education, and Welfare (HEW), the Departmental Task Force on Prevention was convened in December, 1977, to review and analyze departmental activities in preventing disease and promoting health. The basic premise of this report of the Task Force—which is essentially "a work plan for departmental action to be considered by the Secretary in establishing program priorities"—is that there are many available preventive practices that can improve health, and current research in this area appears to be promising.

Present knowledge about prevention and topics of future research related to 12 goals for health are discussed, including reduced incidence of major diseases and enhanced development of children and adolescents. A section on strategies for action encompasses ways of promoting health that improve lifestyle, measures that protect the environment, and personal preventive health services, noting the settings in which these actions are implemented and Federal responsibility for them. Efforts within HEW to support these strategies, as well as deficiencies in the Department's programs, are then identified, and the responsibilities for preventing disease and fostering health assigned to 10 departments and 17 agencies outside of HEW are described. Also indicated are standards that can be used to evaluate the relative magnitude of selected health problems and criteria that can be used to set priorities and develop recommendations. A concluding section presents recommendations for departmental efforts in 15 major areas (hypertension, occupational health, mental health) and considers their implications for health programs. Information on obtaining copies of the 10 appendixes to the report is provided.

Copies of this publication are available for $4.50 from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. *(Stock No. 017-001-00418-9)*

EMPLOYMENT

See p. 193.

EMPLOYMENT—PROGRAMS

See 311.

EPILEPSY—NURSING CARE

273. **Beniak, Judy** *(Comprehensive Epilepsy Program, Univ. of Minnesota, Minneapolis, Minn. 55455)*

The reality of epilepsy: An up-to-date approach for patients and practitioners, by Judy Beniak, Diana Miller, and Kathy Blesi. *J. Practical Nursing.* Mar., 1980. 30:3:22-26,38.

Since patients with epilepsy may be encountered in a variety of clinical settings, nurses must understand the condition and the implications for treating and educating the patient. Described are general characteristics of epilepsy and types of seizures, including absence (petit mal), generalized tonic clonic (grand

mal), partial seizures, and status epilepticus—occurrence of repetitive or continuous seizures without the regaining of consciousness. Diagnosis stems from results of various measures, including patient and family history, neurological exam, EEG, and obtaining an accurate description of the seizures. Nurses are encouraged to train patients and family members in accurately observing and describing seizures; a sample record form is given. Drug therapy and surgery are the 2 methods of management of epilepsy; circumstances indicating the latter option are delineated, and reasons for monitoring concentration of antiepileptic drugs in the blood are enumerated. Tabular data are included on drugs, their uses and side effects, as well as on nursing considerations with a hospitalized patient. Patient and family education is described as an essential component of nursing care of persons with epilepsy. Discussed are goals in education regarding medication, special concerns as to the general health needs of the patient, safety recommendations, patients' rights and responsibilities, and sources of additional information for patients and families.

FINGER PAINTING

274. **Alleyne, Antoinette**

Finger painting: A projective technique. *Can. J. Occupational Therapy.* Feb., 1980. 47:1:23-26.

Finger painting was used as a mode of therapy with 2 groups of psychiatric patients—hospitalized psychotic and severely depressed patients, and outpatients recovering from psychotic episodes and behavioral disorders. In this technique patients make a painting and verbally associate with it, providing an objective profile of personality and psychopathology that reveals mood and current conflicts. This medium provided for expression of feelings, collection of diagnostic data, and detection of change in mental status. The procedure for helping patients to paint, observations from the study, and analyses of paintings and verbal associations are discussed. Theories on the significance of the use of particular colors are reviewed. Finger painting was found to be an effective method of eliciting data, and further evaluation of the technique is recommended.

Canadian Journal of Occupational Therapy is published by the Canadian Association of Occupational Therapists, 25 Imperial St., Toronto, Ontario, M5P 1B9 Canada.

GLAUCOMA

275. **Penland, Lynn R.** *(School of Health, Phys. Educ., & Recreation, Ohio State Univ., 1760 Neil Ave., Columbus, Ohio 43210)*

The school's role in preventing blindness from glaucoma, by Lynn R. Penland and William R. Penland. *J. School Health.* Mar., 1980. 50:3:125-127.

Glaucoma, which is rarely accompanied by pain or warning signs, occurs when abnormal fluid dynamics within the eye cause increased pressure that can lead to blindness. Regular eye examinations and health education are recommended as the best means of preventing blindness from this disease. The structure and function of the eye are reviewed to explain the blockage of the outflow of aqueous humor fluid through the trabecular meshwork. The progressive loss of vision in glaucoma and examinations for its detection—consisting of a thorough case history, measuring of intraocular pressure and field of vision, and evaluation of the head of the optic nerve—are described. A rationale and practical suggestions for incorporating information on the prevention of glaucoma in school curricula are also presented. Illustrations of the eye are included.

HANDICAPPED

See 279.

HANDICAPPED—EQUIPMENT

276. **Dubose, Rebecca F.** *(Dept. of Educ., Univ. of Washington, Seattle, Wash. 98195)*

Easily constructed adaptive and assistive equipment, by Rebecca F. Dubose and Kristine Deni. *Teaching Exceptional Children.* Spring, 1980. 12:3:116-123.

As more physically disabled students enter public schools, administrators and teachers must supply adaptive equipment and materials that will allow the children to learn in the new environments. Presented is assistive equipment that was designed, constructed or adapted, and used in a classroom of severely physically handicapped children at the Harris Hillman School in Nashville, Tenn. Made from inexpensive materials, the equipment was constructed by a teacher and a maintenance employee and was designed for individual needs. The purpose, method of construction, and uses and variations for the following illustrated equipment are provided: ring pull toy, backpack, wireless signaling device, dowel rods for chairs, cut-away cup, foam cushions for lying on one's side, circular walker, adapted tricycle, seating inserts, a board for vestibular stimulation, a ladder to develop standing, and stilts, pads, and frames for toilets.

277. **Ivey, Ann** *(Consulting Physical Therapist, Arlington Independent School District, Arlington, Tex. 76012)*

Vestibular stimulator for handicapped clients, by Ann Ivey and Donald D. Roblyer. *Physical Therapy.* Mar., 1980. 60:3:309-310.

Stimulation of the vestibular cavity in the ear, which influences muscle tone, is used to improve gross motor skills and to facilitate reflex integration in physically handicapped persons. Small children can be held and moved around by the therapist providing treatment, but older patients require an assistive device. Described is a round scooter board with uprights and a rim that can be used in vestibular stimulation with moderately and severely disabled patients. Methods and materials (costing approximately $35.00) used to construct the stimulator are presented. A rope is used to pull the device in different directions at various speeds, according to clients' tolerance; facial expressions and noises are noted so that the therapist can stop when the client indicates. The

vestibular stimulator, illustrated by 2 photographs, is recommended as an enjoyable way of practicing balance and head, arm, and hand control.

278. **Wilshere, E. R.**, comp.

Equipment for the disabled: Hoists, walking aids. Oxford, England, Oxford Regional Health Authority, 1980. 64 p. photos, tabs. paper.

Containing over 200 illustrated items, this catalog is another edition in the frequently updated series on commercially available products in Great Britain that handicapped persons have found useful. The booklet is divided into 2 sections: equipment that helps disabled persons in transferring from one place to another, and aids that assist in walking. These sections are introduced, respectively, by information on assessment of patients and transfer techniques, and the use of walking equipment and alterations in the home for persons with arthritis. The hoists are grouped according to overhead, bathroom, hydrotherapy, car, slings, and carry seats. Standing aids, forearm trough crutches, walking sticks, and walking frames are among the 13 types of equipment presented in the latter half of the text. The listings contain addresses of manufacturers, dimensions, and approximate prices.

This publication is available for £2.40 in the United Kingdom and £5.75 in other countries from Equipment for the Disabled, 2 Foredown Dr., Portslade, Brighton BN4 2BB, England.

HANDICAPPED—PROGRAMS

See 248.

HEALTH SERVICES

See 244, 248, 295.

HEALTH SERVICES—PROGRAMS

See 247.

HEARING

See 303.

INDEPENDENT LIVING

279. **Milofsky, Carl** *(Institution for Social Policy Studies, Yale Univ., New Haven, Conn. 06520)*

Serving the needs of disabled clients: A task-structured approach. *Social Work.* Mar., 1980. 25:2:149-152.

As disabled persons achieve greater independence through deinstitutionalization and begin to form self-help groups for their own interests, rehabilitation professionals must consider consumers' requirements when establishing programs and services. This article discusses 4 types of tasks that professionals can help handicapped persons perform so as to enhance their independence: *1)* routine daily—mundane chores, such as cooking, cleaning, and repairs; *2)* personal—toileting, washing, dressing, and eating; *3)* community support—finding a job and housing; and *4)* institutional access—understanding service systems (services provided, requirements for aid, and logistics for securing assistance) and advocacy for rights. Various persons and resources that can be used to aid in completing these tasks—such as family and friends, practical nurses, and community networks—are described. It is suggested that social workers can help handicapped persons effectively use social institutions by learning about the complexities of the law, the availability of programs, direct intervention, and methods of advocacy.

See also 283.

INDEPENDENT LIVING—AUSTRALIA

280. **Parmenter, Trevor R.**

Vocational training for independent living. New York, World Rehabilitation Fund, 1980. 111 p. figs., tabs. paper.

The evolution of services for disabled persons in Australia generally corresponds to developments in other countries, but 2 important factors have influenced Australian programs in this area: awareness of the civil rights of minority groups has not been prevalent in the society, and the country's legal system does not support due process for individuals. Considering these differences, this booklet describes vocational programs that promote independent living skills among disabled persons based on the Australian perspective.

The rehabilitation services that are provided by the government (mainly through the Commonwealth Rehabilitation Services) and the private sector are summarized and evaluated. The concepts of vocational training and independent living are discussed as integral means of fostering the autonomy of handicapped persons, and a rationale for new approaches to these concepts that propose changes in the environment in which these persons live and structured programs that increase vocational choices is presented. One approach that is detailed is a systems model that takes into account the full range of needs of disabled persons, resources available in the community, and possible limitations. A problem statement is then formulated, programs are evaluated to ensure that goals are accomplished, and consumers are encouraged to offer feedback on the system. Six recommendations are made for improving the rehabilitation system in Australia, and a personal account of a disabled person's efforts to achieve greater independence is included. Eight appendixes contain descriptions of specific rehabilitation programs in Australia and approaches to assessment.

Further information on this publication is available from International Exchange of Information in Rehabilitation, World Rehabilitation Fund, 400 E. 34th St., New York, N.Y. 10016.

INDEPENDENT LIVING—PROGRAMS

See p. 169.

JUVENILE DELINQUENCY

See 264.

KNEE

See 257.

LARYNGECTOMY

See 245.

LARYNGECTOMY—EQUIPMENT

281. Kelly, Dan H.

The cover-up: Neckwear for the laryngectomee and other neck-breathers, by Dan H. Kelly and Peggy Welborn. Houston, Tex., College-Hill Press, 1980. xi, 98 p. illus. paper.

Laryngectomees often experience greater difficulties adjusting their self-concept than persons who have had other forms of surgery because the area of their stoma is visible to everyone they meet. To provide persons who have had a laryngectomy or a tracheostomy with more choices about their personal appearance and to help them gain greater confidence, this book describes how they can make and buy attractive neckwear. Two types of neckwear are presented: fashionable covers coordinated with the patient's wardrobe, and covers that are worn underneath clothing. Opening sections discuss the regular breathing pathways and the changes produced by tracheostomy and laryngectomy, and the associated problems caused by these operations—reflex coughing, incrustations, secretions, fistulas, and pedicles. Other benefits of neckwear besides appearance—such as keeping dust out of lungs, increasing the humidity of the air, and protecting against involuntary discharge—are noted. The main portion of the text consists of simplified, step-by-step sewing instructions for 10 types of neck coverings (turtlenecks, T-shirts, dickies, ascots), including a complete set of full-sized patterns, information about materials and fabrics, and illustrations of the completed garments. Also included are covers that can be made without patterns and those that are commercially available (with addresses of distributors).

This publication is available for $14.95 from College-Hill Press, P.O. Box 35728, Houston, Tex. 77035.

LEGISLATION

See p. 162, *p.* 174.

LIBRARY SERVICE—PERSONNEL—ACCESSIBILITY

See 241.

MENTAL DISEASE

282. National Rehabilitation Association

The rehabilitation of the mentally ill in the 1980's: A report of the fourth Mary E. Switzer Memorial Seminar, edited by Leonard G. Perlman. Washington, D.C., The Association, 1980. x, 126 p. figs. paper.

The Fourth Annual Mary E. Switzer Memorial Seminar was hosted by the Postgraduate Center for Mental Health in New York City on Oct. 31-Nov. 2, 1979. The conference was attended by 19 experts in the field of mental illness representing consumers, the Veterans Administration, mental health facilities, and rehabilitation personnel—including professionals from the National Institute on Handicapped Research and the National Institute of Mental Health. This text contains 6 papers written for the Seminar that address the current problems of discrimination against mentally ill persons in housing and employment and rehabilitating persons discharged from institutions. The monograph includes comments and questions from the participants and recommendations and implications for policy and program development, research, service delivery, training of personnel, and legislation.

Contents are: What Constitutes the Rehabilitation of the Mentally Ill in the 1980's? by Robert J. Grantham, p. 1-24.—Reducing Disincentives and Fostering the Rehabilitation of the Mentally Ill: A Psycho-Systemic Approach, by Les Brinson, p. 25-46.—Strategies for Coordinating Services in the Rehabilitation of the Mentally Ill, by Brockman Schumacher, p. 47-68.—Pretensions and Realities of Rehabilitating the Mentally Ill, by Leon R. McKinney and Doris W. Dennard, p. 69-86.—Reducing Disincentives and Fostering the Rehabilitation Process: An Existing Model Program, by Marshall Rubin, p. 87-112.—Post-Employment Services: An Essential Approach in the Rehabilitation of the Mentally Disabled, by Jerome Radin and Harry Sands, p. 113-122.

Copies of this monograph are available for $4.00 from the Switzer Memorial Fund, Monograph #4, National Rehabilitation Association, Suite 1120, 1522 K St., N.W., Washington, D.C. 20005.

MENTAL RETARDATION—EMPLOYMENT

See p. 190.

MENTAL RETARDATION—INSTITUTIONS

283. Sitkei, E. George

After group home living—what alternatives? Results of a two year mobility followup study. *Mental Retardation.* Feb., 1980. 18:1:9-13.

The recent placement of mentally retarded persons in community residences rather than institutions prompted an investigation of the number of persons who leave these residences and the types of alternatives that are available to them. The directors of 105 facilities that met specified criteria were interviewed regarding the living arrangements and characteristics of a total of 1,804 clients, and follow-up questionnaires were sent to them after 1 and 2 years to determine the whereabouts of the clients. After 1 year, 23% of the clients in the sample had changed their place of residence; 17% had done so after 2 years. Publicly operated facilities produced the largest number of transfers. The directors' subjective opinion was that 63% of the transfers moved to less supervised situations; the new residential status for the total group that moved (744 persons) is indicated in a table of data, which also includes reasons why the clients left the group home. A comparison was made between persons transferring and those remaining in

a group home for their personal attributes of sex, IQ level, and age, as well as previous placement, type of training or job status, and responsibilities in the home. Obtaining a paid job before leaving the group home appeared to increase chances for successful independent living, although 31% of the sample managed to move without jobs. Other characteristics of the residents, including social relationships within the group home, are discussed, and the role of the group home as a transitional stage between institutionalization and independent living is evaluated.

A complete report of this study has been published as Working Paper #107, which is available for $.50 from the Center for the Study of Mental Retardation, Clinical Services Building, University of Oregon, Eugene, Ore. 97403.

MINIMAL BRAIN DYSFUNCTION—PARENT EDUCATION

See p. 193.

MULTIPLE SCLEROSIS

See 246.

MUSCULAR DYSTROPHY—PSYCHOLOGY

284. Siegel, Irwin W. *(Dept. of Orthopedic Surgery, Louis A. Weiss Memorial Hosp., 4640 N. Marine Dr., Chicago, Ill. 60640)*

Kinetic family drawing test for evaluating families having children with muscular dystrophy, by Irwin M. Siegel and Marcia S. Kornfeld. *Physical Therapy.* Mar., 1980. 60:3:293-298.

The Kinetic Family Drawing Test (KFD) requires children to draw a picture with everyone in their family performing an activity in order to elicit the child's concept of family dynamics. Since an understanding of the effect of muscular dystrophy (MD) on family relationships is essential for treatment, KFD's were obtained from 10 boys with MD and from a nonhandicapped sibling of each of them. The drawings were then interpreted, and the actions, styles, and symbols were compared, accounting for the maturational and developmental processes of the various age groups (4 to 16 years). Ten drawings are presented and thoroughly analyzed. In the drawings of both the children with MD and their unaffected siblings there was evidence of personal anxiety that was said to be repressed at the expense of individual growth. The drawings of the children with MD sometimes depicted their siblings expressing marked anger and frequently demonstrated dependence on their mothers. Although the 10 families presented no complaints in interviews, drawings from 14 of the children showed problems in communication.

NUTRITION

285. Hoskins, John A. *(M.R.C. Toxicology Unit, Woodmansterne Rd., Carshalton, Surrey SM5 4EF England)*

Enzymatic control of phenylalinine intake in phenylketonuria, by John A. Hoskins and others. *Lancet.* Feb., 1980. 8165:392-394.

The plant enzyme phenylalanine ammonia lyase (PAL) remains active in the gut long enough to deplete the phenylalinine from food protein and thus reduce the level of this acid in the blood after a meal with protein. This effect was demonstrated in this study in 15 healthy persons and in patients with phenylketonuria (PKU). The excretion of hippuric acid was noted as a monitor of the enzyme's activity *in vivo.* The enzyme was also given to a 30-year-old man with PKU, who was not treated as a child, for 12 consecutive days (3 doses a day after meals). The levels of phenylalanine in his blood were reduced on the average by a quarter. Implications of the results for the treatment of PKU are discussed. Graphs of data and 13 references are included.

PARALYSIS AGITANS

286. Nausieda, Paul A. *(1725 W. Harrison St., Suite 909, Chicago, Ill. 60612)*

Dystonic foot response of parkinsonism, by Paul A. Nausieda, William J. Weiner, and Harold L. Klawans. *Arch. Neurol.* Mar., 1980. 37:3:132-136.

One third of 73 patients with idiopathic Parkinson's disease were found to experience debilitating, painful dystonic movements of the lower extremities. The prevalence of the involuntary movement disorder positively correlated with the duration of dopaminergic treatment, but it also occurred occasionally in untreated persons. This symptom of dystonic movement of the foot in parkinsonism is described as a distinct clinical entity that has no localizing value in frontal lobe disorders and is associated with extrapyramidal disease. Although it is exacerbated by dopaminergic therapy, the disorder also differs from well established dopaminergic side effects and does not consistently respond to manipulation of medications for parkinsonism. Although the exact pathophysiology of this movement dysfunction is unknown, its response to baclofen therapy suggests that neurotransmitter systems other than cholinergic or dopaminergic ones may be involved. Photographs illustrating this disorder and 24 references are included.

PARAPLEGIA

287. Bracken, Michael B. *(Dept. of Epidemiol. and Public Health, Yale Univ. Medical School, 60 College St., New Haven, Conn. 06510)*

Relationship between neurological and functional status after acute spinal cord injury: An epidemiological study, by Michael B. Bracken and others. *J. Chronic Diseases.* 1980. 33:2:115-125.

Examined are the relationship between neurological function (motor and sensory) and functional status as defined by 4 activities of daily living (ADL) after acute spinal cord injury. Motor function among the 192 participants improved significantly during hospitalization ($p<0.0001$) and during the year after discharge ($p=0.002$). Improvement in sensory function occurred both during treatment and rehabilitation,

but was only significant when measured over the entire year after injury ($p=0.01$). Sensory loss was 3 times more prevalent than motor loss after hospital discharge. Motor and sensory function were highly correlated at a 1-year follow-up, due to relatively greater improvement in motor as opposed to sensory function. All 4 ADL scores—walking, self-care, movement of limbs, and ability to transfer—indicated significant improvement ($p<0.0001$) between discharge and 1-year follow-up. Walking and self-care activities depended on both the independent and additive effects of motor and sensory function, while movement of limbs and ability to transfer depended more on motor function alone and on its combined effect with sensory function. The tabular data is thoroughly discussed.

288. Donovan, William H. *(Royal Perth Rehab. Med., Selby St., Shenton Park, West Australia 6008)*

Sensory and motor activity in the posterior primary rami following complete spinal cord injury, by William H. Donovan and George M. Bedbrook. *Arch. Phys. Med. & Rehab.* Mar., 1980. 61:3:133-138.

To determine the sensory and motor function existing below the level of bony spinal cord injury, 22 patients with post-traumatic, complete spinal cord injuries (8 with quadriplegia, 10 with paraplegia with thoracic lesions, and 4 with paraplegia with cauda equina lesions) were studied clinically and electromyographically. Motor function in the ventral rami was preserved only as far as the level of bony injury in persons with quadriplegia and those with paraplegia with cauda equina lesions; pain and light touch extended to similar levels anteriorly in these patients but was found to end at 1 to 3 segments proximal to the bony injury in 5 of the 10 persons with paraplegia with thoracic lesions. Electrical activity within the paraspinal musculature was found to be normal as far distal as the bony lesion; however, less than normal electrical activity consistently extended from 1 to 5 vertebrae distal to the bone injury. Pain and light touch from the posterior rami were preserved in all but 1 patient from 1 to 6 vertebrae below the osseous insult. The study indicates that there is a definite disparity between preservation of anterior and posterior rami level of function, and the level to which reduced electromyographic activity was seen to extend below the lowest injured vertebrae correlated reasonably well with the extent to which pain was appreciated. Diagrams of injured vertebrae and tabular data are included.

PARAPLEGIA—STATISTICS

289. DeVivo, Michael J. *(UAB Spinal Cord Injury System, Univ. of Alabama-Birmingham, Univ. Station, Birmingham, Ala. 35294)*

The prevalence of SCI: A re-estimation based on life tables, by Michael J. DeVivo, Philip R. Fine, and Samuel L. Stover. *Model Systems' SCI Digest.* Winter, 1980. 1:3-11.

Reported differences in incidence of spinal cord injury and survival statistics for persons with these injuries, the need for long-term health care services by these persons, and plans for national health insurance that would affect such services prompted an investigation of the prevalence of paraplegia and estimations of the life expectancy of persons with the condition. Estimates of prevalence were based on its relationship with incidence and duration of illness, using tables that compare the mortality rates of a specific population during selected periods of time. The use of a computer to calculate survival probability, based on the cases of spinal cord injured patients treated at one hospital between 1945-1966, is explained. The statistics present life expectancy tables for men and women with paraplegia by age at time of injury and characteristics of lesions; determination of differences in average life expectancy among patients of different ages at time of injury and of either sex, as well as among those whose spinal cord lesions are complete or incomplete at different levels; and re-estimation of the prevalence of spinal cord injury in the U.S., including an initial projection of the number of beds needed for persons with these injuries. The data are interpreted, and 21 references are included.

PHYSICAL EDUCATION—SEGREGATION AND NONSEGREGATION

290. Cathey, Mary Lee *(Dept. of Phys. Educ., Univ. of Iowa, Iowa City, Iowa 52242)*

Mainstreaming orthopedically disabled individuals in various physical activities: Parts I & II, by Mary Lee Cathey and Paul Jansma. *Directive Teacher.* Fall, 1979. 2:2:9,29. Winter, 1980. 2:3:16,27.

Physical education is the only curriculum area referred to in the P.L. 94-142 definition of special education and is frequently the first area in which handicapped students participate in regular class activities with limited or no supportive services. These articles, the first two of a 4-part series, present guidelines for helping children who use wheelchairs, crutches, or canes become active members of a physical education class while still challenging nonhandicapped students.

The first article provides general principles for programming in this area that are applicable to all students, emphasizing normalcy, minor modifications, and full participation. Among these principles are teaching students how to fall correctly, using activities and games that allow nonhandicapped students to simulate a disability (1-legged race), applying the same rules of discipline for all students, and random selection of teams.

Integrating physically disabled students in swimming activities is discussed in the second article. Suggestions for safety, accessibility, and maximum benefits for students are given for the locker room and pool exterior, the pool itself, swimming instructions, and assisting students with amputation, paralysis, and other restrictions. Swimming strokes that can be performed by students with specific disabilities are described.

In future issues, mainstreaming students in badminton and soccer will be considered.

PHYSICAL THERAPY

See 277.

PROSTHESIS

291. Leal, J. M. *(Prosthetics Research Lab., Veterans Admin. Medical Cntr., Tucson, Ariz. 85723)*

For accelerated postamputation rehabilitation: Zoroc intermediate prostheses, by J. M. Leal and others. *Orthotics & Prosthetics.* Mar., 1980. 34:1:3-12.

The Zoroc resim-coated plaster technique for the fabrication of an intermediate prosthesis is described, and the therapeutic effects of the prosthesis are discussed. The basic principle of the Zoroc technique is control of the size and shape of the amputated stump by use of predesigned shapes, such as the quadrilateral brim for above-knee amputations. A medial window is used when necessary for ease of application. Construction of above-knee, knee-disarticulation, and below-knee prostheses using this method is detailed and illustrated by 12 photographs. The intermediate prosthesis is said to allow for progressive rehabilitation without loss of ambulation time, an objective, economical determination of the rehabilitative potential of a patient, and shortened hospitalization through continuous treatment of patients while the plastic prosthesis is being fitted. These benefits are demonstrated in a review of the cases of 19 patients.

See also 267.

PSYCHIATRY

See 236, 274.

PSYCHIATRY—PROGRAMS

292. Murphy, Marjorie

Developments in a rehabilitation service for psychiatric patients. *Can. J. Occupational Therapy.* Feb., 1980. 47:1:15-22.

Described are the interdisciplinary rehabilitation services offered at the Clarke Institute of Psychiatry in Toronto, Ontario. The main goals of the program are to improve the quality of vocational assessment and adjustment, to facilitate patients' transition to the community, to act as a liaison with the community, to address vocational problems in a context other than strictly medical, and to allow professionals to concentrate on their fields of expertise. Topics covered include a historical review, current procedures, the roles of the rehabilitation team members, demographic information on clients served, and studies presently underway (computerized data collection, outcome, program analyses). The work adjustment program, which culminates in community placement, is discussed in detail. Tabular data and flow charts of procedures for providing services are included.

Canadian Journal of Occupational Therapy is published by the Canadian Association of Occupational Therapists, 25 Imperial St., Toronto, Ontario, M5P 1B9 Canada.

RECREATION (THERAPEUTIC)—SEGREGATION AND NONSEGREGATION

293. *Therapeutic Recreation J.* Fourth Quarter, 1979. 13:4:1-51.

Special issue devoted to mainstreaming handicapped individuals in the community.

The guest editor of this special issue points out that several recent activities in the field of recreation emphasize the importance of serving handicapped persons. Among these are government funded personnel preparation projects in colleges and universities and demonstration projects in selected agencies and communities focused on recreation for handicapped persons, numerous continuing education sessions on this subject, initial publication of literature on the topic, evidence of integrative efforts in community recreational programming, and inclusion of information about the needs and abilities of disabled persons in college curricula on parks and recreation. These seven articles on mainstreaming in recreation—which are grouped according to philosophy, staff training, and programming—propose to add to these efforts by encouraging therapeutic recreational specialists to integrate disabled persons into regular community programs and activities.

Contents are: Mainstreaming—In Recreation Too!? by Charles C. Bullock, p. 5-10.—A Conceptual Basis for Mainstreaming Recreation and Leisure Services: Focus on Humanism, by Roxanne Howe-Murphy, p. 11-18.—A Systematic Approach to Mainstreaming in a Public Recreation Department, by Jacquelyn Stanley, p. 19-26.—A Catalyst to Change, by Kathleen Collard and Ethel Charboneau-Klein, p. 27-30.—Is Mainstreaming for Everyone? Concepts and Issues as Experienced in One Program, by Michael Mushett, p. 31-33.—Mainstreaming: Social Ramifications of Integrating Physically Handicapped and Normal Populations, by Robert Antozzi, p. 34-40.—Mainstreaming in a Municipal Recreation Department Utilizing a Continuum Method, by Catherine Burdett and Mary E. Miller, p. 41-47.

Therapeutic Recreation Journal is published by the National Therapeutic Recreation Society, 1601 N. Kent St., Arlington, Va. 22209.

REHABILITATION

294. *J. Rehabilitation.* Jan./Feb./Mar., 1980. 46:1:19-57.

Special section entitled "The Professional Touch."

Contents are: Team Strategies for Family Involvement in Rehabilitation, by Grady P. Bray, p. 20-23.—Program Evaluation for State Rehabilitation Agencies: Federal Standards and Advocated Models, by Carl Hauser, p. 25-28.—Psychosexual Sequelae to Mastectomy: Implications for Therapeutic and Rehabilitative Intervention, by Harold J. May, p. 29-31,41.—Fads, Flaws, Fallacies and Foolishness in Evaluation of Rehabilitation Programs, by Randall M. Parker and Kenneth R. Thomas, p. 32-34.—High Speed Electronic Typing Aids Rehabilitation Program, by Beverly J. Grosick and Joyce Greb, p. 35.—Biofeedback: A New Rehabilitation Service, by William H. Knight, p. 36-37.—Follow-up Study: Patients Who Had Corrective Surgery for Idiopathic Scoliosis, by Dorothy C. Bean, p. 38-41.—A Rehabilitation Process Model, by J. Stuart Phillips, p. 42-45.—Assertiveness Training for Emotionally Dis-

turbed Clients, by Robert R. Douglas, p. 46-47.—An Eco-behavioral Perspective on Habilitative Programming: The Case of the Accidental Withdrawal Design, by Virginia Fraser and others, p. 48-51.—Developing and Implementing the Management Control Project (MCP) in the Georgia DVR Agency, by Jack R. Crisler, Timothy F. Field, and Jean Pierson, p. 52-57.

Journal of Rehabilitation is published by the National Rehabilitation Association, 1522 K St., N.W., Washington, D.C. 20005.

REHABILITATION—EUROPE

See p. 194.

REHABILITATION—PERSONNEL

295. Roemer, Ruth *(School of Public Health, Univ. of Calif.-Los Angeles, 5151 State University Dr., Los Angeles, Calif. 90032)*

Health service developments: Their impact on regulation and functions of rehabilitation personnel. *Arch. Phys. Med. & Rehab.* Apr., 1980. 61:4:182-187.

The responsibilities and limits of rehabilitation personnel are defined by direct regulation of personnel through licensure and certification and by indirect regulation through the system in which the health professionals work. This article summarizes current developments in health services that will probably affect the regulation and performance of rehabilitation personnel in the U.S. Discussed are the major trends initiated in the country during the past 15 years in the area of direct regulation, among which are important changes in existing licensing laws (expanding delegation of functions, strengthening supervision of performance, and increasing public accountability), the establishment of licensure among various rehabilitation professions, formation of the National Commission for Health Certifying Agencies and the Council of Postsecondary Accreditation, and passage of the Health Profession Educational Assistance Act of 1976. Direct regulation of rehabilitation personnel in Australia, Canada, Belgium, Norway, and Poland is reviewed. Regional planning and resources development for health services, the growth of health maintenance organizations, and enactment of some form of compulsory national health insurance are cited as 3 types of indirect regulation that will alter the duties of health personnel, the settings in which they work, and the ways they are reimbursed. The probable effects of these developments on functions, education, and certification of rehabilitation professionals are also addressed. 20 references.

SEX EDUCATION

296. Gordon, Sol *(Dir., Institute of Family Research & Educ., Syracuse Univ., 760 Ostrom Ave., Syracuse, N.Y. 13210)*

Family life education for the handicapped, by Sol Gordon and Craig W. Snyder. *J. School Health.* May, 1980. 50:5:272-274.

Stating that only 10% of the students in U.S. public schools receive adequate sex education, the authors point out that self-concept is directly related to a sense of sexual well-being and that the confidence and self-image of disabled adolescents can be greatly improved by comprehensive family life education. The following concepts are recommended as the basis for sex education for handicapped teen-agers: enhancing the self-concept, preparing for making responsible decisions and for marriage and parenthood, understanding of love, emphasizing the need for equal opportunities for men and women, encouraging tolerance of differences in sexuality, and appreciation of the sexual dimension of life. Moral considerations and obstacles to helpful sex education are also discussed, and 8 suggestions for enhancing disabled students' self-esteem are provided.

See also 249.

SHELTERED WORKSHOPS

See p. 180.

SICKLE CELL ANEMIA—MENTAL HYGIENE

297. Conyard, Shirley *(Sickle Cell Program, Dept. of Med., Jewish Hospital and Medical Cntr., 555 Prospect Pl., Brooklyn, N.Y. 11238)*

Psychosocial aspects of sickle-cell anemia in adolescents, by Shirley Conyard, Muthuswamy Krishnamurthy, and Harvey Dosik. *Health & Social Work.* Feb., 1980. 5:1:20-26.

Reported are results of a pilot test of a task-oriented group approach to handling psychosocial problems of adolescents with sickle cell anemia. A 1972 study conducted by the authors, involving 21 adolescents, had revealed that psychosocial aspects of sickle cell disease resemble those of other chronic illnesses, including withdrawal from normal relationships, poor self-image, depression, and preoccupation with death. However, the article claims that society offers less hope to persons affected by sickle cell disease, and individual casework has been unsuccessful in meeting the psychosocial problems. The task-oriented approach (defined as "putting into practice the concerns of the group as expressed in its discussions through the carrying out of assigned tasks") was used with 6 of the teen-agers to build on the strengths and knowledge they possessed in order to reduce anxiety, enhance social functioning, achieve self-fulfillment, and participate more fully in the mainstream of life. Through weekly meetings held over a 20-month period ending in 1975, the group, guided by a social worker, held discussions and participated in a series of tasks that required increasing self-initiated action: a group-organized party, field trips to which each member invited a friend, removal from special classes in school, adoption of independent hobbies, attendance at a residential camp, and obtaining a summer job. All but one group member successfully participated in all tasks. Initial tasks reportedly increased members' self-esteem and subsequent tasks enabled members to become somewhat independent, socially active, and eager for self-fulfillment. Tabular data and 18 references are included.

SOCIAL SECURITY—SURVEYS

298. U.S. Social Security Administration

Survey of blind and disabled children receiving supplemental security income benefits: Executive summary. Washington, D.C., The Administration, 1980. 12 p. paper.

Before the Supplemental Security Income (SSI) program was instituted in 1974, there was a debate among legislators concerning whether or not disabled children in low-income families have greater financial needs than nondisabled children from these families. To answer questions raised by this debate, representative payees of over 1,850 children receiving SSI benefits were interviewed using a structured questionnaire. This executive summary presents data from the questionnaires in 4 categories: *1)* a basic socioeconomic and demographic descriptive analysis of children receiving SSI benefits and their families; *2)* a descriptive analysis of the disabilities of children receiving these benefits, the dysfunction that the disabilities cause, and the effect of the disability on the child's family; *3)* an evaluation of the adequacy of SSI benefits for children and of the administration of the program; and *4)* a descriptive analysis of the ways in which health care, education, and social services are provided for the children by their families and public and private programs. A method for investigating particular policy concerns in greater depth is indicated.

Additional information on this publication *(SSA Publ. No. 13-11728)* is available from Urban Systems Research & Engineering, 36 Boylston St., Cambridge, Mass. 02138.

SOCIALLY HANDICAPPED

See 267.

SPECIAL EDUCATION

299. *J. School Health.* May, 1980. 50:5:242-294.

Special issue on the child with a handicap.

Due to medical advances that allow high-risk infants to survive and the implementation of P.L. 94-142, a greater number of handicapped children are entering public and private schools with nonhandicapped students. This special issue is addressed to all health professionals and their colleagues in education who must meet the various challenges that disabled children present. A prologue to the 18 articles identifies major areas that educational programs should consider in the future: a continuum of care from infant stimulation through adult services, involvement of children and parents in formulating educational programs, long-range planning, legal ability, a multidisciplinary approach, and evaluation.

Partial contents are: An Historical Perspective, by Edwin W. Martin and Julius B. Richmond, p. 244-245.—Support Services in the School Setting: The Nursing Model, by Clydia B. Steenson and Allen R. Sullivan, p. 246-249.—Medical Assessment of the Child with a Handicap, by Carol Coleman Gray and Patricia L. McDonald, p. 250-251.—Psychosocial Assessment of the Handicapped, by John L. Johnson, p. 252-255.—Educational Assessment: Presumed Intelligent Until Proven Otherwise, by Asa G. Hilliard, III, p. 256-258.—Use of Medical Information in School Planning, by Elizabeth Bryan, p. 259-261.—The Individualized Educational Program (IEP): New Concept? or New Label? by J. A. Camille Vautour and Mary E. Vautour, p. 262-263.—Physical and Occupational Therapy, by Ruth A. Kalish and Stephanie Presseller, p. 264-267.—Adapted Physical Education: Perspective on Systematic Implementation, by Kenneth W. Duke and Claudine Sherrill, p. 270-271.—Coping with Double-Barrelled Discrimination, by George W. Fair, p. 275-276.—Mainstreaming Handicapped Children: The Underlying Legal Concept, by Jerry W. Vlasak, p. 285-287.—Summary of Statement on School Nurses Working with Handicapped Children, prepared by Judith B. Igoe, p. 287.—Financial and Administrative Consideration, by William Schipper, p. 288-290.—Values of the Professional and Their Effect on Handicapped Youth, by Paul H. Chesmore, p. 291-292.—Predictions, by Frank A. Borreca, p. 293-294.

Journal of School Health is published by the American School Health Association, 1521 S. Water St., P.O. Box 708, Kent, Ohio 44240.

See also p. 186; 243, 276.

SPECIAL EDUCATION—PARENT PARTICIPATION

300. Turner, Ruth M. *(D.J.M., Dept. Research & Evaluation, Dallas Independent School District, Dallas, Tex. 75204)*

Involving parents in special programming, by Ruth M. Turner and Daniel J. Macy. *J. School Health.* May, 1980. 50:5:281-284.

The concepts of individualized education program and due process as specified by P.L. 94-142 have led to greater involvement by parents in evaluation, placement, and programming. In this article, parent programming is defined as direct services to parents that help them manage their personal and family life, as well as educate their handicapped children. Stating that the content and methodology of parent programming should be based on the assumptions of both parents and professionals, the authors present their own basic assumptions, the foremost of which are that parents should assume a major teaching role in the education of their handicapped child and that they can be helped to become more competent. Competency-based programming consists of selection of an accepted set of skills that are important to a particular group of parents, determination of parents' levels of competency (through self-assessment scales), and teaching to improve skills (through group discussions on child development, viewing videotapes of children at play, reading relevant material). Individualizing these programs for parents is recommended. Also reported are the results of a rank ordering by 31 parents and 75 school professionals of 69 competencies in terms of significance for parents of young handicapped children. Both parents and professionals gave higher priority to affective skills—

such as encouraging children to try new experiences—than to those related to instructional materials and the self-confidence of parents. Tabular data and 18 references are included.

SPECIAL EDUCATION—PHYSICAL THERAPY

See 240.

SPECIAL EDUCATION—SEGREGATION AND NONSEGREGATION

301. Liddle, John T. *(Dept. of Phys. Educ., Pullman School District, Pullman, Wash. 99163)*

What is it like to be handicapped? by John T. Liddle and Susan K. Breihan. *J. Phys. Educ. & Recreation.* Mar., 1980. 51:3:35, 76, 79-80.

To help nonhandicapped students appreciate the difficulties of their disabled peers, practical lessons that simulate the experiences of persons with sensory, speech and language, and physical impairments are presented. The lessons, which require a minimum of equipment and may be taught as a single unit of instruction or planned over a full school year, consist of introductory activities, a core concept, and a supplementary game. Sample questions encourage students to discuss their frustrations and feelings experienced during the activities at the completion of the lessons. The games and activities include walking around a mat with closed eyes, giving directions for a game in sign language, tying shoelaces with one hand, and asking students to read with marshmallows in their mouths. The importance of preparing students for stress that may be caused by these lessons is emphasized.

SPECIAL EDUCATION—STUDY UNITS AND COURSES

302. Edwards, Linda L. *(Dept. of Special Educ., Univ. of Missouri-Kansas City, 5100 Rockhill Rd., Kansas City, Mo. 64110)*

Curriculum modification as a strategy for helping regular classroom behavior-disordered students. *Focus on Exceptional Children.* Apr., 1980. 12:8:1-11.

A validation of a strategy for improving the academic performance and classroom conduct of behaviorally disordered, low achieving, mainstreamed elementary students is presented. A review of the focus of previous strategies—task, task and academic performance, and antecedent events and teaching performance—is followed by a rationale for an intervention that decreases problematic behavior by increasing academic success. The proposed intervention consists of 2 components: modified curriculum—formulation of specific instructional objectives, adaptation of the content of the unit for various reading levels, immediate corrective feedback, visual reinforcement through graphing of test scores, and modification of workbooks to promote successful responses; and motivation—reinforcement of attention to task, reinforcement of percentage scores on tests, and consequences of behavior used with nonhandicapped children.

These 2 components were evaluated with 23 fourth graders with behavioral and academic problems in 4 classrooms randomly assigned to modified or traditional curricula. The 3 reinforcements were used with all of the students. Based on percentages of correct answers on examinations, the academic achievement of students in the modified curriculum was significantly higher than those in the traditional curriculum. The reinforcement procedures did not appear to have a beneficial effect on the achievement of either group. Students in the modified curriculum also showed greater attention to task, particularly when no systematic reinforcement was employed, and exhibited significantly fewer deviant behaviors. The implications of the data, which are presented in 3 graphs, are thoroughly discussed. 32 references.

SPEECH

See 262.

SPEECH CORRECTION

See 238.

SPEECH CORRECTION—PROGRAMS

303. Subtelny, Joanne D. *(National Technical Inst. for the Deaf, Rochester Inst. of Technol., 1 Lomb Memorial Dr., Rochester, N.Y. 14623)*

Description and evaluation of an instructional program to improve speech and voice diagnosis of the hearing impaired, by Joanne D. Subtelny, Robert L. Whitehead, and Nicholas A. Orlando. *Volta Review.* Feb., 1980. 82:2:85-95.

The principles for improving diagnosis of speech problems among hearing impaired persons are stated, and an instructional program designed to develop diagnostic skills among students in speech and language pathology is described. Ten characteristics of speech and voice were identified to assess general competency in speaking as well as various processes involved in generating speech. A method for training professionals to use the diagnostic procedure consisted of 2 parts: 3 audio tapes explaining the rating systems and presenting speech samples of each characteristic with varying degrees of severity, and 2 tapes for practicing diagnosis and evaluating the auditor's mastery of the rating system. The validity and reliability of the training materials were evaluated by 15 speech pathologists experienced in working with young hearing impaired adults. Further study with 25 graduate students in this field, who had not previously listened to the speech of hearing impaired persons, demonstrated that the use of training materials significantly improved their diagnostic skills. The materials are recommended for academic programs, inservice training, and mainstreamed classrooms. Included are graphs and tabular data.

SPINA BIFIDA—BIOGRAPHY

304. Bennett, Carol J.

Giant steps for Steven. Mayfield Heights, Ohio, After School Exchange, 1980. 25 p. photos. paper.

"Did you ever have an accident?" 5-year-old Steven Bennett asks younger readers in the opening of this informative book, which is written by his mother in his own words. Steven then says that an "accident" happened to him before he was born—an open spine—and relates how he used braces to strengthen his legs. The 32 photographs show Steven using crutches, riding a tricycle, painting and playing in nursery school, and participating in physical and occupational therapy. In the various pictures Steven appears reflective, inquisitive, playful, happy, and determined. His use of a catheter and a shunt are also explained and illustrated. This unique portrait of a child with spina bifida is a useful introduction for children, parents, and professionals.

Copies of this publication are available for $2.95 (plus $.75 for postage and handling) from After School Exchange, 1111 Belrose Rd., Mayfield Heights, Ohio 44124.

SPINA BIFIDA—PARENT EDUCATION

305. Spina Bifida Association of America

The child with spina bifida, by Charles A. Swinyard. Fifth edition. Chicago, Ill., The Association, [1980]. ii, 54 p. figs., paper.

Emphasizing that no 2 disabled children are exactly alike, this revised booklet responds to concerns common to all parents of children with spina bifida. Characteristics of the condition and its effects on children's motor development are detailed, and the associated defect of hydrocephalus and its treatment are discussed. An overview of problems with muscle weakness and bowel and bladder dysfunction includes management methods, and a section on mobility and immobility complications—including osteoporosis, pressure ulceration, and obesity—reviews preventive measures. Treatment concerns regarding deformities of the foot and ankle, knee, hip, and spine are included. Parents are counseled regarding the likelihood that children born to them later will also have spina bifida; prenatal detection using amniocentesis is explained in detail.

The abundance of knowledge provided is intended to help parents understand the ways in which various medical and allied health specialists will preserve children's lives and help them function independently in many aspects of life. Since fears regarding the future of children with spina bifida are common to their parents, the booklet concludes by briefly addressing concerns regarding the children as members of the family, educational experiences both before and during formal schooling, and sexuality and marriage.

Copies of this publication are available for $1.00 (10 copies, $.75; 50 copies, $.60) from Spina Bifida Association of America, 343 Dearborn St., Chicago, Ill. 60604.

STRESS

306. Goodwin, Lloyd R. *(Inst. for Social and Rehab. Services, Assumption College, 500 Salisbury St., Worcester, Mass. 01609)*

Stress management for rehabilitation clients. *Rehab. Counseling Bul.* Mar., 1980. 23:3:193-201.

Stress—the general response of the body to a situation demanding readjustments or adaptation—is an important factor in the onset, progression, and treatment of almost every disability. This article discusses how rehabilitation counselors can help clients manage stress to prevent the onset of new illnesses, adjust to existing disabilities, and improve their quality of life. After a consideration of disorders caused by stress and patients' and families' patterns of reaction to disability, sources of anxiety and stress in rehabilitation are identified. The innate neurophysiological response to stress and an analogous physiologic response that enables the person to relax are explained. Teaching handicapped persons to relax through such methods as meditation, yoga, biofeedback, and autogenic training is suggested. 37 references.

STUTTERING

307. Silverman, Franklin H. *(College of Speech, Marquette Univ., Milwaukee, Wis. 53233)*

The stuttering problem profile: A task that assists both client and clinician in defining therapy goals. *J. Speech & Hearing Disorders.* Feb., 1980. 45:1:119-121.

Behavioral therapy for stuttering begins with identification of specific behaviors to be modified. Described is a profile that provides qualitative data to use in establishing goals for stuttering therapy. Used by several hundred clinicians during the past 10 years in over a dozen facilities, the profile does not yield a score but instead elicits clients' responses as a basis for discussion. The 86 first-person statements that comprise the diagnostic aid were abstracted from the responses of 108 stuttering adults to a question regarding ways in which their stuttering problem had improved during the past 5 years. In addition to identifying therapeutic goals, the profile (a copy of which is included) can be used to avoid a stereotyped approach to therapy, to define what can be expected from therapy and what the clinician is trying to accomplish, to document the effects of therapy, and to determine if therapy should be terminated.

STUTTERING—EQUIPMENT

308. Dewar, Ann

The long term use of an automatically triggered auditory feedback masking device in the treatment of stammering, by Ann Dewar and others. *Brit. J. Disorders of Communication.* Dec., 1979. 14:3:219-229.

Described are the portable and clinical bench models of an auditory feedback "masking" device and results of their use by persons who stutter. The portable model is made up of a pocket-sized control unit connected by a single lead to a throat microphone and earpieces, with an oscillator that varies the frequency of the masking tone in response to that of the user's vocal cords; the clinical bench model is a more versatile derivative, with greater range of volume and controls for varying the tone and frequency of the masking sound. Both models are pictured and the

procedure for testing the device is described. The aid effectively reduced stuttering in 89% of a sample of 195 persons, and improvements in speech were noted among the majority of users for as long as 3 years. In a follow-up study of 67 persons who had used the device for 6 months or longer, 82% of the participants reported a high degree of benefits, and 67% stated that their unaided speech fluency had improved. Graphs and tables of data from these tests are presented. Undesirable side effects have not been observed among users.

British Journal of Disorders of Communication is published by the College of Speech Therapists, Harold Poster House, 6 Lechmere Rd., London NW2 5BU, England.

VOCATIONAL EDUCATION

309. Taborn, John M. *(Univ. of Minnesota, 214 Social Science Bldg., Minneapolis, Minn. 55455)*

Career development for diverse populations of handicapped students, by John M. Taborn and Pearl S. Barner. *J. School Health.* May, 1980. 50:5:278-280.

Educators are advised on how to apply theories and models of vocational and career development so as to enable handicapped students to realize their potential for work. The effects of disability and socioeconomic background on main stages of vocational development—growth, exploration, establishment, maintenance, and decline—are discussed. A 3-phase vocational program for handicapped students with specific areas of focus at the following levels of schooling is described: *1)* elementary school—awareness of personal feelings and values and their relation to the environment, *2)* middle and junior high school—exploration of possible careers, and *3)* high school—preparation for careers through precollege courses, vocational training, work-study, and assessment. It is recommended that professionals learn to acknowledge their discomfort in working with handicapped and minority students as an initial step in developing self-esteem among these students, who should be provided with appropriate role models through formal meetings and biographical or fictional readings.

VOCATIONAL GUIDANCE

See 280.

VOCATIONAL GUIDANCE—PROGRAMS

310. Kneipp, Sally A. *(Dir. of Training, Rehab. Research & Training Cntr., Temple Univ., Philadelphia, Pa. 19122)*

An evaluation of two job-search skills training programs in a vocational rehabilitation agency, by Sally A. Kneipp, David Vandergoot, and Richard E. Lawrence. *Rehab. Counseling Bul.* Mar., 1980. 23:3:202-208.

A follow-up study of 122 persons with physical or mental disabilities (or both) assessed the relationship between 2 methods of vocational counseling and job-seeking skills. Training program I used films to teach interpersonal and job-search skills in a 2-day period, and program II consisted of a 1-hour slide presentation (with sound) supplemented by various group activities. Five dependent variables were studied: number of job placements, number of job contacts, knowledge of job-search skills 6 weeks after treatment, job readiness at the end of the programs, and job readiness 6 weeks after treatment. The methods of measuring these variables, procedures for collecting data, and 5 hypotheses that were tested (at a .05 level of significance) in comparing the 2 programs are described. The only significant difference found between the 2 groups of clients was in the retention of preparedness for work. Six weeks after training, there was a greater mean number of clients with good job-readiness skills among those who participated in program I than among those who participated in program II. However, at the conclusion of the study only 21 of the 122 participants were considered to be ready for employment. Implications of the tabular data are discussed.

VOCATIONAL REHABILITATION—PROGRAMS

311. National Urban Coalition

The disabled worker: A community guide to vocational rehabilitation programs. Washington, D.C., The Coalition, 1980. 19 p. photos. paper.

The premise of this booklet is that given basic assistance and encouragement in obtaining employment, "people with handicaps can achieve not only greater financial security and personal satisfaction, but can add to community resources rather than depleting them." The federal vocational rehabilitation programs that offer this assistance are described, and ways in which community organizations, business, industry, and labor unions can join in these efforts are recommended. The vocational rehabilitation programs authorized by the Rehabilitation Act of 1973 and administered by the Rehabilitation Services Administration (RSA) are discussed in terms of eligibility, serving severely handicapped persons, and comprehensive services (including those intended to foster independent living). State and federal funding and administrative responsibilities, referrals and evaluations, and job training are covered in a section on the operation of these programs, and examples of Projects with Industry—in which corporations, labor unions, and community organizations participate in training and other programs related to work—are provided. Also considered is coordinating RSA programs with employment programs of the Comprehensive Employment and Training Act, special educational services, Veterans Administration programs, vocational education, and federal offices serving handicapped persons (summarized in 2 appendixes). Four opportunities for organizations to become involved in the delivery of vocational rehabilitative services are presented: planning and monitoring programs, referring clients to services, operating programs, and placing clients in jobs.

Single free copies of this publication are available from the National Urban Coalition, 1201 Connecticut Ave., N.W., Washington, D.C. 20036.

WHEELCHAIRS

312. **Janelli, Harvey V.** *(Thomas A. Krouskop, Rehab. Engineering Cntr., Texas Medical Cntr., 1333 Moursund Ave., Houston, Tex. 77030)*

Positive pressure respiratory assist for wheelchair-mobile persons, by Harvey V. Janelli and others. *Arch. Phys. Med. & Rehab.* Mar., 1980. 61:3:143-144.

Described is a low-profile (8.5 cm thick), lightweight (4.5 kg), battery-operated respirator that fits under a wheelchair lapboard and propels the chair. The device operates by pressurizing the abdomen to compress the lungs and force exhalation, eliminating the need for a mouthpiece or tracheal tube. Methods and materials used in the construction of the respirator are presented, and plans for improving the design (including a new type of cam and shaft mechanism) are discussed. This device has been used successfully in test cases of over 9 months for as long as 9 hours each day. Photographs of the equipment mounted on a wheelchair lapboard are included.

Author Index

REHABILITATION LITERATURE

Rehabilitation Literature is intended for use by professional personnel and students in all disciplines concerned with rehabilitation of the handicapped. It is dedicated to the advancement of knowledge and skills and to the encouragement of cooperative efforts by professional members of the rehabilitation team. Contributors of feature articles and book reviews are people of standing in their own fields and give free expression to their own ideas and opinions.

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