A FOLLOW-UP STUDY OF CLIENT SATISFACTION WITH VOCATIONAL REHABILITATION SERVICES

by

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A THESIS

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A FOLLOW-UP STUDY OF CLIENT SATISFACTION WITH VOCATIONAL REHABILITATION SERVICES

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ABSTRACT

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Purpose

The purpose of this thesis encompassed two objectives. The first was to present a follow-up study of client satisfaction of services, e.g. halfway house placement, vocational training, job placement, surgical services, physical and/or mental therapy, and counseling and guidance, that the client received. The second objective was to find out whether or not satisfaction or dissatisfaction differed with the type of disability group.

Methods

The methods used in this study were: (1) the collection of data regarding the client's name, age, social security number, counselor's number, and region; (2) the sorting of this information by closure status, region, and counselor number; (3) the random selection of the sample, which was limited to those clients who were successfully rehabilitated in the Fiscal Year of 1975; (4) mailing a questionnaire to each client in the sample; (5) determining, from the responses, the numbers and percents of clients who were either satisfied or

dissatisfied with each service area and determining the numbers and percents of clients who did not receive each service; (6) conducting an analysis to determine if there were any differences among the individual disability groups, as well as among the general disability categories, with regard to their satisfaction or dissatisfaction of each service area.

Findings

1. This study indicates that clients revealed a higher percentage of satisfaction than dissatisfaction in all service areas.

2. Satisfaction did differ according to the type of disability group with regard to the service of halfway house placement.

3. Satisfaction did not differ according to disability group with regard to the kind of vocational training, benefits from training, results of surgical services, physical and/or mental therapy, job placement and counseling and guidance.

4. Over one-half of the respondents indicated that they did not receive the service of job placement, which is a mandatory service provided by the Texas Rehabilitation Commission.

5. Approximately one-third of the respondents indicated not receiving counseling and guidance, which

is an essential service, in their rehabilitation program.

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CHAPTER I

INTRODUCTION

The American State - Federal vocational rehabilitation program has had an impressive history, which covered half a century in rehabilitating the medically, physically and mentally disabled. Legal restraints and inadequate financial support, however, caused a limiting of the number of persons served to a small percentage of the vocationally handicapped and dependent population. In spite of the barriers that existed, the development and acceptance of vocational rehabilitation programs was inevitable. These programs attribute their growth and development to the public's recognition of the necessity of vocationally rehabilitating the disabled person.

Work and disability, two important concepts that have existed since its beginning, are of central considerations in studying vocational rehabilitation. Work is the basic ingredient in our culture. In fact, most people organize their lives around their occupations. If one is unsuccessful in finding and securing employment because of a disability, then the disability becomes traumatic. The economic aspects alone could produce such a burden that would be further detrimental toward re-establishing one's place in the community. A person can relieve his community of the burden of supporting him

only if he works or uses the assets accruing to him because he works.

The National Health Survey of the Public Health Service reports that 43 percent of the workers with diagnosed disabilities have family incomes of under $4,000.00 per year (Oberman$_1$, 1965). Only 28 percent of those who are not recognized as handicapped have incomes below $4,000.00 (Oberman$_1$, 1965). In addition, numerous studies (c.f. Oberman$_1$, 1965; Reagles, Gay and Wright, 1971; Sears, 1975; Splaver, 1967) have shown that rehabilitated disabled workers are as stable and productive on the job as non-disabled workers. The Vocational Rehabilitation Administration estimates that there are about 3,000,000 disabled adults who could be employed or more productively employed if the special procedures of vocational rehabilitation were applied to them.

The economic burden of a disabled person can be further complicated by social and psychological difficulties. Altogether, these facts not only imply the necessity of vocational rehabilitation services, but at the same time imply the broad range of services that should be provided, i.e. social, psychological and medical, to ensure effectiveness. With respect to the development of vocational rehabilitation, these areas of services emerged gradually as their needs were

recognized.

The rate of growth of vocational rehabilitation varied among the states. Texas, in particular, was slow in realizing the need for these services. Legislation providing vocational rehabilitation in Texas did not occur until 1929, which was nine years after federal legislation was passed. In 1965, however, the 61st legislature in this state designated the Texas Rehabilitation Commission as the agency which would provide rehabilitation services to eligible handicapped clients. At this time, it was recognized that vocational rehabilitation,

> is a service for disabled persons designed to equalize employment opportunities for those persons, who, because of accident, disease, or congenital deformity, have a physical or mental impairment that constitutes a barrier to normal employment [Rehabilitation Services Manual, 1977].

The primary purpose, then, of vocational rehabilitation, is to provide the disabled person with an opportunity to be useful and self-sustaining in our society.

Employment of the handicapped individual should be the ultimate goal of the vocational rehabilitation counselor (R.S.M., 1977). The primary activities of the rehabilitation counselor consist of assisting clients to identify and select vocational objectives, supervising the preparation for employment, seeking employment opportunities, and assisting with satisfactory job

adjustment. Because each handicapped person presents distinct problems, the solutions require understanding, imagination and ingenuity if a satisfactory vocational adjustment is to be made. It would likewise seem that a successful vocational adjustment would be contingent upon the effectiveness of services rendered by the vocational rehabilitation agency and upon the overall satisfaction of the client.

Statement of the Problem

A primary concern of professionals in the field of vocational rehabilitation has been the outcome of these services for clients. Only recently, however, have researchers recognized the complexities involved in analyzing successful rehabilitation. In turn, subjective evaluations by persons in the client's milieu--the rehabilitation counselor, the employer and close friends--have been surveyed to gain insights into the more subtle effects of the rehabilitation process. The client's own evaluation of his rehabilitation experiences and their ramifications have, however, been largely overlooked (Reagues, Wright, Butler, 1970). The assessment of the client's satisfaction with the services have, in fact, been lacking in all forms of helping relationships. There is a need to obtain feedback from clients served by a rehabilitation agency, so that insight

could be gained into their perceptions of service satisfaction. Obtaining feedback from clients likewise has implications for program policy regarding rehabilitation services.

Purpose

The purpose of this thesis encompasses two objectives. The first is to present a follow-up study of client satisfaction or dissatisfaction with various services, e.g. halfway house placement, vocational training, job placement, surgical services, physical and/or mental therapy, and counseling and guidance, that the client has received. The second objective is to find out whether or not satisfaction or dissatisfaction differs among different types of the disability groups.

The present study is based on the assumption that disabled clients can reveal valid responses about their feelings regarding satisfaction or dissatisfaction of services.

Research Questions

1. Are clients satisfied or dissatisfied with the various services rendered to them by the Texas Rehabilitation Commission?

2. Does satisfaction or dissatisfaction in

each service area differ according to the disability group?

3. What are the implications of the results of this study for the rehabilitation services of the Texas Rehabilitation Commission and policies regarding these services?

Specific Services Defined

The types of services mentioned in this study can be broken down into specific areas and include the following: services in a halfway house, vocational training, job placement, surgical services, physical and/or mental therapy, and counseling and guidance. A description of each service will now be given to provide a better understanding of the rehabilitation program.

According to the State Plan for Rehabilitation Services (June, 1976), a halfway house is defined as,

> a transitional living facility which provides the essentials of group living designed to produce changes in social behavior and the ability to function independently within the community.

Clientele engage in meaningful or pre-vocational activities outside of the facility part of the day, while participating in planned activities within the facility during the remaining hours. Services specifically offered include the following: room, board, supervised living, personal-social adjustment classes and work orientation (R.S.M.,

1977). Usually a halfway house facility specializes in certain disability groups and is designed to meet the needs of these handicapped individuals.

Vocational training is a service rendered to those clients who require additional knowledge or skills to enter into employment. This training must be consistent with their aptitudes and abilities and should be compatible with their physical or mental impairments (R.S.M., 1977). There are several kinds of training available to rehabilitation clients. Examples include skills training for a specific occupation, work adjustment training applicable to clients who have not yet developed work habits, educational training, or on-the-job training. The benefits a client receives in a vocational training situation would involve the degree to which he acquired the anticipated skills in his training program. The case file should be documented to reveal that the client has the potential and interest to achieve the selected vocational objective.

Job placement, a necessary and vital service appropriate to all rehabilitation clients, is the responsibility of all counselors of the Texas Rehabilitation Commission (McGowan and Porter, 1967). The rehabilitation counselor must carefully match the skills of the handicapped person with the duties of the job.

Selective placement services for a client should include a complete reappraisal of the individual's capacity and limitations for prospective employment. This reappraisal not only constitutes the basis for selecting a specific job for the client, but also serves as a basis for the counselor's evaluation of his counseling and planning with the client.

The area of surgical services along with physical and/or mental therapy comes under a broader category defined as physical and mental restoration. More specifically, these are services which are necessary to correct or substantially modify, within a reasonable period of time, a physical or mental condition, which is stable or slowly progressive. These services can only be provided when the medical diagnosis is based on clearly established medical standards, procedures, and experience (Rehabilitation Services Manual, 1977).

The last specific area of services included in this study is counseling and guidance. This service, which is continually administered throughout the client's rehabilitation program, is another extremely important service in vocational rehabilitation. Thomason and Barrett (1959) define counseling and guidance as,

> a process in which the counselor thinks and works in a face to face relationship with a disabled person in order to help him understand both his problems and potentialities, and to carry through a program of adjustment and self-improvement to

> the end that he will make the best obtainable vocational, personal and social adjustment.

The counselor, then, is mainly concerned with all phases and facets related to vocational adjustment, rather than with the development of therapeutic insights.

Categorizations of Disability Groups

The subject of disabilities has significance in this study, both in relation to the selection of the random sample and as a major criterion in analyzing the final results. Before the writer categorizes these disability groups as they were used here, an explanation will be made in regards to the basic criteria for eligibility of services.

It is the responsibility of the vocational rehabilitation counselor to secure the necessary information, apply the criteria for eligibility, and certify whether or not a person is eligible for vocational rehabilitation services. According to the Rehabilitation Services Manual (1977),

> there are two basic criteria for eligibility that are inherent in the purpose and scope of the program and provided for in Federal and State law: (1) the presence of a physical or mental disability which constitutes or results in a substantial handicap to employment, and (2) a reasonable expectation that Vocational Rehabilitation Services will benefit the individual in terms of employability.

The information on the disability groupings will be taken from the Rehabilitation Services Manual (1977). This manual presents a description of the various physical and mental handicaps that could indicate eligibility. In spite of the presence of a disability, the client must meet both eligibility requirements before he can be accepted for services.

The first disability grouping, deafness and other hearing impairments, require a specialist examination from an Otologist, Otolarynagoligist, or EENT Specialist, regardless of severity of hearing. An audiometric examination also required, must reveal an average loss of at least 40 decibels in the best ear computed in the average speech range falling between 500 to 200 hZ levels.

The second grouping, orthopedic impairments, has two classifications, orthopedic impairments without amputations and orthopedic impairments with amputations. The classification of orthopedic impairments without amputations is further divided into more specific categories including: impairment involving three or more limbs or entire body, impairment involving one upper and one lower limb, impairment involving one upper limb, impairment involving both limbs, impairment involving one lower limb, impairment involving both lower limbs, general neuro-muscular disorders, and

accident or injury involving the spinal cord. These disabilities could be due to any of the following: cerebral palsy, congenital malformation, diseases, arthritis, intracranial hemorrage, poliomyelitis, muscular dystrophy, multiple sclerosis or Parkinson's disease. Absence or amputation of major and minor members, the second classification, is defined as the loss of any combination of extremities. This could be due to the following conditions: malignant neoplasms, noninfectious diseases, accidents, injuries and poisonings.

The third major grouping, Mental, Psychoneurotic and Personality Disorders, includes psychotic illnesses, psychoneurotic disorders, alcoholism, drug addiction, behavior disorders and mental retardation. These areas must be diagnosed by a physician or psychologist, whichever is appropriate in order to determine eligibility.

The fourth major grouping involves somatic disabilities for which the etiology is not known or is not appropriate. This would include malignant or benign neoplasms, metabolic diseases, disorders of the blood, epilepsy, circulatory disorders, respiratory diseases and disorders of the digestive system. Examples of specific conditions which would be included in the somatic disability group would be leukemia, cystic

fibrosis, hemophelia, tuberculosis and stomach ulcers.

The last grouping includes disabling diseases and conditions that are classified nowhere else. This area would involve such impairments as language and/or learning disabilities and diseases of the skin and cellular tissue. Also included in this grouping are speech impairments, e.g. cleft palate, stuttering, aphasis and laryngetomies.

CHAPTER II

REVIEW OF LITERATURE

Historical Background

A study of history is necessary to understand the present. Oberman (1965) observes,

> Today's attitudes, institutions and activities are intelligible only if they are seen in their relationships to the personalities, forces and events of yesterday. Such a development as the vocational rehabilitation of disabled people can be better understood, its significance can be better appreciated and its objectives can be more effectively realized if we can trace the paths of that development.

Nineteen-hundred and twenty was a landmark year in the history of vocational rehabilitation. It was at this time that the first bill that provided for vocational rehabilitation services to disabled civilians passed the United States Congress and was signed by President Wilson. Steps leading up to this historical event deserve some attention as there were many barriers to be overcome.

Ancient attitudes toward disability were negative, nearly to the point of creating a feeling of aversion toward the handicapped. There were even occasions reported when the physically defectives were killed or abandoned to die because they were considered to be an indication of the ill favor of the gods. The disadvantaged individual not only felt frustrations resulting from lack

of capability, but he also suffered social ostracism and personal feelings of unworthiness. From the 15th to the 16th centuries, witchcraft continued to dominate men's minds. Seventeen-hundred and thirty-six marked the year that the United Kingdom repealed the laws against witches; however, the public's feeling of intolerance toward the disabled remained. During this period of time, few records were kept and it seems conceivable that the neglect and ostracism toward the handicapped individual caused a high mortality rate.

The attitude of intolerance of the physically disabled began to change to a more constructive attitude toward the latter part of the 18th century. This was largely attributed to the rise of orthopedic surgery which gave some hope to many crippled individuals that their condition might be corrected. The beginning of voluntary organizations, also occurring around this period presented a struggle to the people involved, as they had to overcome the general attitude that the poor and disadvantaged were unworthy and depraved (Dean, 1972). The contribution of the voluntary agencies in setting the directions, defining the goals and establishing the basic philosophies of vocational rehabilitation are significant (Oberman$_1$, 1965). The organization of the American Red Cross, the National Tuberculosis Association, Goodwill Industries and the Easter Seal Society all had significant

impact toward the development of this service.

Private agencies in addition to voluntary organization, began to handle rehabilitation work of disabled workers. It soon became clear that neither source could meet the requirements for restoring health and usefulness to the great numbers of handicapped people. As societal affluence increased, the courage for the public to accept responsibility for the disabled grew. Rehabilitation at this point was being regarded as something to be supplied by legislative enactment.

Two significant events which lead to the Vocational Rehabilitation Act of 1920 included the stress on workmen's compensation laws and the passing of the Smith-Hughes Act of 1917. It was pointed out by Dean (1972) that,

> it was not easy, in industry, to overcome old ways of doing things and to convince both management and skilled professionals of the virtues of pooling talents in search of a better product.

In spite of initial opposition, however, workmen's compensation laws were slowly adopted in various states. The emphasis of rehabilitation at this point included vocational training and bridging the gap to include medical services was not easy. People, however, were beginning to realize the importance of medical treatment for the injured worker.

Increased industrial development and productivity were:

> hailed as the fruits of the maturing industrial revolution, but the by-product of disabled workmen could be seen as a deduction, that materially and increasingly reduced the net social values resulting from this development and productivity [Oberman, 1965].

As more workmen's compensation laws were passed, the importance of vocational rehabilitation grew. The first step in protecting and salvaging workmen in industry was accident prevention; the second was compensation for those involved in industrial accidents; and the third was treatment and retraining so that injured workmen would be rendered fit to return to some type of employment.

The initial workmen's compensation laws did not make a specific provision for vocational rehabilitation; however, the possibilities in rehabilitation were brought to focus by the veterans rehabilitation legislation in 1918 and the Civilian Rehabilitation Act in 1920. It was considered by the leading spokesman for workmen's compensation that the program could not be fully successful without a well-administered rehabilitation activity. The concept of vocational rehabilitation then became an essential portion of the entire program.

It has been felt that workmen's compensation has had significant impact toward the growth of vocational rehabilitation. Dr. R. M. Little, first Director of Vocational Rehabilitation in New York stated that the vocational

rehabilitation effort grew immediately out of workmen's compensation (Franklin, 1949). The Smith-Hughes Act of 1917, however, also had a significant impact. This act provided for federal assistance grants to the states in support of vocational education. It also created the Federal Board for Vocational Education, which had the responsibility of coordinating the state and federal relationships in the operations under this act (Dean, 1972). This act and the board furnished a format for establishing a system for vocational rehabilitation that was soon to be provided (Oberman$_1$, 1965).

Other legislation was passed which also became an essential part of the vocational rehabilitation program. As part of the veteran's legislation in 1918, the Soldier's Rehabilitation Act was passed which had significance in its emphasis for the area of vocational training. This act gave exclusive control of retraining disabled veterans, after their discharge from the service, to the Federal Board for Vocational Education. The eligibility requirements were:

> Any disabled veteran who was unable to carry on a gainful occupation, to resume his former occupations, or to enter upon some other occupation, or having resumed or entered upon such occupation was unable to continue the same successfully [Dean, 1972].

The event immediately proceeding the Act of 1920 was the introduction of the Smith-Sears Bill, later

becoming the Veteran's Act of 1918. The number of disabled individuals by World War I brought to the attention of the public the problems of the disabled group. "This was the first recognition on a national basis that the problems of the disabled individual are public problems" [Franklin, 1949]. Between 1918 and 1920 a constant struggle and continued arguments resulted from a proposal to establish a civilian vocational rehabilitation act. Finally in 1920 it passed, and at that point a state-federal plan was instituted for vocational rehabilitation. Public Law No. 236, its official name, was entitled, 'An Act to Provide for the Promotion of Vocational Rehabilitation to Persons Disabled in Industry or Otherwise and Their Return to Civil Employment' (R.S.M., 1977).

Appropriations under Public Law No. 236 were on a temporary basis and provided the following services:

1. Allocation of funds to the States were to be made according to the population, with expenditures authorized on a 50:50 matching basis.

2. The funds were to be used to provide vocational counseling and guidance, training, occupational adjustment, prosthetics and placement services only.

3. The act provided a maximum Federal authorization per State.

4. The authority for granting funds was enacted on a temporary and not a permanent basis [McGowan and Porter, 1967].

The vocational rehabilitation program, between the years of 1920 to 1935, lacked permanency and existed only through a series of short-term congressional extensions. The Federal Social Security Act of 1935 alleviated this situation as it gave permanent status to vocational rehabilitation by providing for a continuing appropriation. The passage of this act clearly demonstrated that the consensus of congressional thought was that vocational rehabilitation should be an incessant program in the United States (McGowan and Porter, 1967).

The year of 1943 was a landmark year toward the development of vocational rehabilitation services. Prior to this time, the types of services were mainly limited to vocational training, counseling and guidance, and job placement. In 1943, the law was amended to permit the provision of medical and physical restoration services (Cobb, 1973). As a result, the Rehabilitation Medicine Service was created in New York City's Bellevue Hospital in 1946. This was the first rehabilitation medicine service in the United States. Since that time, physicians have come to be more familiar with the aims and procedures of rehabilitation and,

> recognize that medical care cannot be considered complete until the patient, with the residual physical handicap, has been trained to live and to work with what he has left [Rusk, 1971].

Medical services, either in the capacity of being diagnostic

or restorative, are necessary and needed toward the vocational rehabilitation of handicapped clients.

The year 1943 saw significant development, not only for medical services, but also for the development of halfway house facilities. The amendments passed during this year actually made a provision for funding the establishment of these rehabilitation services as needed. Prior to this time, halfway houses existed, but rarely dealt with vocational rehabilitation. Their existence largely began as a resource for released prisoners who were not self-supportive. The need for these facilities grew, and, in turn, their programs were expanded to include such disabilities as alcoholism, drug abuse, mental retardation and other disorders of a behavior type (Dressler, 1969).

The state of Texas accepted the provisions of the Federal Vocational Rehabilitation Act when the 41st legislature, in 1929, passed the Senate Bill Number 89, known as the Texas Vocational Rehabilitation Act. This act provided for cooperation between the State Board of Vocational Rehabilitation in accordance with the terms and conditions of the Federal Act. At a later date, the 61st legislature created a separate commission for rehabilitation, prescribing its powers, duties, functions, financing, and procedures. The Texas Rehabilitation Commission at this time was designated as the principal

authority in the state on matters relating to the rehabilitation of the handicapped and disabled individuals, except for those matters involving visual impairments (Rehabilitation Services Manual, 1977).

The basic difference between vocational rehabilitation of the present and that of the 1920's is not the difference in the millions of dollars in appropriations, nor the difference in techniques and procedures. It is the difference in the public and professional attitudes toward disability and toward the rights and potentialities of disabled persons (Oberman$_1$, 1965). Vocational rehabilitation constantly underwent a continuous redefinition and realignment because of this gradual change. At intervals since the original act was passed, it has been necessary to amend it several times to allow for these continual changes to take place. This act was amended to include several provisions:

1. Require cooperation with workmen's compensation to the states.
2. Provide funds for expansion and research.
3. Include persons with mental disabilities as eligible for services.
4. Provide for physical restoration.
5. Permit payment of maintenance costs during periods of training.
6. Provide for special grants to colleges and universities for the professional training of rehabilitation personnel.

7. Liberalize eligibility requirements.
8. Emphasize services to the severely disabled.

The public's realization of the need for this service was partially attributed to a significant increase in the number of people successfully rehabilitated and restored to optimum functioning. It was reported that through the public rehabilitation program a total of 9,422 handicapped people were rehabilitated into employment in 1935, which was an excellent growth in services over the 523 restored back in 1921 (Dean, 1972). By 1970, the State-Federal program had grown to the point where nearly 267,000 were rehabilitated during one year (Dean, 1972).

As the vocational rehabilitation program grew and developed by establishing its needs, so, in turn did problems arise. One of the main problems arising out of this growth and development is the limited amount of funding available through federal resources. Although this condition of limiting amount of funds places a significant restriction on the entire rehabilitation process, including clients as well as counselors, the services still continue as a necessary element in today's society.

Rehabilitation Process

The final goal of vocational rehabilitation has

been defined as being the best possible vocational adjustment of a handicapped individual. This writer feels that this concept can best be understood by discussing the various components within the rehabilitation process. And from this basic framework one can conceptualize how each of the parts of this process are related to the final goal.

The rehabilitation process is a planned, orderly sequence of services related to the total needs of the handicapped individual. It is a process built around both the problems of a handicapped individual and the attempts of the vocational rehabilitation counselor to help solve these problems and thus bring about the vocational adjustment of the handicapped person. According to McGowan and Porter (1967), several basic principles underlay this process. They include the following:

1. Action must be based upon adequate diagnostic information and accurate and realistic interpretation of the information that is secured.

2. Each rehabilitation client must be served on the basis of a sound plan.

3. Guidance and counseling of clients and close supervision of all services are essential at each step of the process.

4. Each service must be thoroughly rendered and followed up.

5. The cooperation and involvement of the client and all others concerned with his

rehabilitation are necessary and must be secured before adequate rehabilitation can be accomplished.

6. Adequate records must be kept.

Initial casefinding or referral begins the process, and ends with the successful placement of the handicapped individual on the job. In order for the client to progress in his rehabilitation program to the final stage of successful job placement, he must go through several stages. This process is easily distinguishable from all other types of counseling as it emphasizes the realistic and permanent vocational adjustment of the handicapped individual as its primary objective.

Selection and the preliminary investigation is the first step in the initial casefinding process with the counseling interview as being the basic method for securing information. The purpose of the interview is to help the counselor understand as much about the applicant as may be necessary to assist in his vocational adjustment. The case investigation interview is a planned, but flexible procedure, for securing vocationally significant information, including the emotional significance to the client of his health, educational, vocational and social history. Interview forms or fact sheets are used to record the information from the interview. This is supplemented by a narrative recording. During the

initial interview, the counselor attempts to gain insight into the client's motivation to participate in the program.

The second step in the beginning stage is the study of client data which involves a determination of the types and the amount of case information needed to supplement the client's history. The counselor's study of each applicant should be carried out to the degree necessary to determine eligibility and to constitute a basis for counseling. The investigation should include a medical evaluation, psychological evaluation, vocational evaluation, a determination of educational achievement, and a social and cultural evaluation.

Each applicant receives a complete medical examination for several reasons and includes the following:

1. To determine the nature and extent of the disability.
2. To appraise the general health status of the individual for a determination of his capabilities and limitations.
3. To ascertain if physical restoration services might remove, correct or minimize the disabling condition.
4. To contribute a sound medical basis for selection of a vocational objective.

The medical report, which should be returned to the counselor, includes a description of the client's total

condition rather than just a portion of his anatomy. The report should also include a date in which both the examination was done and in which any follow-up laboratory tests were given. The medical examination is not only done at the referral stage, but is an on-going activity throughout the rehabilitation process.

The psychological evaluation is required for all mentally retarded clients or those claiming to have a behavior disorder. According to Section 401.22(e) of the regulations implementing the Vocational Rehabilitation Act Amendments of 1965,

> In all cases of mental retardation, a psychological evaluation will be obtained which will include a valid test of intelligence and an assessment of social functioning and educational achievement. In all cases of behavior disorders, a psychiatric or psychological evaluation will be obtained, as appropriate [McGowan and Porter, 1967].

A psychological evaluation is likewise closely related to counseling needs and subsequent rehabilitation services to clients. Psychometric data and information during interviewing, counseling and other evaluation procedures are included in the overall assessment.

Vocational evaluation is a process to assess and synthesize all the vocationally significant data regarding the individual and to relate them to occupational requirements and opportunities. Consideration of the disability, age, employment opportunities, per-

sonal adjustment, mobility and family situation of the client are all important factors. Relating his work and vocational training history to present circumstances and a reasonable expection that vocational rehabilitation services will render him fit to participate in a gainful occupation are also of significance.

Educational and social evaluations are also necessary to the rehabilitation process. The educational level at which the client is functioning and his potential for further education should be assessed by an educational evaluation. Standard measures of achievement in addition to indicators of proficiency and performance should be considered. The social evaluation involves the securement of social history material which, taken as a whole, brings the client into focus as an individual distinct from others and reveals his potential for benefiting from the rehabilitation process (McGowan and Porter, 1967). Diagnosis of the total problem necessitates a social history. The client's past and present personal and social adjustment must be considered in devising a program of services.

Several other evaluations are necessary to set the diagnosis in motion. For example, a cultural and environmental evaluation must also be considered in

diagnosing the problem and in developing an appropriate rehabilitation program. Factors of significance include the impact of cultural and social deprivation, chronic poverty, public offense, illiteracy, long-term unemployment or dependency, community prejudices and residence in poverty areas. These evaluations can be obtained most easily by means of a thorough interview with the client. After securing the necessary identifying data, e.g. name, age, social security number, etc., of the client during the interview, several other areas should be discussed. These would include the reason for referral, history of the disability, personal and family history, early life and cultural climate of the home, educational background, work history, present family relationships and economic situations.

Following the careful analysis of the information in these evaluations, the second step, the rehabilitation diagnosis, is set into motion. This process entails three components, which are a determination of eligibility, the identification of problems and the rehabilitation services as needed, and a vocational appraisal for purposes of selecting a job objective.

A client is determined eligible or ineligible for services at this point in time. If he is considered eligible, the counselor begins the third stage of the rehabilitation process, which is the planning and provision

of rehabilitation services. The counselor works out a program which is acceptable to the client and which he can justify on the basis of medical, psychological and social data. A determination is made at this stage, whether the client will need halfway house placement, vocational training, further medical restoration services and the like. Through this process, the vocational rehabilitation counselor attempts to help the client accept and implement his written plan. Necessary arrangements are made and the steps are initiated to authorize the needed services.

Selective placement and follow-up is an integral part of each rehabilitation program and represents the fourth stage of the process. Specific provisions for the job placement and follow-up rehabilitation clients were made in 1966 with an amendment to the original Rehabilitation Act of 1920. These regulations state,

> The State Plan shall provide that the State or local rehabilitation agency will assume responsibility for placement of individuals accepted for service. The State Plan shall set forth the standards established for determining if a client is suitably employed, and shall provide for a reasonable period of follow-up after placement to assure that the vocational rehabilitation of the client has been successfully achieved.

The ultimate responsibility of job placement, then, is with the vocational rehabilitation counselor. The

counselor should carefully interpret the client's disabilities and abilities to the employers. As part of selective placement, the emphasis should be placed on what the client can do, rather than on what he cannot do. In addition, the counselor should refer his clients to the state employment service and inform the client as to the process of applying for a job. Placement planning should be done far enough in advance so that the client can find work soon after the completion of rehabilitation services.

The last stage in the rehabilitation process involves a careful evaluation of placement and case closure. Several considerations of the placement should be made. For example, the work should be suitable and in line with the plan at the time of placement. In addition, the job duties, working conditions, wage rates, client adjustment, employer satisfaction and completion of all necessary services are also key factors in deciding whether a case is ready to be closed as being the successful rehabilitation of the client. A client closed in a successful rehabilitation status is the goal of the services rendered by a vocational rehabilitation agency.

Description of Disabilities

The types of clients processed through vocational

rehabilitation agencies vary greatly as do their disabilities and needs. Understanding the processes involved during the completion of the rehabilitation program is necessary to see how the vocational goal is achieved for each client. The breakdown of disability categories implicates a wide range of handicaps encompassing areas of hearing impairments, orthopedic disorders, mental disorders, somatic impairments and conditions nowhere else classified. Exploring these disability groups more closely lends insight into the wide range of needs, as well as services necessary for successful vocational rehabilitation to take place.

Hearing Impairments

Hearing impairments represent the first disability category and includes both deafness and hard of hearing. According to Susan Splaver (1967), three major types of hearing losses are noted. First, conductive hearing loss represents vibrations of sound which are not properly transmitted to the inner ear. Second, when sound waves are effectively conveyed to the inner ear but are improperly transmitted beyond this, sounds are distorted and a sensorineural hearing loss is the result. The third type is central hearing loss which is a result of diseases that caused a defect or a degeneration of the auditory nerve, the hearing center

of the brain. This results in either total deafness, or the inability to comprehend sounds if they are heard.

Deafness and hard of hearing represent the two major categories of hearing impairments. Deafness is a hearing handicap where there is a total loss of the sense of hearing. This sense is malfunctional in daily life. Hard of hearing is less severe and represents a hearing loss ranging from a mild, moderate or severe level. Several routes can be explored in assisting a client with a hearing impairment to maximize his use of potential. Through special auditory training, speech therapists can actually teach people with major hearing handicaps to speak. Another method often used is speech reading, which was the first known form of rehabilitation of the deaf. This involves a visual form of hearing, but, because of the concentration it requires, is difficult to accomplish. Sign language, a manual form of communication, is often the preferred method in rehabilitating the hearing impaired. For those with a less severe hearing loss, hearing aids can be effective.

Orthopedic

The orthopedically disabled, the second category, includes impairments and defects of the skeletal system, involving absence, amputation or loss of use of muscles,

bones, joints, and/or the nerves which activates these muscles, bones and joints. Because this is a visual handicap, the victim is often faced with a problem of self-image and a concern for how he appears to others. Those in this category would include the spinal cord injured, spine deformities, cerebral palsy, rheumatoid arthritis, muscular dystrophy and multiple sclerosis.

According to Hardy and Cull (1974), rehabilitating the victim of spinal cord damage is one of the most challenging tasks that can be undertaken by the rehabilitation team. This disability requires the highest quality of services from all those involved in the rehabilitation process. The spinal cord is a large bundle of nerves, cells and fibers which help connect the brain with all parts of the body. Nerve messages from the brain keep many different types of bodily processes functioning properly. Paralysis results when the spinal cord is injured and nerve tissue is damaged. The nerve impulses cannot be transmitted in the affected region.

Paraplegia and Quadraplegia are two common types of impairments resulting from spinal cord damage. Paraplegia is a state of paralysis, either partial or total, of both legs due to spinal cord injury at the upper levels of the cord. Quadraplegia is paralysis of the

arms and legs due to the lower parts of the spinal cord being injured. There are an estimated 150,000 paraplegics alone in this country, which has direct implication for the need of vocational rehabilitation services (Splaver, 1967). Rehabilitation should include medical treatment, physical and occupational therapy, emotional readjustment and vocational guidance. Mechanical devices, such as braces, crutches, and wheelchairs, can be purchased to aid in the client's mobility. A decision of a vocational objective should be within the degree of impairment as described in the medical evaluation report.

Cerebral Palsy, a major crippler of children, results from lesions in the brain which primarily occur prior to or during birth, leaving the person with a permanent motor impairment (Hardy, Cull, 1974). In addition to motor malfunctions, there is usually one or more co-existing conditions, such as mental retardation, sensory loss, convulsions or residual emotional disturbances. Most cerebral palsy victims are multiple handicapped and as such require intricate and extensive counseling, evaluation and training, followed by individualized vocational placement (Splaver, 1967).

Arthritis, an inflamation of the joints, is the world's leading crippler. There are approximately 13,000,000 persons in this country suffering from arthritis (Splaver, 1967). Rheumatoid arthritis, a disease of

great severity, is a chronic, progressive disease that results in deformity, atrophy and abnormally immobile and constricted joints. The great significance and importance of this disease to the vocational rehabilitation services is that it attacks individuals during the prime working years. A medical analysis, as well as a functional evaluation of the patient, would be significant in determining an appropriate vocational objective.

Multiple scherosis and muscular dystrophy are significant disorders classified in the orthopedic disability category. Multiple sclerosis is a major disorder of the central nervous system and is progressive and crippling. Common results are disturbances of body balance, instability of gait, spasticity, and sometimes paraplegia. The age of onset of this disease is between twenty and forty. Muscular dystrophy, another disease of great seriousness, involves a progressive weakening and wasting of skeletal muscles. Medical evaluations as well as vocational assessments would be important factors in determining the physical limitations and the implications of vocational feasibility.

Spine deformities, another category within this classification, include three types. The first type, scloesis, is a lateral curvature of the spine and the

body axis of the victim is turned to one side. Lordosis, the second type, is an inward curvature of the spine resulting in a protrusion of the abdomen. The third type, kyposis, is outward curvature of the spine. These deformities may limit the victim's ability to perform physical work requiring substantial effort and may be accompanied by breathing and circulatory impairments (Splaver, 1967).

Amputees, both of lower limbs and upper limbs, comprises the last category in this section. Clients with an absence of lower limbs may have varying degrees of difficulty in jobs requiring standing or walking. Generally, the higher the level of amputation, the harder it is to adjust to and ambulate with the aid of a prosthesis. Amputees involving the upper limbs, likewise, are limited in certain vocational functions. Often, balance is affected if the arm is lacking up to the shoulder. The amputee must go through a thorough period of training so that the development of maximum vocational potential can be accomplished.

Mental

The third major classification involves mental, psychoneurotic and personality disorders. Within this classification, the disabilities of psychosis, psychoneurosis, mental retardation, alcoholism, and drug abuse

will be discussed. A psychological evaluation by a licensed psychologist is necessary to establish the exact severity of these disabilities.

Psychotic disorders can be classified as mild, moderate or severe, depending on the severity or seriousness of the disorder. Mild would constitute minor distortions of thinking with little or no disturbance in activities of daily living and with the provision of rehabilitation services. One classified in this degree can maintain independent living in the community and engage in competitive employment. This category would include those who were institutionalized one time and can do well on medication (R.S.M., 1977). Clients classified as moderate would involve definite disturbances in behavior. With the provision of rehabilitation services, he can become capable of maintaining himself in the community and of engaging in low stress, competitive employment. He would, however, initially require continued supervision, guidance, motivation and support (R.S.M., 1977). The severe classification of psychotic disorders would involve severe disturbances of thinking and behavior that would entail potential harm to himself or others. In addition, severe disturbances of all components of daily living are noted. The client in this category is unable to communicate readily or distinguish between reality and

fantasy. Also, his behavior is often deceptive and menacing to others. Professional intervention and medication are especially important during the early stages of the rehabilitation process for the client in the psychotic disorder category (R.S.M., 1977).

Psychoneurotic disorders also are classified as either mild, moderate or severe, depending on the client's ability to tolerate stress in daily living. Medication would be especially important in the severe stage because of frequent bizarre and disruptive behavior. Likewise, for the client in this classification, continued supervision, guidance, motivation and support by professional staff would be important in a work situation.

Mental retardation, the next category, is defined as "the sub-average intellectual functioning which originates during the developmental period and is associated with an impairment in adaptive behavior." The behavioral component of mental retardation, rather than the measured intelligence quotient, is most meaningful in determining the individual's need for vocational rehabilitation services as well as his ultimate employment potential. Another consideration in dealing with the mentally retarded client is his present life situation. Whether or not he is institutionalized will have a direct bearing on the rehabilitation program

devised.

Alcoholism, the next category, establishes the presence of a disability following the diagnosis by a qualified physician. All clients with this diagnosis should be involved in a therapeutic program during the vocational rehabilitation process. The provision of vocational rehabilitation services is based on the alcoholic's demonstrated and indicated ability to maintain abstinence from alcohol and accept on-going treatment during the rehabilitation process.

Prior to working with a client in the drug usage group, a determination must be made as to whether the client is drug abusive, drug dependent or drug addictive. Drug abuse is a general diagnosis and in itself is not recognized as a disability. It implies that the person is abusing the intent of a drug's medical use by taking it for mind-altering purposes. Drug dependence or addiction is defined as psychological and/or physical dependence of one or more drugs (R.S.M., 1977). To accept a client with a diagnosed disability of drug dependence, he should be engaged in a therapeutic program and demonstrate the ability to maintain abstinence from drugs or to remain in a maintenance program.

Somatic

Somatic maladies do not specifically and solely affect the victim's mobility or communications skills,

but are more encompassing and affect a person's overall state of health (Cobb, 1973). As a result of the person's reduced vitality and depleted total well-being, limitations are placed not only on his ability to get about and to communicate, but also on all of his daily activities (Splaver, 1967). Disabilities under this category include malignant conditions, diabetics, epilepsy, cardiovascular conditions, respiratory disorders, and renal failure.

Malignant conditions, typically called cancer, represent a disease that is characterized by abnormal growth and spread of cells. It often begins as a localized disease--at the start just one of the tiny cells becomes malignant. The cancer cell reproduces itself by dividing into two cells, which in turn divides, etc. The cancer grows through this process. From the standpoint of vocational rehabilitation, cancer has always presented practical problems. The Administrative Service, Series Number 64-6 (Splaver, 1967), emphasizes that cancer is a qualifying disability for rehabilitation purposes and encourages the state agencies to look with greater receptiveness at the afflicted applicant. The prognosis of the condition would be of the utmost importance in planning the rehabilitation program.

Diabetes mellitus, often called sugar sickness,

can be described as excess sugar in the blood (Rusk, 1971). It is a chronic metabolic disease where the body does not produce enough insulin or does not make proper use of the insulin it has. Diabetes is a serious and widespread health problem. Estimates have indicated that approximately 4.4 million persons in the United States have this disease (Hardy, Cull, 1974). It becomes even more complicated in recognizing other physical complications, such as heart disease, eye lesions, etc., which often accompany diabetes. The rehabilitation counselor should be aware of the medical implications, including diet, vulnerability to infections, and identifying physical defects in determining an appropriate rehabilitation program (Splaver, 1967).

Epilepsy is a brain disorder resulting in a tendency toward recurring seizures which are frequently characterized by loss of consciousness (Schmidt and Wilder, 1968). This disorder is usually classified according to the seizure pattern, either grand mal or petit mal. A grand mal seizure is a major attack which is less frequent but more severe. It is characterized by violent convulsions and loss of consciousness. The less severe type, petit mal, is marked by more frequent episodes, but brief in duration with only a momentary blackout. Medication is an important aspect in

rehabilitating the epileptic. According to statistics, at least 50 percent of all cases have complete seizure control with medication (Hardy, Cull, 1974).

The heart and blood vessels constitute the human cardiovascular system. When it does not function properly, the afflicted person is said to have a cardiovascular disorder. There are many types of these disorders and many forms and stages of each type. Each case is specific and special medical advice and treatment are necessary to meet the special requirements of each patient. When working with a heart patient, the rehabilitation counselor should have the client's condition reviewed frequently to accurately assess prognosis of the disability and the vocational implications.

The next category is respiratory disorders, which represent a malfunction in the respiratory system, e.g. lungs, bronchioles, etc. Diseases in this category include: sinusitis, which is an inflamation of the lining of sinuses; chronic bronchitis, as represented by an inflamation of the bronchial tubes; asthma, characterized by attacks which constrict the bronchial tubes; and tuberculosis, which is an infectious respiratory disease. Vocational planning should take into consideration the strenuousness of work activity and the condition of the general work surroundings.

Renal failure, the last disability within this classification is a kidney disease and occurs when the kidneys finally stop with little hope of any return to function. Unless medical treatment is implemented, death will occur. Treatment could include either dialysis, which is an artificial kidney used to remove body wastes, or an actual kidney transplant. Medical evaluation for patients having this condition are of great significance toward developing the rehabilitation program.

Miscellaneous

The last grouping includes conditions that are classified nowhere else. These impairments would come under the miscellaneous category. The two major disabilities within this classification include speech impairments and language and/or learning disorders.

Speech impairments represent a significant disability, as the person's verbal interaction is impaired to some degree. Speech defects fall into three categories. Articulation disorders, the first category, represent the largest percentage of clients. Sounds are distorted to the person and one sound is then substituted for another, e.g. lispers. Stutterers are representative of the second category--rhythm disorders. Vocal volume disorders are the third category and are

characterized by problems with vocal volume, quality and pitch. Treatment would include a speech diagnosis to determine the areas of damage. A speech restoration program is then formulated.

Language and/or learning disability is the second category under this classification. These individuals are often so deficient in the acquisition of language and/or learning skills, including the ability to reason, think, speak, write, spell or to make mathematical calculations, that they must be provided special services in order for educational, vocational and overall adjustment progress to take place (R.S.M., 1977). This disability can be determined by documented evidence indicating that the individual's learning style so deviates from the norm of his age that he requires special services. A physician's report can be further supportive in establishing this disability.

A Summary of Services Appropriate for the Disability Groups

Because of the wide range of needs within each major disability group, the services provided by a vocational rehabilitation agency should likewise be varied to meet these needs. The major services, e.g. halfway house placement, vocational training, job placement, surgical services, physical and/or mental therapy,

and counseling and guidance, represent the diversity necessary to work with these disability groups. Thus the attempt is made to achieve the ultimate outcome of complete vocational adjustment.

Halfway houses are utilized for clients with limited types of disabilities. Usually each facility of this type specializes in working with a certain handicapped group. The rehabilitation program developed within each of these facilities are unique as they directly relate to the disability group of which they specialize. For example, a halfway house for mental retardants usually includes a carefully designed program of personal social adjustment and work orientation as these areas are usually deficient for most mentally retarded clients. Clients diagnosed with a mental impairment are quite frequently referred to a halfway house facility. There are also some halfway houses for clients with severe orthopedic impairments and medical disorders; however, they are not as common.

Clients with a wide variety of disabilities would be appropriate as far as vocational training is concerned. Clients with disabilities that would largely be excluded would be those functioning in the lower ranges of mental retardation or those having a severe personality or behavior disorder. For those clients

with orthopedic or physical handicaps, the type of training selection should be in congruence with the potential and vocational limitations of the individual.

Job placement is a vital service which would be applicable to all disability groups. This service, which is necessary to accomplish the final goal of vocational adjustment is supported by legislative enactments, e.g. amendments in 1966 of the Vocational Rehabilitation Act of 1920, and the Rehabilitation Act of 1973. Because of this, it has recently been an emphasized area in the service training of vocational rehabilitation counselors.

The next area of service would involve surgical procedures and physical and mental restoration. This category of service could encompass clients with all types of disability areas; however, it would be especially appropriate for those having a somatic disability, orthopedic dysfunction or a severe mental condition. Clients having these disabilities are placed in physical and/or mental restoration, whichever is appropriate, until they are able to overcome their disability to the point of being capable of pursuing their rehabilitation program.

Counseling and guidance is a necessary and mandatory service for effective vocational planning and adjustment. As a continually administered service

throughout the client's rehabilitation program, the vocational rehabilitation counselor utilizes this counseling in developing a theoretical framework and then implementing it with techniques that are aimed at helping his client make the best possible vocational adjustment. Regardless of the disability of the client, the foundation of the rehabilitation program lies with counseling and guidance.

CHAPTER III

METHODOLOGY

This study was designed to develop a base line of knowledge concerning the vocational rehabilitation client's satisfaction of services. A descriptive survey was designed utilizing a mail questionnaire. Data were obtained from the returned questionnaires.

The mail questionnaire has several disadvantages, which this writer recognizes. The method of research used for this study, however, was bound by the limits of the larger survey from which it was extrapolated. One of the most serious drawbacks in using the mail questionnaire is the possible lack of response. Responses to mail questionnaires are generally poor. Returns of less than 40 or 50 percent are common (Kerlinger, 1973). As a result of low returns in mail questionnaires, valid conclusions cannot be made. The response rate in this study was only 32 percent. Using a follow-up questionnaire would have been a possibility in securing larger return; however, the Texas Rehabilitation Commission was unable to view this method as being economically feasible.

Another disadvantage to the mail questionnaire is that the questions are often interpreted differently by different people. A face-to-face interview with each client in the sample would have been a more efficient

manner of assuring a higher degree of uniformity in the interpretation of the questions. The methodology of the larger survey, however, did not include this technique.

Collection of Data

This study utilized data collected from a more comprehensive survey done by a designated research team, which included the Director of Research of the Texas Rehabilitation Commission, her assistant and the writer. As a member of this team, the necessary sections of the questionnaire were developed by this writer for this research. In addition, this writer contributed to the development of the remaining portions of the questionnaire unrelated to this study.

The Case Service Report, which is the method of identifying rehabilitation clients of the Texas Rehabilitation Commission, is a form completed on each client at the referral stage. Information on the client, including his name, age, social security number, counselor number and region, are contained on this form. Data from the Fiscal year of 1975 client files containing information input from the Case Service Reports was retrieved on computer tapes. This information indicated that 47,884 clients were accepted for services during the Fiscal year 1975. In addition, there were 26,154 cases closed in a successful rehabilitation status. Through the use

of the computer, 2,597 of the successfully rehabilitated clients were randomly selected for this study.

The total random sample represents a 10 percent sampling of each of the disability groups (see Table 1), the sizes of which differ. The disability groups which represent the largest sample sizes include personality and behavior disorders, mental retardation, alcoholism, and psychoneurotic disorders. The disability groups with the smallest sampling sizes include orthopedic impairments with the loss of one arm and one leg, loss of unspecified part, disorders of the blood, and loss of one or both arms. This variation within the sample sizes of the disability groups was anticipated when this study was initiated as it is only logical to assume that certain disability groups are more prevalent in a community and will therefore constitute a larger percentage of clients served.

Additional information was retrieved at this point to reveal the social security number of each client in the sample, along with his name, region, the counselor number and supervisor number. This information was sorted by region, supervisor and counselor. Following the accumulation of this information, the counselors were sent a list of names of their clients with a request for verified addresses when possible. The inability of the counselors to verify some of the client's addresses

TABLE 1

Original Sample Size and the Number of Questionnaires Returned

Disability Group	Original Sample Sizes	Questionnaires Returned
Deaf	33	14
Other Hearing Impairments	60	17
Orthopedic Impairments Involving:		
3 or more limbs	26	9
1 arm and 1 leg	15	4
1 or both arms	44	14
1 or both legs	125	38
General Muscular Disorder	31	9
Injury to spinal cord	78	28
Loss of 1 arm and 1 leg	2	0
Loss of 1 or both arms	7	2
Loss of 1 or both legs	28	14
Loss of unspecified part	2	0
Psychotic	159	42
Psychoneurotic	167	38
Alcoholism	201	31
Drug Addiction	44	7
Personality, Behavior Disorders	713	111
Mental Retardation	295	80
Malignant and Benign Neoplasms	10	5
Allergic, Metabolic System	49	14
Hemophilia	5	1
Epilepsy	62	19
Circulatory	67	25
Respiratory	18	5
Disorders of Digestive System	125	39
Genito-Urinary System	67	32
Speech Impairments	10	5
Miscellaneous	154	35
TOTAL	2,597	638

reduced the sample size to 2,424.

A questionnaire, which was written at a high school education level since most clients were at or above this level of education, was then devised. A large amount of information was covered in the questionnaire, e.g. the client's mobility, work status, salary, current living arrangements, length of employment and means of transportation; however, only data from the major question was used in developing this study. This question involved the client's consideration of his satisfaction or dissatisfaction with the vocational services, e.g. halfway house placement, the kind of vocational training, benefits from training received, job placement, results of surgical services, results of physical and/or mental therapy, and counseling and guidance, that he received. In the questionnaire the client was asked to consider each service separately and check yes is satisfied, no if dissatisfied, or received none if he was not rendered the service. A questionnaire along with a return stamped envelope was personalized and mailed to each client having a verified address.

The information in Table 1 indicates that several of the individual disability groups had only a small number of respondents. For example, the disability of blood disorders had only one respondent;

the disability involving the loss of one or both arms had two respondents; the disabilities involving speech impairments, respiratory disorders and malignant or benign neoplasms had only five respondents; those clients with an orthopedic impairment involving one arm and one leg had only four respondents; and the disability involving general neurological and muscular disorders had nine respondents. Each of these disability groups had less than ten respondents. Because of the small number of respondents in these individual disability categories, they will not be analyzed separately, but instead will be included in the examination of the general disability group, e.g. hearing impairments, orthopedic impairments, mental disorders, somatic impairments and miscellaneous.

Coding the information began as the questionnaires were completed and returned by the clients. As indicated in Table 1, a total of 638 questionnaires were returned. The first stage in coding the data began by determining the number of clients who answered the questionnaire but did not respond to every part of the question regarding services, as indicated in Table 2. The second step in coding the information involved a specific number count of the respondents who answered yes, no, or received no service in each service area from the 638 questionnaires returned.

TABLE 2

Numbers and Percents of Respondents and No Respondents to Questionnaire

Services	Number of Responses	Percent of Responses	Number of No Responses	Percent of No Responses
Halfway House	411	64%	227	36%
Kind of Vocational Training	436	69%	202	31%
Benefits from Training	434	69%	204	31%
Job Placement	427	67%	211	33%
Surgical Services	427	67%	211	33%
Physical and/or Mental Therapy	408	64%	230	36%
Counseling and Guidance	445	71%	193	29%

The analysis of data was accomplished in two stages. The first stage involved finding out the numbers and percents of clients who were satisfied and dissatisfied with the services they received. This stage also involved determining the numbers and percents of clients who did not receive each service area. The interpretation of the data was brought about by use of percentages and demonstrated in tables.

The second stage in analyzing the data involved determining any differences among the individual disability groups as well as among the general disability categories with regard to their satisfaction or dissatisfaction of

each service area. These data were presented in tables and displayed in numbers and percentages.

Delimitations

This study encompassed two major delimitations in the selection of the sample. First, the study was limited to clients of the Texas Rehabilitation Commission, who were closed in a successful rehabilitation status. According to the Rehabilitation Services Manual (1977), a case closed in a successful rehabilitation status must meet the following requirements: (1) he must have received appropriate and related services; (2) he must have been declared eligible; (3) he must have had an Individualized Written Rehabilitation Program, I.W.R.P., for vocational services formulated; (4) he must have completed the individualized Written Rehabilitation Program insofar as possible; (5) he must have been provided counseling and guidance as an essential rehabilitation service; and (6) he must have been determined suitably employed for a minimum of sixty days. The second delimitation was that only cases closed successfully during the Fiscal year of 1975, e.g. July, 1974 to June, 1975, will be used.

CHAPTER IV

ANALYSIS AND INTERPRETATION OF DATA

The analysis and interpretation of data are presented in two major sections. The first includes the results of overall client satisfaction or dissatisfaction with each service area. The second includes an analysis of the responses of the individual and general disability groupings as they are related to each service area.

Results of Client Satisfaction of Service

Table 3 reflects the data obtained from the questionnaire regarding client satisfaction of services. In examining the information on this table, it can be concluded that the clients who actually received each service were more satisfied than dissatisfied. There was very evident satisfaction in all service areas except for that of halfway house placement. According to the information gathered, 11 percent (46) of the clients who received the service of halfway house placement were satisfied and 10 percent (41) were dissatisfied. The difference between the responses of satisfaction and dissatisfaction in the service area was only 1 percent (6). Based on these data, a possible deficiency in the service area of halfway house placement is implicated. This would warrant further investigation.

TABLE 3

Responses of Client Satisfaction of Services

Services	Number Satisfied	Percent Satisfied	Number Dissatisfied	Percent Dissatisfied	Received No Service	Percent Received No Service
Halfway House	46	11	41	10	324	79
Kind of Vocational Training	201	46	43	10	192	44
Benefits from Training	188	43	43	10	203	47
Job Placement	153	36	55	13	221	52
Surgical Services	119	28	20	5	288	67
Physical and/or Mental Therapy	117	29	28	7	263	65
Counseling and Guidance	266	60	38	9	141	32

Additional significant data can be observed in the service areas of job placement and counseling and guidance. Both of these services are essential components of each client's rehabilitation program. However, according to the information on Table 3, 52 percent (221) of the clients responded that they did not receive the service of job placement. Similarly, 32 percent (141) of the clients responded that they did not receive the service of counseling and guidance. These data will be analyzed in more detail in the next section of this chapter.

Analysis of the Responses of Disability Groups as Related to Services

The analysis of the responses of disability groups as they are related to each service area revealed that satisfaction and dissatisfaction did not differ with the type of disability group, except in the area of halfway house placement. In this service area, differences were noted both within the general disability categories as well as within the individual disability groups. Table 4 reflects the data obtained from the responses of clients who answered the question on halfway houses.

First of all, differences were noted with regard to the responses of clients within the hearing impairment

TABLE 4

Responses of Disability Groups to the Question of Halfway House Services

Disability Category	Disability	Number of Satisfied	Percent Satisfied	Number of Dissatisfied	Percent Dissatisfied	Received No Service	Percent No Service
HEARING IMPAIRMENT	Deaf	0	0	2	22	7	78
	Other Hearing Impair.	2	22	0	0	7	78
	GROUP SUB TOTAL	2	11	2	11	14	78
ORTHOPEDIC IMPAIRMENTS	Orthopedic Impairment						
	3 or more limbs	0	0	0	0	7	100
	1 arm, 1 leg,	1	25	2	50	1	25
	Or both arms	0	0	1	13	7	88
	Or both legs	2	8	1	4	21	86
	General Neurological						
	Muscular Disorder	1	14	0	0	6	86
	Accident, Involving						
	Spinal	1	6	0	0	17	94
	Loss of 1 or both arms	0	0	0	0	0	0
	Loss of 1 or both legs	0	0	0	0	4	100
	GROUP SUB TOTAL	5	7	5	7	63	86
MENTAL IMPAIRMENTS	Psychotic	4	15	3	11	20	74
	Psychoneurotic	1	5	1	5	20	90
	Alcoholism	14	64	2	9	7	32
	Drug Addiction	1	20	0	0	4	80
	Personality Behavior						
	Disorder	5	6	7	9	69	85
	Mental Retardation	9	16	10	18	38	67
	GROUP SUB TOTAL	34	16	23	11	158	74

TABLE 4--Continued

Responses of Disability Groups to the Question of Halfway House Services

Disability Category	Disability	Number of Satisfied	Percent Satisfied	Number of Dissatisfied	Percent Dissatisfied	Received No Service	Percent No Service
SOMATIC IMPAIRMENTS	Neoplasms, malignant and Benign	0	0	0	0	1	100
	Allergic, Endocrine System, Metabolic	0	0	1	11	8	89
	Disorders of the Blood	0	0	0	0	1	100
	Epilepsy, Neuro System	2	15	1	8	10	77
	Cardiac, Circulatory	1	8	2	15	10	77
	T.B. & Respiratory	0	0	0	0	5	100
	Disorders, Digestive, Hernia	1	5	4	21	14	74
	Genito-Urinary Systm.	0	0	2	18	14	88
	GROUP SUB TOTAL	4	5	10	13	63	82
MISCELL-ANEOUS	Speech Impairment	0	0	0	0	4	100
	Disabling condition nowhere else classified	1	4	2	8	22	88
	GROUP SUB TOTAL	1	3	2	7	26	90

group. Although 11 percent (2) clients exhibited satisfaction within this general group, 11 percent (14) likewise expressed dissatisfaction with the service of halfway house placement. In breaking this information down further by the individual disabilities, none of the clients classified as being deaf expressed satisfaction with this service area and 22 percent (7) expressed dissatisfaction. Of the clients classified with the disability as other hearing impairment, 22 percent (2) of them expressed satisfaction with halfway house services and none expressed dissatisfaction. After researching the availability of halfway houses in serving clients classified as being deaf or having a hearing impairment, this writer found that there is presently only one halfway house designated for deaf clients. In addition, there were no halfway houses for clients specifically designed for clients with a hearing impairment. This information indicates that halfway house services are quite limited for clients with a hearing impairment. This factor should be explored further to determine whether or not halfway house services are feasible for clients with this disability and also to determine the reason for dissatisfaction with the halfway house presently available for deaf clients.

Responses of clients within the orthopedic impairment group also exhibited some differences. Table

4 reveals that 7 percent (5) of the clients within this general disability group were satisfied with the services of halfway houses. Similarly, 7 percent (5) of these clients were dissatisfied with this service. In reviewing these data by the individual disability group, none of the clients with an impairment of both arms revealed satisfaction and 13 percent (1) revealed dissatisfaction. Clients with an impairment involving one arm and one leg exhibited more dissatisfaction than satisfaction with this service, as 25 percent (1) were satisfied and 50 percent (2) were dissatisfied. On the other hand, the clients with a spinal cord injury responded largely as being satisfied, with 6 percent (1) being satisfied and 0 percent being dissatisfied. Halfway houses are not commonly used for clients with an orthopedic impairment. This is reflected by the fact that 86 percent (63) of the clients in this category responded as not having received this service. However, since there were some differences noted with regard to satisfaction and dissatisfaction of halfway house services by clients with an orthopedic impairment, this would warrant further investigation.

More differences can be observed in reviewing the responses of clients in the somatic disability category. As a group, 5 percent (4) responded as being

satisfied with the service of halfway house placement and 13 percent (10) responsed as being dissatisfied. Examining the data by the individual type of disability reveals further differences. Of those clients with epilepsy, 15 percent (2) revealed satisfaction and 8 percent (1) revealed dissatisfaction. Clients classified with a digestive disorder, however, responded as being dissatisfied, with 5 percent (1) being satisfied and 21 percent (4) being dissatisfied. Those clients with a metabolic deficiency also responded as being dissatisfied with no clients being satisfied and 100 percent (1) being unsatisfied.

The clients within the disability group of mental impairments, as a whole, exhibited general satisfaction with halfway house services, as 16 percent (34) responded as being satisfied and 11 percent (23) indicated dissatisfaction. Differences, however, were noted within the individual categories. For example, clients classified in the alcoholic group revealed a definite positive response, as 63 percent (14) were satisfied and only 9 percent (2) were dissatisfied. Other disabilities within the mental impairment group that reflected a positive response included the psychotics, with 15 percent (4) being satisfied and 11 percent (3) being dissatisfied, and the drug addicts, with 20 percent (1) being satisfied and 0 percent being dissatisfied. Those clients in the mental retar-

dation category, however, answered negatively, with 16 percent (9) being satisfied and 18 percent (10) being dissatisfied. Likewise, those clients with a personality disorder revealed dissatisfaction with 6 percent (5) responding as being satisfied and 9 percent (7) indicating dissatisfaction. Halfway houses are commonly used for clients with a personality disorder. Because of the levels of dissatisfaction noted, in the disability areas of mental retardation and personality disorder, further investigation would be important to determine the reason for the dissatisfaction.

The last major disability group area, which is the miscellaneous category, reflected results indicating dissatisfaction of the service of halfway house placement as 3 percent (1) were satisfied and 7 percent (2) were unsatisfied. In the speech impairment disability group, which is within the miscellaneous category, all the clients who responded indicated that they did not receive the service. Of those clients classified as having a disabling condition nowhere else classified, 4 percent (1) indicated satisfaction and 8 percent (2) indicated dissatisfaction. For clients who are classified within the miscellaneous category, the availability of halfway houses would be limited since few of these facilities exist to incorporate the needs of these disabilities.

It can be assumed from the data obtained, that satisfaction does differ with the disability group regarding the service of halfway house placement. This would imply the need for further research to determine the reason behind these differences in all of the disability areas.

Responses obtained from the questionnaires of clients with regard to the kind of vocational training revealed overall satisfaction with no major differences between the disability groups (see Table 5). In reviewing the responses of the disability groups to this service area, 56 percent (10) of the hearing impaired clients revealed satisfaction and 11 percent (1) revealed dissatisfaction. Of those in the orthopedic impairment group, 55 percent (44) responded as being satisfied and 9 percent (7) responded as being dissatisfied. The clients in the mental impairment group responded similarly, with 50 percent (114) satisfied and 10 percent (22) being dissatisfied. Nineteen percent (16) of the clients in the somatic impairment group revealed satisfaction where 12 percent (9) responded as being dissatisfied. As with the other disability groups, clients in the miscellaneous category largely responded as being satisfied as 52 percent (17) were satisfied and 12 percent (4) were dissatisfied.

Overall satisfaction was also noted from the

TABLE 5

Responses of Disability Groups to the Question on the Kind of Vocational Training

Disability Category	Disability	Number of Satisfied	Percent Satisfied	Number of Dissatisfied	Percent Dissatisfied	Received No Service	Percent No Service
HEARING IMPAIRMENT	Deaf	3	33	1	11	5	56
	Other Hearing Impair.	7	77	0	0	2	22
	GROUP SUB TOTAL	10	56	1	11	7	39
ORTHOPEDIC IMPAIRMENTS	Orthopedic Impairment:						
	3 or more limbs	4	57	1	14	2	29
	1 arm, 1 leg,	1	25	1	25	2	50
	Or both arms,	5	50	1	10	4	40
	Or both legs	14	50	4	14	10	36
	General Neurological Muscular Disorder	9	100	0	0	0	0
	Accident, Involving Spinal	10	51	0	0	9	47
	Loss of 1 or both arms	0	0	0	0	0	0
	Loss of 1 or both legs	1	33	0	0	2	67
	GROUP SUB TOTAL	44	55	7	9	29	36
MENTAL IMPAIRMENTS	Psychotic	10	39	1	4	15	58
	Psychoneurotic	22	73	0	0	8	27
	Alcoholism	8	36	2	9	12	55
	Drug Addiction	4	57	0	0	3	44
	Personality Behavior Disorder	44	52	12	14	29	34
	Mental Retardation	26	46	7	13	23	41
	GROUP SUB TOTAL	114	50	22	10	90	40

TABLE 5--Continued

Responses of Disability Groups to the Question on the Kind of Vocational Training

Disability Category	Disability	Number of Satisfied	Percent Satisfied	Number of Dissatisfied	Percent Dissatisfied	Received No Service	Percent No Service
SOMATIC IMPAIRMENTS	Neoplasms, malignant and Benign	1	50	0	0	1	50
	Allergic, Endocrine System, Metabolic	2	22	1	11	6	67
	Disorders of the Blood	1	100	0	0	0	0
	Epilepsy, Neuro system	2	17	3	25	7	58
	Cardiac, Circulatory	2	15	0	0	11	85
	T.B. & Respiratory	2	40	1	20	3	40
	Disorders, Digestive, Hernia	4	15	2	10	15	75
	Genito-Urinary System	2	13	2	13	12	75
	GROUP SUB TOTAL	16	19	9	12	55	69
MISCELL-ANEOUS	Speech Impairment	2	50	2	50	0	0
	Disabling condition nowhere else classified	15	52	2	7	12	41
	GROUP SUB TOTAL	17	52	4	12	12	36

responses of clients with regard to the benefits from training received (refer to Table 6). Of those clients with a hearing impairment, 45 percent (9) were satisfied with this service area and 10 percent (2) were dissatisfied. Forty-seven percent of the clients within the orthopedic impairment group indicated satisfaction and 9 percent (7) indicated that they were dissatisfied with this service area. The clients in the mentally impaired group revealed that 46 percent (102) were satisfied and 10 percent (23) were dissatisfied. Of those clients in the somatic impairment group, 31 percent (25) revealed satisfaction and 9 percent (7) revealed dissatisfaction. Finally, those clients in the miscellaneous category also indicated satisfaction, as 47 percent (16) were satisfied and 12 percent (4) were dissatisfied.

Table 7 reflects data obtained from the returned questionnaires regarding to service of surgery. The overall satisfaction in these areas is apparent in viewing the numbers and percentages of satisfaction and dissatisfaction of the different disability groups. The responses of the disability groups produced the following results: hearing impairments, 37 percent (6) satisfied and 5 percent (1) dissatisfied; orthopedic impairments, 35 percent (27) satisfied and 1 percent (1) dissatisfied; mental impairments, 11 percent (22) satisfied and 6 per-

TABLE 6

Responses of Disability Groups to the Question on the Benefits From Training

Disability Category	Disability	Number of Satisfied	Percent Satisfied	Number of Dissatisfied	Percent Dissatisfied	Received No Service	Percent No Service
HEARING IMPAIRMENT	Deaf	3	30	1	10	6	60
	Other Hearing Impair.	6	60	1	10	3	30
	GROUP SUB TOTAL	9	45	2	10	9	45
ORTHOPEDIC IMPAIRMENTS	Orthopedic Impairment:						
	3 or more limbs	2	33	1	17	3	50
	1 arm, 1 leg,	2	50	1	25	1	25
	Or both arms,	3	30	2	20	5	50
	Or both legs	10	40	3	12	12	48
	General Neurological Muscular Disorder	8	89	0	0	1	11
	Accident, Involving Spinal	9	50	0	0	9	50
	Loss of 1 or both arms	0	0	0	0	0	0
	Loss of 1 or both legs	2	50	0	0	2	50
	GROUP SUB TOTAL	36	47	7	9	33	43
MENTAL IMPAIRMENTS	Psychotic	9	35	2	8	15	58
	Psychoneurotic	19	63	1	3	10	33
	Alcoholism	8	38	0	0	13	62
	Drug Addiction	1	20	1	20	3	60
	Personality Behavior Disorder	42	48	11	13	34	39
	Mental Retardation	23	42	8	15	24	45
	GROUP SUB TOTAL	102	46	23	10	99	44

TABLE 6--Continued

Responses of Disability Groups to the Question on the Benefits From Training

Disability Category	Disability	Number of Satisfied	Percent Satisfied	Number of Dissatisfied	Percent Dissatisfied	Received No Service	Percent No Service
SOMATIC IMPAIRMENTS	Neoplasms, malignant & Benign	1	100	0	0	0	0
	Allergic, Endocrine System, Metabolic	5	46	1	9	5	46
	Disorders of the Blood	1	100	0	0	0	0
	Epilepsy, Neuro system	5	42	1	8	6	50
	Cardiac, Circulatory	2	10	1	8	9	75
	T.B. & Respiratory	2	40	0	0	3	60
	Disorders, Digestive, Hernia	4	19	2	10	15	71
	Genito-Urinary System	5	29	2	12	10	59
	GROUP SUB TOTAL	25	31	7	9	48	60
MISCELL-ANEOUS	Speech Inpairment	3	60	1	20	1	20
	Disabling condition nowhere else classi-fied	13	45	3	10	13	45
	GROUP SUB TOTAL	16	47	4	12	14	41

TABLE 7

Responses of Disability Groups to the Question on Surgical Services

Disability Category	Disability	Number of Satisfied	Percent Satisfied	Number of Dissatisfied	Percent Dissatisfied	Received No Service	Percent No Service
HEARING IMPAIRMENT	Deaf	2	25	1	13	5	63
	Other Hearing Impair.	5	46	0	0	6	55
	GROUP SUB TOTAL	7	39	1	5	11	58
ORTHOPEDIC IMPAIRMENTS	Orthopedic Impairment:						
	3 or more limbs	2	29	0	0	5	71
	1 arm, 1 leg,	1	25	0	0	3	75
	Or both arms,	3	33	1	11	5	56
	Or both legs	11	41	0	0	16	59
	General Neurological Muscular Disorder	0	0	0	0	7	100
	Accident, Involving Spinal	7	35	0	0	13	65
	Loss of 1 or both arms	0	0	0	0	0	0
	Loss of 1 or both legs	3	75	0	0	1	25
	GROUP SUB TOTAL	27	35	1	1	50	64
MENTAL IMPAIRMENTS	Psychotic	3	14	2	9	17	77
	Psychoneurotic	2	8	0	0	23	92
	Alcoholism	4	20	0	0	16	80
	Drug Addiction	0	0	0	0	5	100
	Personality Behavior Disorder	10	13	5	7	61	80
	Mental Retardation	3	6	5	10	41	84
	GROUP SUB TOTAL	22	11	12	6	163	83

TABLE 7--Continued

Responses of Disability Groups to the Question on Surgical Services

Disability Category	Disability	Number of Satisfied	Percent Satisfied	Number of Dissatisfied	Percent Dissatisfied	Received No Service	Percent No Service
SOMATIC IMPAIRMENTS	Neoplasms, malignant and Benign	2	67	0	0	1	33
	Allergic, Endocrine System, Metabolic	1	11	2	22	6	67
	Disorders of the Blood	0	0	0	0	1	100
	Epilepsy, Neuro system	1	9	0	0	10	91
	Cardiac, Circulatory	13	72	0	0	5	28
	T.B. & Respiratory	2	40	0	0	3	60
	Disorders, Digestive, Hernia	18	64	1	4	9	32
	Genito-Urinary System	19	68	1	4	8	29
	GROUP SUB TOTAL	56	54	4	4	43	42
MISCELL-ANEOUS	Speech Impairment	0	0	0	0	4	100
	Disabling condition nowhere else classified	7	27	2	8	17	65
	GROUP SUB TOTAL	7	23	2	7	21	70

cent (12) dissatisfied; somatic impairments, 54 percent (56) satisfied and 4 percent (4) dissatisfied; and of those clients in the miscellaneous category, 23 percent (7) satisfied and 7 percent (2) dissatisfied.

The results obtained from the responses of clients concerning the service of physical and/or mental therapy can be observed in Table 8. Overall satisfaction was also apparent in this service area. The results of the disability groups as to their satisfaction or dissatisfaction of this service were as follows: hearing impairments, 25 percent (5) satisfied and 5 percent (1) dissatisfied; orthopedic impairments, 21 percent (14) satisfied and 3 percent (2) dissatisfied; mental impairments, 30 percent (62) satisfied and 8 percent (17) dissatisfied; somatic impairments, 35 percent (29) satisfied and 10 percent (8) dissatisfied; and of those clients in the miscellaneous category, 23 percent (7) were satisfied and 0 percent were dissatisfied.

Overall satisfaction was also revealed from the data obtained regarding the service of job placement (see Table 9). The responses of the disability groups as to their satisfaction or dissatisfaction produced the following results: hearing impairments, 35 percent (6) satisfied and 6 percent (1) dissatisfied; orthopedic impairments, 36 percent (27) satisfied and 11 percent (8) dissatisfied; mental impairments, 41 percent (90)

TABLE 8

Responses of Disability Groups to the Question on Physical/Mental Services

Disability Category	Disability	Number of Satisfied	Percent Satisfied	Number of Dissatisfied	Percent Dissatisfied	Received No Service	Percent No Service
HEARING IMPAIRMENT	Deaf	2	20	1	10	7	70
	Other Hearing Impair.	3	30	0	0	7	70
	GROUP SUB TOTAL	5	25	1	5	14	70
ORTHOPEDIC IMPAIRMENTS	Orthopedic Impairment:						
	3 or more limbs	2	29	0	0	5	71
	1 arm, 1 leg,	2	50	0	0	2	50
	Or both arms,	2	25	1	13	5	63
	Or both legs	3	14	0	0	19	86
	General Neurological Muscular Disorder	0	0	1	14	6	86
	Accident, Involving Spinal	2	13	0	0	14	87
	Loss of 1 or both arms	1	100	0	0	0	0
	Loss of 1 or both legs	2	67	0	0	1	33
	GROUP SUB TOTAL	14	21	2	3	52	77
MENTAL IMPAIRMENTS	Psychotic	10	45	3	13	10	45
	Psychoneurotic	14	50	1	4	13	46
	Alcoholism	14	61	0	0	9	39
	Drug Addiction	0	0	0	0	5	100
	Personality Behavior Disorder	17	22	7	9	53	66
	Mental Retardation	7	14	6	12	37	74
	GROUP SUB TOTAL	62	30	17	8	127	62

TABLE 8--Continued

Responses of Disability Groups to the Question on Physical/Mental Services

Disability Category	Disability	Number of Satisfied	Percent Satisfied	Number of Dissatisfied	Percent Dissatisfied	Received No Service	Percent No Service
	Neoplasms, malignant and Benign	1	50	0	0	1	50
	Allergic, Endocrine System, Metabolic	1	11	2	22	6	67
SOMATIC IMPAIRMENTS	Disorders of the Blood	0	0	0	0	1	100
	Epilepsy, Neuro system	4	33	1	8	7	58
	Cardiac, Circulatory	6	43	1	7	7	50
	T.B. & Respiratory	1	20	0	0	4	80
	Disorders, Digestive, Hernia	11	42	2	8	11	42
	Genito-Urinary System	5	31	2	13	9	56
	GROUP SUB TOTAL	29	35	8	10	46	55
	Speech Impairment	1	33	0	0	2	66
MISCELL-ANEOUS	Disabling condition nowhere else classified	6	21	0	0	22	79
	GROUP SUB TOTAL	7	23	0	0	24	77

TABLE 9

Responses of Disability Groups to the Question of Job Placement

Disability Category	Disability	Number of Satisfied	Percent Satisfied	Number of Dissatisfied	Percent Dissatified	Received No Service	Percent No Service
HEARING IMPAIRMENT	Deaf	3	38	0	0	5	61
	Other Hearing Impair.	3	33	1	11	5	56
	GROUP SUB TOTAL	6	35	1	6	10	59
ORTHOPEDIC IMPAIRMENTS	Orthopedic Impairment:						
	3 or more limbs	2	33	1	17	3	50
	1 arm, 1 leg,	2	50	0	0	2	50
	Or both arms,	2	25	1	13	5	63
	Or both legs	7	30	4	17	12	52
	General Neurological Muscular Disorder	4	44	1	11	4	44
	Accident, Involving Spinal	8	40	1	5	11	55
	Loss of 1 or both arms	0	0	0	0	1	100
	Loss of 1 or both legs	2	40	0	0	3	60
	GROUP SUB TOTAL	27	36	8	11	41	56
MENTAL IMPAIRMENTS	Psychotic	7	28	4	16	14	56
	Psychoneurotic	9	33	4	15	14	52
	Alcoholism	7	33	2	10	12	57
	Drug Addiction	1	20	0	0	4	80
	Personality Behavior Disorder	36	42	12	14	37	44
	Mental Retardaction	30	54	5	9	21	38
	GROUP SUB TOTAL	90	41	27	12	102	46.6

TABLE 9--Continued

Responses of Disability Groups to the Question of Job Placement

Disability Category	Disability	Number of Satisfied	Percent Satisfied	Number of Dissatisfied	Percent Dissatisfied	Received No Service	Percent No Service
SOMATIC IMPAIRMENTS	Neoplasms, malignant and Benign	2	67	0	0	1	33
	Allergic, Endocrine System, Metabolic	1	11	3	33	5	56
	Epilepsy, Neuro system	6	46	1	8	6	46
	Disorders of the Blood	0	0	0	0	1	100
	Cardiac, Circulatory	0	0	0	0	13	100
	T.B. & Respiratory	0	0	0	0	5	100
	Disorders, Digestive, Hernia	2	10	2	10	16	60
	Genito-Urinary System	2	12	4	2	11	64
	GROUP SUB TOTAL	13	16	10	12	58	72
MISCELL-ANEOUS	Speech Impairment	2	50	2	50	0	0
	Disabling condition nowhere else classified	15	50	5	17	10	33
	GROUP SUB TOTAL	17	50	7	21	10	30

satisfied and 12 percent (27) dissatisfied; somatic impairments, 16 percent (13) satisfied and 12 percent (10) dissatisfied; and finally, miscellaneous, 50 percent (17) satisfied and 21 percent (10) dissatisfied.

Although the data regarding the service of job placement reveals overall satisfaction, more significant data are revealed by further examining the information on Table 9. As was previously mentioned, 52 percent of the clients indicated that they did not receive the service of job placement. As broken down by disability group, 59 percent (10) of the clients in the hearing impairment group responded that they did not receive this service. Seventy-two percent (58) of the clients classified as having a somatic impairment indicated that they also did not receive this service. The lowest percentage of responses of this nature was from the responses of clients in the miscellaneous category with 30 percent (10). Job placement is a service applicable to all rehabilitation clients; however, the data obtained from this study indicates that there are clients who are not receiving this service. Although a proportion of the clients probably responded in this manner due to a limited understanding of the question, this writer strongly feels that these data reflect a deficiency in the provision of these services. Further investigation is needed in this area to determine the

reason behind this apparent deficiency.

The last service mentioned in this study concerns the area of counseling and guidance. As with the other service areas, with the exception of halfway house placement, satisfaction did not differ according to the disability group (see Table 10). The responses of the clients with regard to this service area produced the following results: hearing impairments, 62 percent (13) satisfied and 5 percent (1) dissatisfied; orthopedic impairments, 63 percent (49) satisfied and 4 percent (3) dissatisfied; mental impairments, 63 percent (143) satisfied and 9 percent (21) dissatisfied; somatic impairments, 53 percent (46) satisfied and 10 percent (9) dissatisfied; and of those clients in the miscellaneous category, 48 percent (15) satisfied and 13 percent (4) dissatisfied. As with the area of job placement, counseling and guidance is a mandatory service that should be provided to each client of the Texas Rehabilitation Commission. As was previously mentioned, an average of 32 percent (141) clients indicated that they did not receive this service. Breaking these data down by the disability group, as reflected in Table 10, the highest percentage of clients who revealed that they did not receive this service was in the miscellaneous group, with 39 percent (12). The smallest percentage of clients responding in

TABLE 10

Responses of Disability Groups to the Question on Counseling and Guidance

Disability Category	Disability	Number of Satisfied	Percent Satisfied	Number of Dissatisfied	Percent Dissatisfied	Received No Service	Percent No Service
HEARING IMPAIRMENT	Deaf	5	56	1	11	3	33
	Other Hearing Impair.	8	67	0	0	4	33
	GROUP SUB TOTAL	13	62	1	5	7	33
ORTHOPEDIC IMPAIRMENTS	Orthopedic Impairment:						
	3 or more limbs	3	50	0	0	3	50
	1 arm, 1 leg,	3	75	0	0	1	25
	Or both arms,	5	63	1	13	2	25
	Or both legs	17	61	0	0	11	39
	General Neurological Muscular Disorder	3	38	1	13	4	50
	Accident, Involving Spinal	13	72	1	6	4	22
	Loss of 1 or both arms	1	100	0	0	0	0
	Loss of 1 or both legs	4	80	0	0	1	20
	GROUP SUB TOTAL	49	63	3	4	26	33
MENTAL IMPAIRMENTS	Psychotic	19	70	3	11	5	19
	Psychoneurotic	24	72	3	9	7	21
	Alcoholism	18	72	0	0	7	28
	Drug Addiction	2	40	0	0	3	60
	Personality Behavior Disorder	25	48	8	15	19	36
	GROUP SUB TOTAL	143	63	21	9	64	28

TABLE 10--Continued

Responses of Disability Groups to the Question on Counseling and Guidance

Disability Category	Disability	Number of Satisfied	Percent Satisfied	Number of Dissatisfied	Percent Dissatisfied	Received No Service	Percent No Service
SOMATIC IMPAIRMENTS	Neoplasms, malignant and Benign	2	100	0	0	0	0
	Allergic, Endocrine System, Metabolic	4	40	1	10	5	50
	Disorders of the Blood	1	100	0	0	0	0
	Epilepsy, Neuro system	7	58	1	8	4	33
	Cardiac, Circulatory	7	46	2	13	6	67
	T.B. & Respiratory	4	80	0	0	1	20
	Disorders, Digestive Hernia	10	45	3	14	9	41
	Genito-Urinary System	11	55	2	10	7	35
	GROUP SUB TOTAL	46	53	9	10	32	37
MISCELL-ANEOUS	Speech Impairment	3	60	0	0	2	40
	Disabling condition nowhere else classified	12	46	4	15	10	39
	GROUP SUB TOTAL	15	48	4	13	12	39

this manner were those in the mental impairment group, with 28 percent (64). This writer strongly feels that these data reflect a deficiency in the provision of the service of counseling and guidance, and, therefore, should be researched in more detail.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Several conclusions can be made from the findings of this study. First of all, it can be concluded that the services rendered by the Texas Rehabilitation Commission are generally satisfactory as perceived by the client's evaluation, since the data reflected client satisfaction in all service areas. Second, the satisfaction and dissatisfaction of the services did not differ according to the disability group, except in the area of halfway house placement. Since differences did occur in the area of halfway house placement, further research is needed since these data would imply some deficiencies in providing this service.

Another conclusion that can be made from this study stems from the numbers and percentages of clients who responded as not having received the service of job placement. As previously mentioned, job placement is a necessary and mandatory service which should be provided as an essential component to each client's rehabilitation process. However, in spite of this, 52 percent (221) of the clients who responded to the questionnaire indicated that they did not receive this service. From this data it can be assumed that the area of job placement is a deficient area in the rehabilitation program.

The results of this study also indicated that counseling and guidance is a deficient area in the rehabilitation program. This service is essential to every client in developing vocational objectives and enabling the client to understand his limitations and aptitudes. The responses from the clients, however, indicated that 32 percent (141) did not receive this service. This would definitely warrant further investigation.

The final conclusion that can be made from the results of this study is that the methodology utilized in gathering the research data was not effective. The response rate to the mail questionnaire was only 32 percent (638). This writer feels that the response could have been higher and therefore more valid data obtained if alternate methods had been used. This will be discussed further in the recommendations section of this chapter.

Recommendations

Several recommendations can be made from the findings and conclusions of this study. First, the differences in the responses of the disability groups in the halfway house service would warrant further investigation to determine the exact reason behind these differences. This could be done by initiating

a comprehensive study which would include all facets of the halfway house program. This study should specifically include those facilities that work with hearing impairments, orthopedic impairments, somatic impairments, mental disorders and those in the miscellaneous category since all of these groups exhibited some dissatisfaction. It is felt by this writer that information should be obtained from client feedback as well as from a complete program evaluation of these facilities by an outside objective source. A study of this nature would be quite thorough, however, this would be essential in gathering the necessary information to determine the specific deficiencies with this service area.

The findings of this study, with regard to the clients who indicated that they did not receive the service of job placement, have significant implication toward the policies of the Texas Rehabilitation Commission. Since these data reflect that job placement is a deficient area, this writer feels that the counselors should develop employment resources within the community so that they can refer their clients to direct jobs. In addition, workshops should be held to make the counselor aware of the job needs within their community.

Third, the service area of counseling and guidance also revealed some deficiencies as several clients indi-

cated that they did not receive this service. Since counseling and guidance is an essential service in rehabilitating clients, this writer feels that this area should be an emphasized area in the in-service training programs provided to counselors. Once the counselors become aware of the importance in providing this service and develops techniques that are effective in working with the different clients, this should alleviate this deficiency and help the counselor to plan and execute a more effective rehabilitation program for each client.

The fourth recommendation refers to the methodology that was utilized for this study. As a result of the low response rate to the mail questionnaire (32%), this writer feels that using a smaller sample and having a face-to-face interview with each client in the sample would be a more effective method of gathering data.

This study was just a beginning in determining client satisfaction of services. This writer feels that more research is definitely needed to evaluate the client's perception of his rehabilitation program. Information that would lend even more insight into the overall program would include a determination of variables which correlate with the satisfaction of the client. This research is greatly needed and would be an asset

toward evaluating and improving the necessary services of vocational rehabilitation.

This study provided a base line of knowledge with regard to client satisfaction of services. However, since the sample that was used included only those clients who were closed successfully, this writer feels that an additional study needs to be done using clients who were closed in an unsuccessful rehabilitation status. Since these results could be compared to the base line of knowledge already established, more insight could be obtained with regard to the effectiveness of services rendered by the Texas Rehabilitation Commission.

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