EVALUATION OF THE EFFECTIVENESS
OF
REHABILITATION PROCEDURES AND IMPLICATIONS
FOR FUTURE RESEARCH

by

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS (EDUCATION)
for the
BEHAVIORAL SCIENCE FOUNDATIONS

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SIMON FRASER UNIVERSITY
April, 1970
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Date of Approval: April 24th, 1970.
ABSTRACT

The theme of this inquiry is effectiveness of rehabilitation procedures and implications for future research. Its function is to review what has been done and is being done in rehabilitation, and recommend specific procedures to improve the performance of the rehabilitation process.

The major emphasis in the thesis is the importance of co-operation and co-ordination between research and service personnel as a necessary condition for improving professional service.

Rehabilitation is described historically and analyzed as a natural process which is facilitated by effective professional service.

As the core of the rehabilitation process, the counseling relationship is described and differentiations are made between this relationship and other human relationships.

The accreditation movement as it relates to rehabilitation is discussed and current accreditation procedures are defined and evaluated. This evaluation specifies fruitful directions for improved accreditation procedures.

Section Three of this thesis examines rehabilitation research and relevant research approaches. Significant research findings are related and used as a basis for developing a solid
research foundation as a means of generating relevant recommendations to improve the quality of rehabilitation services.

Specific recommendations related to improved professional training in both research and service work in rehabilitation, improved means of facilitating the communication of significant rehabilitation research findings to working service professionals, more relevant research procedures for both rehabilitation research and accreditation, and development and expansion of the accreditation influence in Canada are cited and supported by specific research findings and the writer's own professional experience.
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ACKNOWLEDGMENT

Many thanks to all who have influenced my thinking and enabled me to develop this thesis. Thanks to Dr. Hyman Pomp, Mr. Alan Toppel, and CARF for their long distance assistance. A special thanks to Mr. E.J. Desjardin for his interest and generous help on the accreditation section. Thanks also to the G.F. Strong Rehabilitation Centre and the University of British Columbia School of Social Work for their friendly assistance and the use of their libraries.

I am most grateful to my thesis committee. Their guidance and encouragement enabled me to complete this thesis. Without their support, the work would have been far more difficult.
INTRODUCTION

THE ROAD TO WISDOM

The road to wisdom? -Well, it's plain and simple to express:

Err
and err
and err again
but less
and less
and less.

- Piet Hein

Has man's path to knowledge been directed by a series of errors? How human is it to err? Is trial and error learning the only method man has to seek a greater understanding of his relationship to his environment? These questions form the basis of the following inquiry into the nature of one of the helping professions, rehabilitation, and its current effectiveness in helping people.

The helping professions consist of disciplines such as social work, mental health, and rehabilitation. Medical specialists in physical and rehabilitation medicine are also concerned with the helping professions (i.e., psychiatrists, neurologists, general physicians, physical therapists, rehabilitation nurses).

Social work provides various resources enabling the individual to help himself more effectively. Social work goals
differ for each institution, but they generally are defined as concern for the "positive growth" of the individual. Such a vague definition continues to plague the helping professions and presents a challenge to social researchers.

Without specifying goals, no measurement of effective service can occur. For measurement's sake, precise definition must be the first step in any science. Egan mentions service effectiveness as being social work's desired objective, but without more careful definition of these objectives, there is no way to determine how to develop suitable measuring tools since valid measurement is intimately linked to the goals or objectives.

As long as the helping professionals insist on defining goals in terms of growth, adjustment, or even self-actualization, the counseling process will continue to take on a magical flavour; preventing intelligent understanding of what transpires during this process. Assuming that the counseling relationship is too complex to be investigated shrouds the helping professions in a cloak of ignorance. Before effective program planning can occur in social work, a more thorough understanding of the counseling relationship is needed.

Much current mental health practice assumes a social psychiatry focus on people's social functioning in groups rather than their pathology. This holistic approach observes the individual in his social context involving family, institutions, and community. By providing the individual with information about his social and physical environment and by
helping him develop needed social skills and utilize current social skills more effectively, social psychiatry emphasizes psychological health, not psychopathology. Milieu therapy, a complementary approach, helps an individual to learn to interact effectively within a supportive environment. Effective social functioning is a major goal in mental health.

Rehabilitation employs psychological, social, and medical disciplines to assist the patient in achieving his optimal level of functioning. Vocational information and placement techniques emphasize rehabilitation's unique vocational focus. All of the helping professions are unified in their approach to helping the individual help himself.

Many gaps and severe methodological problems exist in the present body of social work, mental health, and rehabilitation research. Social work research identifies problems, types of clients, and agency services and service needs. Research is needed on the effects of programs, on clients participating in programs, nature of other individuals involved with the client, more precise definition and more effective implementation of agency goals, and rational agency organization.

Serious research obstacles for social work are: a lack of adequate sampling, a lack of objective data collection (e.g., clinical evaluations are highly unreliable measures of behavior), a need for more logical analysis procedures, a misapplication of methods (e.g., equating correlation with causality), and a lack of reliable studies. Both qualitative and quantitative research in social work needs to be formulated on the basis of
the "long range goal of improving services, not merely reporting activities."\(^6\)

Within the helping professions and education, there is a general need for the development and co-ordination of related, significant research findings which will form a valid basis for further research. This basis would give researchers direction and relationship with the research effort of other researchers, rather than producing more isolated and duplicated research work, much of which is irrelevant to the research needed to improve professional practice and extend theoretical and applied boundaries of the professions.

There is recognition of the need for better integration in research and a mature relationship within the research process itself.\(^7\) Treatment and diagnosis must be defined before any measurable patterns emerge from an inquiry regarding the effect of specific activities. Realistic goals need to be defined and clearly related to the proposed treatment. This process will be advanced by a determination of which clients are helped by present methods, and development of appropriate methods to help the clients who haven't benefited from present treatment.\(^8\)

In his aphoristic book, Grooks I, Piet Hein summed up the creative process in a similar way: "The creative process is in formulating the problem. Once that is done in the right way, it's all routine tablework. The problem is solved."\(^9\) Of course, "formulating the problem" covers a tremendous amount of ground. It is interesting that Hein's definition would include research as a creative endeavour. Research and creativity
both appear to be problem solving processes that have similar steps and operations arriving at a final set of statements.

With this definition in mind, the effective framing of a research question will directly influence the validity of the entire procedure. Research design takes on a crucial importance and research difficulties at this stage may invalidate the experiment. Invalid criteria of performance, difficulty in finding control groups, and equating control groups with experimental groups prior to the beginning of the project are some of the serious research problems in field research. Influenced by these difficulties, much applied behavioral research is exploratory in nature. Exploratory substudies may indicate which aspects of a program must be tested under more rigorously controlled conditions.10

Rehabilitation research, unlike laboratory research, cannot be isolated from the reactions of living persons with a disability. The adjustment of disabled persons to their environment and the reactions of other persons to disability can't easily be simulated in laboratory experiments. Often, how a person behaves in a laboratory doesn't reflect accurately his behavior at work or at home. (The counsellor's office also may elicit unrepresentative responses from clients.) For this reason, rehabilitation research can be conducted most accurately in "field" settings where disabled persons interact with their natural environment. (e.g. workshops, community centres, group meetings, etc.)

The subject matter of rehabilitation research deals
with issues common to disability and handicap. These data are collected to clarify the holistic rehabilitation process and how the handicapped adapt to their environment.\textsuperscript{11}

Research in mental health is plagued by the same problems that invalidate rehabilitation and social work research. Relating these fields and their common difficulties provides greater perspective in formulating some comprehensive research principles that apply to all three fields of endeavour.
Notes

Introduction


6 Ibid.


11 Ibid.
Examples of compassionate people helping those afflicted by sickness or injury have occurred throughout human history. Most of these incidents were isolated and individualistic, however, and tended to cease with the death of the concerned person. Only in recent times have men been able to organize themselves into more effective agents of change and to set up programs to assist those in need; programs that continue after the death of their creators.

An early example in the field of rehabilitation is Henry Dannett's School of Instruction for the Indigent Blind in Liverpool, England which was started in 1791. The school offered training in music and mechanical arts. This beginning was followed by the construction of a number of other schools for the blind in England where blind students received training in various trades.

In 1832, John Nepinak founded a school for crippled children in Bavaria. Soon many more schools were built all over Europe.

During this period, the deaf also were receiving attention, and schools were being built for their use. One particularly interesting and far advanced school was founded...
by James Donaldson in the mid-nineteenth century. This school was integrated, with hearing and deaf children learning together.

In 1752, the first United States general hospital was started by Dr. Benjamin Rush in Pennsylvania. Dr. Rush's advanced ideas were demonstrated in his concern for therapeutic and rehabilitating practices with all kinds of sick people.

One of the first efforts on behalf of retarded children and adults was undertaken by Dr. Samuel Gridley Howe when he helped establish the Massachusetts School for Idiotic and Feebleminded Youth in 1851. As a result, other schools for the retarded were started all over the United States.

In 1918, the National Tuberculosis Association drew up plans for the vocational rehabilitation of returning veterans and set up occupational training. In 1928, this same organization issued a classification of work capacities of tuberculous patients, and in 1930 established a rehabilitation service. Today, classifications of work capacities for nearly all disabled persons are readily available.

The Methodists started the Goodwill Industries in 1918. This movement has made substantial contributions to the rehabilitation of disabled people by providing employment and assessment facilities. 1919 marked the founding of the Society for Crippled Children. The first conference on workshop problems was held in 1949 by the National Association of American Social Workers. The Association of Rehabilitation Centers was established in 1952.
After World War I, the Red Cross began to help veterans return to civilian life and find employment. Later, they also developed a handicapped bureau which provided medical diagnosis and work-potential clinics to evaluate clients for employment.

In 1897, the first legislative support for rehabilitation was adopted by Minnesota. This support involved treatment, care, and education for crippled children. 1917 marked the first congressional vocational rehabilitation act called the Smith Hughes Act. This act was followed by the Soldiers Rehabilitation Act of 1918. In 1920 the first U.S. state-federal cost sharing programs in vocational rehabilitation were developed and implemented. During the same year, Public Law 236 set up the mechanism for Workmen's Compensation which established its own rehabilitation program. Then followed the Sweet Bill of 1921 which established a veteran's bureau, the War Veterans Act of 1924, which offered rehabilitation training, the Readjustment Act of 1944 which extended rehabilitation coverage, the state-federal amendments for veterans and non-veterans of 1943, and the Vocational Rehabilitation Act Amendments of 1943. Public Law 565 of 1954 established rehabilitation grants for training and research. Recent legislation has expanded government support of the rehabilitation movement.¹

Of special importance to rehabilitation is the development of orthopedic surgery, physical therapy, occupational therapy, and U.S. federal-state programs in vocational rehabilitation which were all outgrowths of World War I. After
World War I, greater emphasis was placed on the problems associated with disability and chronic disease which extended beyond the medical realm. Rehabilitation counselling, clinical psychology, social work, occupational therapy and other disciplines began to work together as a team to co-ordinate rehabilitation services. These early ventures have strongly influenced the current trends in rehabilitation.²

Rehabilitation and disability are strongly interrelated. Often disability is equated with handicap and the disabled person is considered incompetent and inferior.³ Disability has been defined as "a loss of specific function" (medical) and a handicap defined as "a measure of the functional loss of a person's capacity which places him below the production standards required for employment."⁴ However, a disability is not a functional handicap unless it is a significant barrier to a person's effective performance of a specific job. Because of lack of aptitude or interest, everyone is functionally handicapped for certain vocations. Only when disability precludes effective job performance should it be considered a handicap.⁵

Originally, rehabilitation was considered an activity of medicine.⁶ It soon became apparent to physicians that additional assistance was needed by the disabled patient after his medical treatment was completed before he would be ready to enter into independent living or employment.⁷ Thus yielded the fields of physical or rehabilitation medicine which are oriented towards helping the patient to recover as much of his
functioning as possible before he is referred to other rehabilitation professionals who will help him to discover and utilize his strengths and correct or minimize his weaknesses. The chief concern of rehabilitation medicine is to help the individual to work effectively within the functional limits of his disability.

Besides the physician who usually acts as medical director in a medical rehabilitation setting, rehabilitation nurses help the patient to begin functioning more effectively. The traditional role of the nurse has been to help the passive patient by doing things for him. In this new role, the nurse encourages and supports the patient's efforts to help himself.

This broadening of the concept of rehabilitation has resulted in many more specialized services being added to rehabilitation, the "whole" person's needs being considered as an integral part of his rehabilitation. This historic tendency to view rehabilitation in a therapeutic context is understandable since the various specialized services or therapies have become the tools of rehabilitation. These tools have direct application because each client is a unique person with unique abilities and the therapeutic tools help the person to understand his abilities. In rehabilitation, ability, not disability, determines what vocations are most suitable for the client.

Broadly speaking, vocational rehabilitation encompasses physical restoration, evaluation, adjustment, placement, and follow-up.
Initially, vocational evaluation focuses on the meaning work has for the client before the actual process of evaluation and adjustment takes place. This process is dependent upon the client making a plan or taking part in deciding on the plan that the team will follow.

Rehabilitation process functions include: re-establishing the personal capacity of the client to participate effectively in his environment, increasing his work tolerance, and utilizing his intellectual, social and vocational potentials appropriately. Because of the traumatic effects from a disability, the natural mechanisms that people develop to interact with their environment often are thrown out of balance. One function of rehabilitation is to help the client to re-stabilize himself in his environment.

There are definite steps in the rehabilitation process which assist the person in successfully rehabilitating himself. Prevocational evaluation is a screening process which normally includes an intake interview, medical and psychological interviews if required, and a staff conference to evaluate the person's potential for successful rehabilitation (also called rehabilitation evaluation).

The next step, vocational evaluation, is an assessment of a person's physical, mental, and emotional strengths, limitations and tolerances to predict his present and future employment potential. Often, the client is evaluated during the performance of a variety of work tasks called work samples, or through actual job performance in a workshop (called work
evaluation). This evaluation period lasts anywhere from one week to six months, depending on agency and client needs.

During the final phase, work adjustment, the client is helped positively to modify his work personality. Work habits, relationships with others, and other kinds of on-the-job behaviors constitute the client's work personality.19

There is an important distinction between prevocational evaluation, vocational evaluation, and work evaluation and work adjustment. The first three steps are assessment techniques used to diagnose and predict. The last step is a treatment technique which helps the client modify his work personality to work more effectively in a competitive employment situation.20 Learning through performance facilitates the building of an individual's confidence, work tolerance, competency, and coping behaviors.21

In the rehabilitation setting, the occupational therapist helps the patient to improve his physical and social functioning. Controlled social relationships and activity procedures help the individual to interact more effectively with his environment.22

Both the occupational therapist and the vocational evaluator may be involved in vocational evaluation, establishing possible vocational objectives or guidelines for each client. These broad guidelines allow the counsellor flexibility in planning with his client. The evaluator doesn't decide for the client, but rather establishes the parameters within which the person should be potentially successful (i.e., similar to
psychological test predictions).²³

The vocational evaluation simulates an actual working situation in which the person being assessed learns to operate basic equipment and tools and to perform basic job operations. Coupled with correct work habits, these procedures help the individual to gain confidence in his own capability to work. The person also increases his psychological and physical work tolerance over the evaluation period. The main elements of this process are:

1. Establishing criteria and vocational goals.
2. Collecting information regarding vocational potential.
3. Analyzing information regarding vocational potential.
4. Decision-making on potential vocational goals and predicting outcome.
5. Determining the effectiveness of the evaluation process by feedback obtained through follow-up.²⁴

This scientific process is operational in its application with built-in, continuous feedback through periodic review. This review is a self-checking procedure known as follow-up which determines what happens to the client once his program has ended.²⁵ Observing the individual in this setting allows the team to make adaptations in an industrial setting to fit a particular person if such modifications become necessary. This kind of observation provides information on the person's work attitudes, interests, work performance, and other aspects
of his work personality which are useful in counseling, evaluation, and adjustment.  

There are various techniques that are used in vocational evaluation. One of the most popular present techniques is the work sample. This method simulates an actual job with actual work demands, and allows the team to observe the worker engaged in actual work behavior over a long period of time (compared with psychological testing) in a fairly controlled setting. Unfortunately, this method requires constant revision to keep up to date with new jobs, is expensive and time-consuming, and has definite validity and reliability problems as a predictive instrument.  

Of course, some work sample systems are more effective than others. For instance, as a valid assessment measure for predicting successful future training and placement, there does seem to be close correspondence between some work sample systems' predictions for successful client placement in specific employment and successful placement in the predicted areas of employment in 85 per cent of the cases assessed.  

Work sampling is essentially a combination of job analysis and testing psychology. Job analysis consists of breaking down a given job into its components and analyzing what skills are necessary to perform the various tasks. Unfortunately, this approach has overlooked the fact that the worker is engaged in a continuous process best performed in a continuous fashion. Due to the lack of continuity and lack of accounting for human variability, job analysis is not
an effective instrument for predicting job performance.\textsuperscript{29}

A new approach to this problem is called the situational approach. This approach closely simulates industrial conditions by paying wages, producing actual commodities, setting standards for quantity and quality, maintaining regular working hours, and other standards in industry. Lack of variety in skills and types of jobs and difficulties in measuring the results of the process severely limit this approach.\textsuperscript{30}

Traditional psychological testing is administered by the staff psychologist. Testing each individual client, helping the individual client to cope with his own personal problems, and facilitating communication and teamwork among the rest of the staff are some of the important functions of the staff psychologist in a rehabilitation setting.\textsuperscript{31} The testing or assessment duties usually involve administering and interpreting objective tests and, in some cases, personality tests.

In rehabilitation, tests which are helpful in setting guidelines and making decisions are most commonly used. This testing information is useful to other members of the team in helping the client to formulate a realistic rehabilitation plan.\textsuperscript{32}

One researcher suggests that standardized tests of manual dexterity can predict vocational success as well as, or better than, work samples and can be administered in less time.\textsuperscript{33} These tests, however, don't provide a longer period for clinical observation of the client at work which may be important in his overall program planning. Manual dexterity is necessary,
but not sufficient for many industrial occupations such as assembly. There are other significant factors involved such as travel mobility and good work habits. Because of these intervening factors, tests should be considered as one more measure of behavior in the client's "total environmental field."\textsuperscript{34}

In addition, the norms on which tests were originally standardized may not be applicable to current test takers, the objective criteria of work performance upon which standardization is based are often very unreliable, and the differences between the demands of a work situation (where variables vary widely and are under little control) and a testing situation (in which variables are carefully controlled and attention, concentration, and motivation are maximized) do not correspond very closely.\textsuperscript{35}

All of these techniques as tools in the evaluation tool box are suited to different purposes. Mass screening for employees with certain minimum levels of a certain skill will probably be appropriately served by psychometric tests. Job analysis can best tell us exactly what functions a worker performs on his job. Mastery at a particular skill can probably be best accomplished by a structured work sample. A simulated work situation may be best to observe a person's work personality. To determine all of these different factors would require a much more complex approach with more elaborate facilities. Research and development in these areas are greatly needed and still very primitive.\textsuperscript{36}

The social worker's special contribution to the
treatment team is assisting the client in developing social skills. Social case work is essentially a skilled technique to help individuals function more effectively as human beings. The worker's duties include discussing the client's progress with his family, other staff members, and the community agencies involved in his case, evaluating his resources and ability to benefit from the service, and referring him to appropriate community resources to help him cope with other problems.

The worker acts largely as a social interpreter helping others to understand the client's unique situation. The worker's concern embraces not only the client, but also embraces other significant people in the client's life. Without this comprehensive approach to the client's social environment, the development of effective social skills may be neglected and the client may have difficulty in successfully coping with his rehabilitation program. Social work contributes significantly to the rehabilitation service by helping the client to develop effective social skills which ameliorate some of the difficulties related to disability.

Often, this work involves housing, recreation, education, and "legislation on disability" meetings. Much community work involves improving community services for the disabled.

In recent years, rehabilitation counseling, which includes vocational counseling, and placement counseling, has expanded its role in rehabilitation. Traditionally, vocational guidance helped people to make occupational selections.
Vocational guidance is informational and directional; vocational counseling, involving the person in a counseling relationship, is less directive and information oriented, and more exploratory. The unique service of a rehabilitation or vocational counsellor is helping the person to make the most of his vocational potential. The counsellor helps the client learn to evaluate and understand his vocational strengths and liabilities, and to carry out a realistic program focused on an appropriate vocational goal.

Rehabilitation counsellor training programs revolve around the counseling relationship and utilize medical, social, psychological, and vocational information related to the client's rehabilitation.

Co-operation and co-ordination between professionals are important for effective teamwork and require a meaningful focus. The client's rehabilitation is the most meaningful focus and must take precedence over professional, institutional or individual concerns. The rehabilitation diagnosis develops this focus and defines the actual encompassing handicaps surrounding the client. The rehabilitation diagnosis is an integration of medical, psychological, social, and vocational diagnoses focusing on effective overall functioning of the client.

All disciplines connected with rehabilitation are equally important. Simultaneously working together rather than in sequence, they help the client find solutions to his problems within his environment. This client-centered process
is continuous, integrated, and simultaneous. "This force of combined and integrated disciplines can only be brought to bear in relationship to each other and in co-ordination with each other." 45

Throughout the rehabilitation process, the counseling relationship moves from an exploratory stage to a decision-making stage involving training and placement. Even during the placement process, the counsellor's understanding of his client is needed to assist employers in adapting a job to suit a particular client's abilities as in job modification. Job modification, or tailoring the job to suit the person's requirements when special limitations exist, may make the difference between employment and unemployment for a disabled person. 46

A close examination of the counseling relationship reveals that counseling is used in many different ways and settings. Some distinctions need to be made between counseling and other kinds of personal interactions. Primarily, counseling involves social learning and is directed towards helping people to understand themselves and more effectively utilize their abilities and interests. Unlike psychotherapy, most clients in counseling aren't disturbed, although they may have personal problems to solve or personal ambiguities to resolve. Often, tests, social histories, and other outside resources assist the counsellor in understanding his client. Unlike psychotherapy which releases a person's unconscious and negative feelings, counseling is centered around positive behavioral
A number of common elements characterize the effective counseling relationship. Mutual respect and confidence, faith in human growth, honesty, and openness are common characteristics. Honest communication demonstrates empathy with the client's feelings. The counsellor's knowledge and training help to facilitate the growth process by providing needed facts appropriately. The change in the person's self attitudes and behavior as counseling progresses is the most intangible element. Structuring limits such as time, direction, and client goals are very important elements of the total counseling process.

In psychotherapy, counseling, casework, or interviewing, the person being helped needs a one-to-one relationship with an understanding, trustworthy, and encouraging human being. Understanding comes from an ability to identify with the person's difficulties. Afflicted by emotional illness, Dr. Hincks, a pioneer in mental health, felt his disability was an asset because it helped him personally to understand his patient's suffering.

This ability to empathize or step into another's shoes and see things from his point of view is a necessary skill in counseling. To what extent empathy can be learned or measured is unclear. Counsellors develop their counseling styles in terms of their personal attributes. Because empathy helps develop and maintain the counseling relationship, selecting counseling students with ability or potential to empathize may be one of the most appropriate selection practices for counsellor
training programs. A counsellor's empathetic understanding can allay defensive client attitudes and help him develop solutions to his problems. Little effective vocational planning can take place if these personal problems become obstacles.\textsuperscript{52}

Today, counsellors are cautioned about giving advice in the counseling relationship. Modern counseling theorists believe the client must be free to develop his own values, and will develop them in relation to existing social realities.\textsuperscript{53} Unless feelings and attitudes are made explicit, they may be communicated unconsciously. The counsellor should become aware of his own values and attitudes, and express them appropriately when they will improve the relationship. However, they should be stated as his views, not the gospel truth. Using this freedom, the counsellor acts more freely and openly; creating a healthy kind of equality in the relationship.\textsuperscript{54}

Once the relationship is successfully established and maintained, it progresses to a decision-making stage. Decisions are indicators that learning has taken place. Through this learning process, the client begins to make independent decisions and take responsibility for these decisions.\textsuperscript{55} Freedom that allows a person to learn to decide for himself can come only from a noncoercive relationship. By encouraging self-reliance and not producing excessive dependency, the counsellor helps the client to begin making decisions.

Sometimes, the counsellor will try to recondition dependency into self-reliant striving. This reconditioning occurs through persuasion, encouragement, and co-operation on
a progressive plan for change.\textsuperscript{56} Regarding the client as a potentially effective human being able to make decisions and carry them out, allows the counsellor to help the client develop self-reliance. As co-manager of his rehabilitation, the client "helps to plan his course within the prevailing realities and possibilities."\textsuperscript{57}

Counseling seeks to help the person to see himself more accurately and to make any necessary changes that will allow him to become a more effective human being. There is a positive relationship between the initial accuracy of self-ratings and the learning by the client that has taken place in the counseling relationship.\textsuperscript{58}

Counseling is a continuous educational process oriented towards counsellor-client co-operation. The focus of counseling is on the whole person and the client learns to see himself as an effective, well-integrated person who makes relevant decisions. The disabled client, as any other client, can be counseled beneficially using these criteria.\textsuperscript{59} Although there has been some progress made, counseling urgently needs to develop valid means of evaluating its effectiveness.\textsuperscript{60}

Today, rehabilitation is advancing very rapidly in both research and clinical work. This advance is the result of a natural interaction between these two complementary processes. Because of this flowering of knowledge, a system of organizing research findings will help in evaluating current and future progress.

Research needs to build on a firm foundation of valid
experimentation. This foundation can be developed by organizing valid findings and indicating directions that would be fruitful for continued research. By building this foundation, pursuing needed directions of research, and effectively translating research findings into improved professional practice, rehabilitation and other helping professions will continue to progress in positive directions.
Notes

Section One


3 Obermann, *op. cit.*, p. 29.


7 Florence Jones (Terry), et al., *Principles and Technics of Rehabilitation Nursing* (St. Louis: The C.V. Mosby Company, 1961) p. 16.

8 Obermann, *op. cit.*, pp. 42-43.

9 Rusk, *op. cit.*, p. 11.

10 Ibid., pp. 282-283.

11 Jones, *loc. cit.*


13 Rusk, *op. cit.*, p. 293.


16 Jones, op. cit., p. 32.

17 Wright, op. cit., p. 345.


24 Loc. cit.


26 Rusk, op. cit., p. 63.


29 Neff, op. cit., p. 685.

30 Ibid., p. 687.

31 Obermann, op. cit., p. 45.

32 Rusk, op. cit., p. 59.


36 Ibid., pp. 687-688.

37 Jones, op. cit., pp. 70-71.

38 Rusk, op. cit., p. 284.


40 Wright, op. cit., p. 250.


42 Hamilton, op. cit., p. 121.

43 Rusk, op. cit., pp. 292-293.

44 Hamilton, op. cit., p. 90.

46 Hamilton, op. cit., p. 179.


51 McGowan and Schmidt, loc. cit.

52 Rusk, op. cit., p. 61.


54 Ibid., pp. 154-155.


57 Wright, op. cit., p. 363.


SECTION TWO

ACCREDITATION IN REHABILITATION

Developing and maintaining an acceptable standard of performance in a profession or field is the business of accreditation. Any discussion of accreditation necessarily implies the presence of some standard of quality of services. This emphasis on quality implies a different meaning than would a quantitative emphasis. Instead of more service the emphasis is on better service! Unlike quantitative approaches, the quality of a program can't be measured in terms of mathematical or accounting values except in the most gross manner. Guaging the quality of performance requires not only a different size of yardstick than that employed by a quantitative emphasis, but a different kind of yardstick all together! "To have quality, the service must have an intrinsic integrity." ¹

This intrinsic integrity involves the use of the latest professional techniques and knowledge in combination with effective performance of the professional team, and the overall capability of the entire facility. This kind of performance while it is expensive in the short run, is economical in the long run. Its intelligent focus searches for proper equipment, training, and personnel to upgrade quality rather than stumbling in the dark with little understanding of what
is necessary for effective rehabilitation.

The concern with numbers and quantity in rehabilitation has had serious effects on the quality of the services offered to clients. Sometimes, there is a padding of client cases. Clients are hustled into jobs that can be considered placements or training programs to justify the counsellor's or facility's existence. In some centres, clients are kept in jobs which don't teach them any skills or offer them anything new in order to keep up the production levels of the facility.

These examples illustrate some of the difficulties that can occur when a program becomes quantity, not quality conscious. In fact, this kind of approach can be likened to that of the sorcerer's apprentice who employs the broom with magical words to carry water to his master's house and is unable to stop the broom because he has forgotten how to stop it!

While the disaster that can occur in a facility isn't quite as dynamic or exciting as the disaster brought on by an overindulgent broom flooding the premises, the cold facts, usually seen in retrospect, demonstrate the harm that can be done to the person who needs the services by not considering his best interests and the overall quality of the program.
SECTION TWO

ACCREDITATION IN REHABILITATION

1 - The Accreditation Process

The evaluation of quality is more of a process than a question of addition. The records of service in an agency are the principle guides to the rehabilitation process. This process begins by identifying the training of personnel and their experience, the facilities available, the kinds and character of the existing services, responsibility and authority throughout the facility as well as "demonstration of continuous sincere efforts at evaluation of the results of the service rendered, coupled with continuous, sincere efforts to learn from this experience and to improve." This crucial point of "continuous, sincere efforts to learn from this experience and to improve" is a central focus of the learning process involved in accreditation.

Accreditation is primarily an educational process moving towards certain kinds of behaviors and away from others. Accreditation shouldn't be considered as a one time examination that a facility crams for, but it should be considered as a continuous inquiry into practices as reflected in the overall operation of the facility.

Although this task sounds like an impossible effort, with thoughtful planning, it can be implemented effectively by staff participation and co-operation. By professional agreement on broad professional standards, improved teamwork,
and continuous efforts to improve the overall organizational functioning of the facility, a synthesis of many disciplines into an effective treatment program will develop.\(^3\)

This integrated, holistic approach suggests a certain viewpoint which must be appreciated by the staff if the standards are to be upgraded. Only by working together in a spirit of co-operation and united effort can effective rehabilitation take place.

Currently, there are a number of accreditation programs. Although these programs were started by different organizations, they do share a number of similar characteristics:

- They are voluntary, self-imposed and self-governing.
- They identify high quality and at the same time encourage the upgrading of all levels of performance.
- They provide recognition, within and without the field, of the achievement and maintenance of given standards of proficiency.\(^4\)

As a voluntary process, accreditation can be an effective means of improving workshop performance because the staff must believe in the value of improving performance and must be motivated to work towards this goal in their own disciplines as well as within the rehabilitation team. This process implies changing the production line attitude and adopting an attitude of co-operative consideration of each client's options and possibilities directly with the client, rather than parceling him into a deadening job where he is exploited for the rest of his life. A quality conscious counsellor helps the client to help himself by supplying him with up to date, relevant information, support, and encouragement to make decisions himself.
Accreditation, then, is essentially a process for upgrading the standards of performance in a given facility. This process examines the facility's approach to and assumptions about rehabilitation. The final outcome is related to the initiating and maintaining of desired performance norms by the facility. 5

Accreditation isn't a suit one buys and stores in the closet for the three year review; it is related to learning which requires proficiency. Proficiency is neither improved nor maintained without continuous practice aimed at more effective performance.

Not only does accreditation benefit the client, but this process is of direct benefit to the facilities themselves. Workshops are beset by many organizational problems which have negative consequences for the workshop rehabilitation program. When the workshop suffers a setback as a result of poor planning, often the first item to be sacrificed is the quality of the program. Even if the condition of the workshop is satisfactory economically, without organized planning and upgrading, "uneven and unstable programs" can result which affect not only the clients, but customers, friends, sponsors, and the wider community. 6 Without regulated, quality-conscious development, co-ordination is jeopardized and the organization may lose control of itself.

The findings of one study show that not only do faulty administrative practices waste community money, but such practices also discourage clients who are motivated to help themselves,
impeding the rate of development of rehabilitation and the rehabilitation movement. 7

It is a serious matter not to be concerned with the quality of performance, but just to blunder blindly along on the path of incompetence. The recipient of this blundering is always the defenseless client!

As in any other endeavour requiring competence in performance and keeping up to date with changes, the rehabilitation worker, if he is to serve his client more effectively, must keep up to date not only in his own specialty, but he must also keep up to date with the general developments in rehabilitation and education.

Man has always stated goals or objectives for himself. Only within recent years have these objectives been broken down into carefully specified procedures. The field of education, for example, has had sets of standards for more than fifty years, but only since 1949 has there been a national commission on accreditation established for the various educational accrediting agencies. 8

The second oldest accreditation operation is connected with medicine and has established accreditation procedures for hospitals for the last eighteen years, although there have been various kinds of hospital standards in existence for fifty-two years. This body, the Joint Commission on Accreditation of Hospitals, was created by the American College of Physicians, the American College of Surgeons, the American Hospital Association. (National standards have existed since 1944). The
American Association of Homes for the Aging and the American Nursing Homes Association have recently become involved in accreditation.9

In 1947, an early attempt at establishing standards in vocational rehabilitation was reported in an early United States Government pamphlet:

1. Early location of persons in need of rehabilitation to prevent the disintegrating effects of idleness and hopelessness.

2. Medical diagnosis and prognosis, coupled with a vocational diagnosis as the basis for determining an appropriate plan for the individual.

3. Vocational counseling to select suitable fields of work, by relating occupational capacities to job requirements and community occupational opportunities.

4. Medical and surgical treatment to afford physical restoration and medical advice in the type of training to be given and in the work tolerance of the individual.

5. Physical and occupational therapy and psychiatric treatment as a part of medical treatment where needed.

6. Vocational training to furnish new skills where physical impairments incapacitate for normal occupations, or where skills become obsolete due to changing industrial needs.

7. Financial assistance to provide maintenance and transportation during training.

8. Placement in employment to afford the best use of abilities and skills in accordance with the individual's physical condition and temperament, with due regard to safeguarding against further injuries.

9. Follow-up on performance in employment to afford adjustments that may be necessary, to provide further medical care if needed, to supplement training if desired.10
This taxonomical approach is fairly common and occurs in many other fields. The difference is that this approach was a beginning in the development of the infant discipline called rehabilitation. Unfortunately, this taxonomical listing of needs isn't too useful in helping rehabilitation workers implement procedures to meet these needs as compared with the standard approach which not only states objectives, but also describes methods of reaching those objectives.

The earliest history of an actual attempt to establish specific standards related to rehabilitation and workshops began in 1944 with the publication of the U.S. Department of Labor pamphlet on sheltered workshops covering the areas of organization and administration, working conditions, wage payments, buildings and equipment, and ethical business practices. There were no considerations for rehabilitation services in this initial statement by the government.

1957 was the year of the National Rehabilitation Association (NRA) meeting to plan a sheltered workshop institute. The need for standards was emphasized at this meeting and a government grant from the Vocational Rehabilitation Administration (VRA) was given to NRA and the National Association for Sheltered Workshops and Homebound Programs (NASWHP) to support the establishment of this institute.

This fledgling organization, "The National Institute on Workshop Standards" (NIWS) began its work in 1958 and completed the set of standards in 1964. This historic institute had made a formal commitment to standard development and work-
shop accreditation, and honoured this commitment with a contribution which has helped to form a basic part of the development of rehabilitation standards generally.

In 1958, the Association of Rehabilitation Centers (ARC) also began a project to develop standards which was completed in 1965. These standards divided the various areas into legal, organizational, patient care, personnel, plant and fiscal management. The types of services to be rendered were medical, psychological and/or social, vocational and/or educational, or a combination of these services. Three levels of evaluation used to rate the various areas were: 1) exceptional, 2) acceptable, and 3) unacceptable.

The standards indicate what the facility should be doing; the manual explains why, and to some extent how, it should be doing certain things; the survey form helps the facility determine what it is doing.11

In 1961, both Goodwill Industries and the American Foundation for the Blind brought out accreditation standards. The standards for Goodwill Industries were revised in 1966 and administered by their own accreditation branch. The report of the American Foundation for the Blind led to the formation of the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped in 1966.12 This council completed the three years' work on their own standards in 1966.

By 1963, the standards material in the ARC Standards included a preliminary set of standards, a questionnaire, a professional subcommittee report, and a large collection of related data. A sample of six rehabilitation facilities was
selected for evaluation and the following were the objectives of the research:

1. Obtain experience in field testing.
2. Informally test applicability of standards.
3. Judge relevance of standards to diversity of facilities.
4. Test standards questionnaire as survey form.
5. Explore methods for evaluating program operation and management.
6. Evaluate standard's educational potential.
7. Judge attitudes of facility personnel toward application of standards.
8. Acquaint facility personnel with standards project.\(^1\)

The results of this study led to a revision of existing standards and the questionnaire.

Between January and June of 1964, eleven rehabilitation facilities were selected for evaluation during a two-to-four day period. The evaluation was essentially the standard accreditation procedure of comparing presurvey responses to observations of the program during the field testing phase.

This process served as a means of evaluating the usefulness of the standards by considering their effects upon the facility program and the attitudes of the staff through interviews with administrators and department heads, observation of the facility program, auditing of the staff conferences, review of the ratings of the standards and the running accounts, and review of records and reports.\(^1\)
The findings of the research project revealed that there was close correspondence between the actual performance of the facilities examined and the requirements of the standards, which suggests a desirable level of rehabilitation operation. The similarity between the findings of the presurvey form and the field visit can be considered to indicate a reasonable degree of validity for the presurvey as an objective recording device.

Similar related findings throughout the sample tested demonstrated the reliability of the presurvey form as a measure of the facility's operation. The procedure of altering below standard aspects of the program to approximate more closely the standards demonstrates the usefulness of the standards in upgrading the program.15

This level of high consistency between the various measures suggests that there is much greater and more efficiently used feedback during the accreditation process than under normal facility operation. One of the major benefits of the process is essentially to reestablish the routine of operation from a passive, task-oriented operation to a more active, striving, holistic involvement for the staff. There also is a much closer correlation between agency goals and agency operations which suggests that the goals are reevaluated during this procedure, altered by greater realism, and means are more clearly related to these new goals. During this process, the goals cease to be high sounding abstractions.

Because of the myriad differences between the many
types of rehabilitation programs, the standards are used primarily as "a measure of effort in direct relation to the specific goals which the facility sets for itself." This kind of individualization is necessary because of the significant differences between the kinds of patients involved in rehabilitation and the types of services offered. "The critical factor which must be recognized in the use of standards by individual facilities is consistency between the goals of the facility and the program established to meet those goals." Consistency is a key concept in the development of standards and is related to the concept of reliability. Consistency is concerned with the correspondence between the goals of programs and their actual performance. Reliability in accreditation is demonstrated through time as different facilities undergo similar changes during the accreditation process and emerge from this process with similar results.

In the 1960's, the most expansive and sophisticated developments to date took place in accreditation. The Commission on Accreditation of Rehabilitation Facilities (CARF) was incorporated in September of 1966. NASWHP and ARC joined together to form the joint CARF organization. On January 1, 1967, CARF officially began operations. On February 1, 1968, an accreditation program was formally launched.

This elaborate program breaks the various facilities down into four different types of programs: 1) physical restoration, 2) social adjustment, 3) vocational adjustment, and 4) sheltered remunerative employment. These four emphases
are supplemented by other disciplines which offer ancillary services (e.g., physical restoration services are supplemented by social adjustment and employment services as part of the total patient program).\textsuperscript{18}

The rehabilitation process in all four types of facilities follows a similar pattern involving evaluation or assessment, treatment or training, placement or referral, follow-up for continuation of services as required, follow-up to assess efficacy of program based on results of outcomes obtained.\textsuperscript{19}

Effectively facilitating the accreditation process is the job of the accreditation commission. With a set of standards as guidelines, workers can determine if their services approach the level of services recommended by the accreditation commission. This basis of comparison is an important benefit and is necessary for any kind of upgrading of services.

The specific areas that are examined by CARF are: purposes, organization and administration, services, personnel, records and reports, fiscal management, physical facilities, community involvement and relations. These categories are carefully specified in terms of procedures to follow generally and the general requirements necessary for each area. Though originally developed through professional consensus, these standards have been tested and revised for closer correspondence with the needs of the facilities.

Any analysis of this process must include certain specific definitions of key concepts. Both ARC and CARF have agreed on the definition of a rehabilitation facility:
A rehabilitation facility is an organizational and physical entity in which a soundly and ethically based program of integrated and co-ordinated services is provided. The services are directed toward the physical, mental, social, and vocational restoration and adjustment of handicapped, disabled children and adults. The services consist of evaluation, treatment, education, training and placement, and are provided by competent personnel especially qualified in the various phases of the rehabilitation process.20

This emphasis on integration and co-ordination is implicit in CARF's approach for evaluating these facilities. Although a facility may specialize in one particular area, there are still expectations on CARF's part to find integrated services as part of the facility's program.

The clients or patients who are served by these agencies have permanent residual disabilities as a rule, and require many types of services besides medical treatment. The rehabilitation process is holistic and offers co-ordinated and integrated multi-professional services which are both curative and educational, involving restoration of client functioning and adjustment to disability. The rehabilitation process is directed by the needs of its clients.21

The accreditation procedures are well organized and systematic. The first step in this process is to initiate contact between CARF and the particular facility requesting accreditation. CARF sends out its criteria for accreditation and the facility is granted a period of time to correct any existing deficiencies in its program.

These criteria of eligibility state that a facility's major purpose must be rehabilitation of one of the four types
mentioned earlier, must operate without "limitation by reason of race, color or national origin," must operate "under a legally constituted governing body," must have operated for one year, must have appropriate ancillary services available, must have an annual professional review of employable clients in a sheltered workshop, must have certain requirements depending on the type of facility regarding full-time professional staff, must have "administration vested in a chief executive," and plant and equipment must be used exclusively by rehabilitation facility's program and under their control.\(^{22}\)

The requirement that a facility be a nonprofit organization was recently amended (effective March 7, 1969) to include facilities that meet all of the other CARF requirements even though they are proprietary facilities.\(^{23}\)

When the facility staff are ready for the next step, they apply to CARF for the presurvey and field testing part of the process. This second step is perhaps the most important because the decision on whether to accredit or not is based largely on the findings of this evaluation.

A presurvey is sent to the executive director which indicates the kinds of evaluations that will be made (e.g., documents, program, staff, equipment, etc.). After the executive director and his staff have completed the presurvey, the CARF field testing team consisting of "a full-time field representative, experienced in rehabilitation facility administration, and highly trained in survey techniques and procedures," and a survey consultant who has experience in the particular specialty
of the facility as well as experience in program administration visit the facility. (Survey consultants are trained at a CARF training institute for this purpose.) This field testing period ranges from two to four days.

Initially, an orientation meeting is held with senior management, program staff, and interested board members to establish good relationships. Following this orientation, each team member will survey sections individually and both may survey the same section at different times. These latter evaluations serve as a cross-check on the objectivity of the entire survey. A closing session is held with the key staff to discuss the survey team's general evaluation of the facility's program.

After the field research is completed, a report is prepared by the research committee with its recommendations. This report indicates any deficiencies which correspond to the CARF standards by number and includes corresponding recommendations to correct these deficiencies.

Before the report leaves the CARF office, it undergoes a thorough office review during which time other CARF field staff check the evaluation of the field research team for any errors.

When the report has been passed at the office review, it is reviewed by the CARF board of nine trustees by mail ballot and must be passed unanimously by the members or it will be held over until the first regular CARF board meeting where a majority vote will decide on a course of action.
The trustees inform the executive director of the facility, the facility's board president, and the head of the professional services on the findings of the CARF report. Copies of the survey report are sent to all three at the same time to assure that discussion of the report and its recommendations will take place.

There are essentially three possible outcomes to this process. The first possibility is full accreditation for a period of three years with a subsequent review every three years. The next outcome is provisional accreditation for a period of one year. This status implies that the facility in question will be reviewed in one year and that any reported deficiencies must be corrected before that time.

From the results gathered so far, all of the facilities in this status have subsequently been granted full accreditation. Judging from these initial results of provisional status, it would appear that one year provisional status for facilities is a motivating factor which encourages facilities to improve their programs in order to become fully accredited.25

The third possibility is nonaccreditation because the facility is unable to meet minimum standards to gain even provisional status. There has been a new appeal procedure for any facility that questions the outcome of their facility's evaluation. The facility must contact CARF and request a board hearing during which time they present their grievances. Their grievances are heard by a committee from the board of trustees. If the appeal is won, the facility will be granted a new
The CARF accreditation procedure is similar to procedures used in accrediting hospitals and paramedical facilities. The important point to remember regarding the accreditation process is that it is educational, continuous, and voluntary. It involves a systematic and periodic review and requires continuous motivation towards higher quality service for continued accreditation. Facilities which have failed to be reaccredited have waited until the last few months before their three year review to begin to correct deficiencies, rather than continually improving the program during the three year period.

Accreditation involves a constant process of re-examination and revision, of stepping back as an artist would and evaluating the total effect of the canvas. From this experience, professionals learn to evaluate their efforts and even learn how to learn more effectively. Inquiry is the basis of accreditation. Accreditation, like education, must be an ongoing, continuous inquiry to be relevant and effective.
Notes

Section Two - Part One


2 Loc. cit.


9 Porterfield, loc. cit.


14 Ibid.

15 Ibid.

16 Ibid.


18 Ibid.

19 Porterfield, *loc. cit.*

20 Standards and Accreditation Program for Rehabilitation Facilities, CARF brochure, (Chicago: CARF, 1967)


22 CARF Brochure, *op. cit.*


27 Desjardins, *op. cit.*
II - Critique of Present Accreditation Procedures

As an overall technique for improving and maintaining the quality of services of rehabilitation facilities, accreditation is still in its formative stages and CARF continues to seek answers and evaluations of CARF services.

The same approach to the evaluation of rehabilitation facilities has been employed to evaluate CARF procedures. This evaluation involves clarifying goals, developing measurement tools to evaluate results, recording experimental or environmental changes that have occurred and evaluating these changes.

One actual evaluation of CARF involved a survey of fourteen participating facilities. These facilities were surveyed for their assessments and recommendations regarding the quality of accreditation services. This survey occurred after the first three months of operation of the field program and is an example of the kind of evaluation that has continued to be initiated by CARF. The findings of this survey are listed below. (Percentages are used, since not all questions were answered by every facility.)
| Adequacy of understanding of accreditation process prior to site visit |  
| Adequate or good | 54%  
| Not fully clear | 46%  
| Capabilities of Survey-Consultation Team |  
| Adequate or good | 86%  
| Ambivalent | 7%  
| Some Criticism | 7%  
| Validity of Survey Instrument and Techniques |  
| Average or high | 30%  
| Poor | 20%  
| Cost of Survey Versus Benefits Received* |  
| Positive | 63%  
| Negative | 37%  
| Exit Interview at Conclusion of Site Visit |  
| Positive | 85%  
| Negative | 15%  
| Value of Written Survey-Consultation Report |  
| Positive | 100%  
| Negative | -  
| Did Survey-Consultation Process Help Facility Identify or Clarify Problems? |  
| Positive | 100%  
| Negative | -  

*Negative comments were related more to availability of funds for this purpose, rather than to essential value to facility. Both positive and negative aspects of the evaluations are being used to develop plans and procedures for improving the information program, refining evaluation materials and modifying survey techniques.2

To insure continued flexibility and easier updating, the National Policy and Performance Council (NPPC) involved with CARF's efforts, has carefully planned for the new accreditation process. The council decided initially that the standards
should be broad in scope and deal with the entire agency or facility structure, not just the rehabilitation program or professional performance. Other existing standards were studied and incorporated into the updated and upgraded new standards.

There seemed to be common agreement in the areas of organization and administration, records and reports, and community relations. Only in staff requirements and services were there disagreements. These areas have since been revised and strengthened by the council. The CARF Manual makes a point of discussing the differences that exist in the kinds of services offered by facilities and also among the kinds of patients admitted for services.

Because great differences do exist in these areas, CARF has suggested that standards be "designed to be used as measures of effort in direct relation to the specific goals which the facility sets for itself." This approach allows much greater flexibility and doesn't demand that a facility conform to some preordained concept of what a rehabilitation facility must be; a concept which may be totally alien to this particular facility.

Within very broad limits, there is much room for individual facility differences and facilities continue to be evaluated on an individual basis. "The critical factor which must be recognized in the use of the standards by individual facilities is consistency between the goals of the facility and the program established to meet those goals."
This point about consistency between goals and program is also stressed by Massie when he points out that "Emphasis should be placed on standards as goals to be achieved." The various facilities are competing against themselves essentially and attempting to better their own performance rather than competing against some ideal rehabilitation facility.

From the facilities' responses to the CARF survey, there appears to be a number of clearly defined benefits that accrue from the accreditation process.

Perhaps the most significant gain, however, is in the commitment that a facility makes to undertake a "systematic process of self-assessment which takes place, enhanced by the objective, independent observation and measurement of its operations by a skilled survey-consultation team." This attitude of self-improvement is crucial in motivating the facility's staff to implement the recommended procedures and correct existing deficiencies. Without this kind of motivated correction of deficiencies, the most expert evaluation in the world is of little use.

While accreditation certainly appears to offer a most promising avenue for upgrading rehabilitation workshop services, there are still many problems in the accreditation process:

1. Cost is sometimes a problem.

2. Further refining of standards is necessary as well as incorporation of new standards. Much work is needed on definition and measurement of quality.

3. Duplication is problematical.

4. Lack of outcome criteria.
The areas of outcome criteria and definition and measurement of quality have become the most illusive and most critical shortcomings of standards research, because the entire question and proof of validity rests, to a great extent, on development of these areas. There are obvious improvements in facilities after accreditation that can be pointed to as improvements, but assessing what is meant by quality of service and actually developing valid and reliable measures of this variable are most difficult and challenging tasks in rehabilitation.

Development of outcome criteria is a related problem which is dependent on the development of definitions of quality services and development of valid measuring tools. Until these areas are developed, it doesn't appear that any sophisticated outcome criteria can be developed.

Other criticisms from the province of sociology raise some very interesting queries regarding relationships in the rehabilitation process:

1. Problems of power relationships among professionals.

2. No reference to the fact that agency atmosphere or milieu therapy is important and that structurally similar agencies may have quite different milieux and outcomes of treatment of patients.

3. No reference to even the existence of informal systems within organizations and to the fact that, if a formal system is not working very well, an informal system usually develops to bypass the blockage.

4. Essentially idealized standards regarding client records, available professionals, facility location and parking.
5. Reviewer would like to see a standard codifying method of implementing organizational change throughout the standards.

6. The manual still falls short of requiring such things as random sampling of case records, random interviewing of clients and staff, and random checking of shop machinery to see that it is in working order.9

Robert Overs regards the CARF standards as a valuable contribution to rehabilitation and a significant piece of research. His criticisms deal mainly with the need for effective qualitative evaluation on a more extensive and sophisticated level.

The elementary nature of our present evaluation tools in rehabilitation are accentuated further by the lack of resources available for field testing procedures in actual industrial settings. Employment itself has become the only measure of a program's success because of the difficulty of following up the client on an actual job with any kind of controlled measurement.10

CARF is not unaware of these problems and recent CARF Bulletins have highlighted many criticisms of the present approach:

What is needed is the designing of a workable plan embodying the formulation of individual client outcome objectives, the establishment of realistic criteria of the extent to which some objectives are achieved and systematic long-term follow-up with periodic reassessment of the client's status. Whole self-monitoring programs should be planned and carried out by professional and technical staff. It is the governing body which is ultimately responsible for the nature of the outcome of a facility's programs....Fundamental to any rehabilitation effort is the need for objective evaluation of the outcome of client services.11
At the present time, the standards are built on the assumptions of the professional rehabilitation workers that certain standards in rehabilitation will produce favourable conditions. There is very little experimental evidence to support these assumptions and because of the nature of the variables involved (i.e. people, sampling problems, lack of standardized rehabilitation performance, lack of appropriate measuring devices, etc.), it is very difficult to develop any experimental findings.

In the future, it will become even more important to relate accreditation and research findings. Research needs to be conducted on the process itself and within the settings being accredited to begin to measure the results of accreditation objectively and make more objectively based predictions.

Some important criticism has resulted from an evaluation of the evaluation tools used by CARF. This evaluation suggests that agency objectives are often too global and unclearly defined, client diagnoses may be unrelated to the objectives and services offered by the agency, and staff members tend to be defined by discipline, not services offered. The solution to some of these problems may be connected to the use of the presurvey questionnaire:

In summary, any evaluation survey questionnaire to be effective, must clearly define what an agency is trying to achieve (objectives), what kinds of clients it serves, and, finally, what services are available within the facility. A clear understanding of these three elements and how they relate to one another is a basic prerequisite in a competent evaluation system. The solution to this problem lies in the development of instruments which can provide the surveyor with the critical sets of information.
Careful specification is certainly a welcome step in a field where sloppy definitions and methodology have been the rule. Defining objectives and double-checking to ascertain if they "accurately reflect and measure observable variations in program emphases," is the beginning of developing a sophisticated approach to rehabilitation evaluation.

These developments must reflect the internal consistency that promises reliability between the different evaluations. Any kind of replication of rehabilitation experiments will require this condition as a basic necessity.

To develop greater internal consistency, Walker suggests developing a basic taxonomy of rehabilitation from which to construct "a series of operational evaluation instruments."13

Self-monitoring on the part of the facilities appears to be somewhat neglected judging from the results of one survey.14 This fact raises some difficult problems because so much of the success of the voluntary accreditation process is dependent upon the co-operation and commitment of everyone involved to evaluate honestly and correct any existing difficulties. Until the attitude of correction is continuous and routine on the part of facility staff members, this problem will most likely continue to exist. Continued education as to the benefits of self-correction may help to eventually resolve much of the problem.

Flexibility is also a crucial variable to maintain if the accreditation process is to retain its dynamic flavour:
1. The survey teams should avoid rigid use of ratios, for example, of clients to staff, since these do not reflect the quality of the staff.

2. A case-study approach by the survey team would give a flavor of the facility's handling of clients.

3. There should be flexibility in interpreting standards, particularly for personnel. Facilities cannot draw on resources of trained people because of the current shortage of training programs, so a "grandfather clause" should be built into standards for facility staff.15

These suggestions were responses from a questionnaire sent to various facilities that had undergone accreditation.

As with any organization, the longer CARF operates, the greater will be the danger of increasing rigidity in its practices. From the present orientation of CARF, it appears that CARF is still quite flexible and continually able to update its own program as well as deal positively with criticisms.

An evaluation of accreditation, at this time, demonstrates that the program has been dynamic in its enlistment of facility support. There were eighty facilities that had been surveyed by December 31, 1969 (see Appendix A). The commission expects to have surveyed five hundred facilities by the end of its third year of operation and a minimum of one thousand facilities within five years.16

There are still many demands that need to be met and many new changes that will occur within the next five years. Dr. William Spencer suggested in a recent address that some of the challenges of the future will involve maintaining flexibility in the concept of voluntary accreditation with each facility continuing to be evaluated within its own framework and development.
of the kinds of outcome criteria and techniques for measuring this outcome criteria which are individualized to each client's growth.\textsuperscript{17}

Because of the great gaps in our present knowledge and the need to know many more things about rehabilitation that are at present unknown, we have special interest in increased research into rehabilitation. Dr. Hyman Pomp, Research Consultant for ARC, has thoughtfully analyzed many of the future research needs in rehabilitation:

1. Studies in organization effectiveness, including quality control and evaluation studies.

2. Studies of operational procedures, such as organizational structure, physical plant and personnel management, the impact of specialization, professional role identity, conflict between professional and administrative roles and responsibilities.

3. Communications, study of decision-making process, teams, small group behavior.

4. Methods of client management, unique administrative problems of multi-professional settings, treatment and training techniques.\textsuperscript{18}

The needs of tomorrow's world will make much greater demands on human resources and require a more prudent use of man's energy in problem areas. Men have begun to realize that the problems which confront mankind are bigger than one individual or one discipline and demand much greater co-operation and co-ordination of efforts and upgrading the quality of life.

An example of this kind of co-operation is the planned merger of the Joint Commission on Accreditation of Hospitals and CARF in the near future. This merger would be a positive combining of "the long experience of the one and the special
expertise of the other."¹⁹

Improved accreditation procedures will improve the general level of rehabilitation services and probably generate more funds for increased rehabilitation research. The chief benefit of accreditation will continue to be taking a "hard look at ourselves and our operation."²⁰

While the accreditation process is a comprehensive method of improving performance in the helping professions, an even more comprehensive approach would involve a continuous interaction between accreditation methods and social research in the actual accreditation setting. By incorporating a research program into the accreditation process, better measurement of goals and outcome will result.
Notes

Section Two - Part Two


5 Loc. cit.

6 Massie, loc. cit.


16 Charles E. Caniff, paper on Standards and Accreditation Program of CARF, (March 5, 1968).


18 Ibid., pp. 5-6.


20 Greenstein, op. cit.
I - Social Innovative Research Method

One of the most promising social research approaches, the social innovative method, has combined traditional methodology with some new procedures. Application of research within social subsystems is the unique part of the social innovative research method.

Traditionally, a control and an experimental group were selected, the experimental group was given a treatment and the control group was not. The results were analyzed to determine the effects of the treatment. With the addition of social subsystems, much greater definition, description and measurement of the participants, the subsystem social situation, and the consensual outcome criterion occurs.

Exacting experimental procedures provide for replication of these experiments. This process involves matching two groups of fifty cases each (a minimum of fifty) on important variables. The subsystems need to be as comparable as possible on the controlled variables. This close conformity and control provide conditions under which effects of experimental variables can be ascertained within the natural field conditions.
With community co-operation and involvement, researchers who know their research area well are needed because many service people follow accepted professional practices whereas social researchers evaluate these practices and develop more effective procedures.

Unless mutual understanding and support are developed, role conflicts may develop between practitioner and researcher. Gaining the co-operation and interest of the practitioners is of crucial importance in social research.

Often, service personnel do not have research training or research orientation and are not likely to become involved in research. A full time researcher is needed by the agencies to conduct effective social research.2

Conflict can result over selecting clients for the different groups because service people may feel the clients are being denied service. Benefit to the client from these practices is assumed as fact! Were this the case, this thesis would not be necessary.

Social researchers believe that until results through experimentation reveal beneficial or deleterious effects of a treatment, nothing is known about its effects. The only way to discover these effects is through research and a practitioner is liable to commit more errors in prescribing a treatment than the researcher because the researcher controls his treatment more rigorously.

Research aims to improve service programs with new and better treatment methods. Ultimately, the researcher works
to help the service person provide better and more reliable service to his clients.\textsuperscript{3}

In social innovative research, validity is a measure of the "magnitude correlation with the social change outcome criterion."\textsuperscript{4} This definition establishes validity as a correspondence between results and objectives.

Reliability is more of a consensus among the judges, much like the standards procedure. While expert bias may produce problems, consensual agreement still is reliable in many cases. These new definitions demand that new measures be developed within the experimental context.\textsuperscript{5}

Validity of the experimental method is dependent upon correct sampling. The importance of sampling is its representativeness of the population studied. Samples must be representative of the entire population. Since randomness is seldom obtainable, careful selection focused on population representativeness is all the experimenter can do to control his work.\textsuperscript{6}

The value of the social innovative method is in establishing a "social change outcome criterion which is typically a real-life behavior directly related to the solution of the problem being studied."\textsuperscript{7} This approach should be of significant value to rehabilitation research.

In spite of possible errors and lack of more rigorous experimental procedures, this method is applicable to field research and will develop more rigorous procedures with experience.
One research evaluator feels that rather than look for totally uncontaminated judgment data, researchers should try to improve the quality of the judgment data and the methods of measurement and analysis to be used.\(^8\)

Only by researching in the actual turbulence of social processes and improving the methods for understanding and interacting with these natural processes can progress in field experimentation continue to advance.

A related field experiment compared rehabilitation clients with "normal workers" and found a valid basis for evaluating the disabled against realistic competitive market standards.\(^9\) As our experience in field research increases, real-life practice will provide clues to new treatment methods.

A curious mind in the field of rehabilitation with an eye towards developments in other fields will help broaden the rehabilitation perspective and allow for continued progress. This attitude is supported by general systems theory research which discovers that similar systems operate in interconnected, interrelated processes.\(^10\)

Learning from other disciplines helps break down intellectual ruts by looking at different subjects from a different vantage point. Tools such as multivariate statistical methods and more sophisticated experimental designs will provide better opportunity to advance in relevant "directions involving development of significant predictive criteria."\(^11\)
Notes

Section Three - Part One


2 Ibid., pp. 92-107.

3 Ibid., p. 31.

4 Ibid., p. 32.

5 Ibid., p. 123.

6 Ibid., p. 121.

7 Ibid., p. 129.


10 Nease, loc. cit.

11 Spergel, loc. cit.
II - Significant Rehabilitation Research Findings and Their Implications

The examination of the role played by the helping professions in today's society has become increasingly important. As more funds are allocated to these professions, many officials and professionals are wondering if the funds are used as advantageously as possible and in the most necessary areas.

The entire question of training or retraining the handicapped for employment roles in a society with increasing automation and technology has raised some grave doubts about the relevancy of much vocational training. An examination of the role of work and its value to the individual may serve to ease some of these doubts.

Work not only provides money for economic advantages, but also provides a social identity or belonging, or social role. In a culture like ours, the worker role is a significant part of most peoples' identities. Often, an unemployed person feels guilt and anxiety without a worker role. His own personal esteem may be reflected in his worker role and without this role, he feels useless and without purpose.
Not only do people need work, but some industries continue to need people. Although there are decreasing employment opportunities in the manufacturing trades, some industries have expanded. There is a need, for example, for workers such as busboy, service station attendant, counter waiter and waitress, and car washer, in the service trades. Because of these increasing demands by industry (not to mention the increasing need for service personnel by all levels of government) continued training will play a more important role in the future. An individual will train for a job, work at the job until it is automated or no longer in demand, then return to training to be retrained for another job.

These serial jobs or careers will become more of a general pattern for many of tomorrow's workers. Planning for this change must take place during the rehabilitation process. Evaluation and training facilities need to be developed for relevant, continuous training and retraining. Work adjustment training for greater versatility will assist clients to retrain more easily for new jobs.³

The need for people to define themselves in terms of a set role or set roles is common to everyone. Homebound programs can provide various kinds of services which help a person see himself as more productive and self-reliant. While medically oriented programs don't have these services, socially and vocationally oriented and comprehensive programs develop work activities for the homebound (e.g. woodworking, leather-crafts, sewing).⁴
Workshops are primarily concerned with service, not business. Many of these programs are not remunerative while other workshops pay salaries to their employees and simulate conditions of competitive employment.

Unfortunately, financial difficulties can detract from and prove detrimental to workshop service. Due to inadequate finances, nonlucrative work contracts, and unbusinesslike methods as well as other handicaps not normally found in private business, the bulk of these workshops struggle to survive.\(^5\)

Having worked as a rehabilitation counsellor in a workshop setting for two years, this writer can substantiate these findings from his own experience.

These alarming conditions (typical for British Columbian workshops) indicate how much further development is needed to provide the quality of evaluation, treatment, and training services to meet the challenges of tomorrow's clients.\(^6\)

In British Columbia, there is only one accredited rehabilitation facility which is also one of the only accredited facilities in Canada.

For these reasons, it is recommended that the federal and provincial governments should publicly endorse the accreditation movement and support accredited over nonaccredited facilities for purchasing services.

Most likely, the terminal workshop will be replaced by activity workshops and noncompetitive work programs. The transitional workshop in the future will combine educational and work experience programs as part of the rehabilitation
process. Evaluation will take place as a continuing process in all three types of programs. The transitional workshop will serve as a bridge to training or work programs which will increase the skills and capacities of the clients.  

Community support of workshops and training centres for both handicapped and nonhandicapped indicates that evaluation and training programs in workshops probably will continue to develop as long as they are needed by society.

Aside from helping the worker, rehabilitation services can help the severely handicapped person who may not become self-supporting, but can learn to care for himself.  

By releasing medical personnel to care for those in greater need, as well as reducing the burden of costly hospital or institutional care for those who can remain at home, rehabilitation provides a worthwhile social service.

Helping men become independent and productive or, at least, able to take care of themselves continues to be an important purpose for which the helping professions are responsible. There will be new demands and new needs in tomorrow's world, but the rehabilitation process will continue to provide a useful vehicle for dealing with human problems. For many, "Rehabilitation breathes meaning into the right to live."  

Some significant research on the counseling process demonstrates that lack of empathy, warmth, and genuineness prevents positive movement while presence of these conditions facilitates growth. Empathy may be greater or more easily
developed between similar personalities. According to one study, resemblance between clients and counsellors on personality variables produced better performance by clients on client learning in counseling.\textsuperscript{12} Training programs should consider ability or potential to develop empathy in their selection of counsellor trainees.

Training seems to be positively related to performance of counsellors. Trained counsellors demonstrated greater sensitivity to their inability to establish or develop counseling relationships, failure to recognize the client's readiness for counseling services, ineffective interpretation of professional evaluation to the client, and working together with the client as an effective means of counseling.

Untrained counsellors believed that advising or directing the client with little client participation was responsible for effective counseling.\textsuperscript{13} This writer's personal observations of counsellor behavior in the field concurs with these findings.

An earlier study regarding warmth, empathy, and genuineness, is applicable, for a counsellor affecting these conditions tends to work with his client; not manipulate him towards the counsellor's own goals.\textsuperscript{14} More studies examining counsellor and administrator role behavior may indicate directions for improving counseling relationships.

Current methods of training people for research and practice in the helping professions may have long term effects on their continuous learning. Continuous training is important
for professionals to keep up with their fields. Leaves of absence, conferences, refresher courses, and in-service training improve current professional practice.\textsuperscript{15}

Continuous training, however, will not correct mistakes made in earlier professional training in many instances. Transmitting positive values to future professionals is one function of any training program.

Utilizing the latest techniques such as movies, videotapes, and group counseling techniques in training prepares the professional to perform his duties using these techniques.

In field settings, these techniques are used to help children with academic learning problems.\textsuperscript{16} Professionals who will be working with these children and other related groups should know how to use these tools. For research training, this learning process includes current theoretical, methodological, and technical research developments.

Effective research training should involve graduate students in a research project as participants.\textsuperscript{17} This experience will help them appreciate the value of research, the researcher's viewpoint and procedures, the research process, and allow them to experience research work in an actual work setting.

An ideal research training centre would have enough of a variety of research projects at one time to allow the student a wide range of choice. He would work with other students and faculty as a team member and receive actual on-
the-job training in "formulating hypotheses, obtaining administrative commitments, organizing the research team, analyzing the data, computer programming, and publication."\textsuperscript{18}

Working on the project from beginning to end, the student would see the entire research process unfold. Course work would be oriented to his unique research needs.

A similar program for practitioners would provide a field setting with field supervisors where a rehabilitation student would work with a client from initial intake through the evaluation phase, during the adjustment and training phases, to the placement phase and follow-up phase. He would see the entire process in action and begin to understand how these various steps relate to each other and the final outcome. He would also understand the value of teamwork. An appropriate setting and order would be provided for social work and mental health students.

Courses would offer specific assistance at the various points in terms of the student's needs and the instructor would act as resource and guide to the student as the student would to the client. The learning process would be greatly facilitated by this arrangement; the student would need to know because of his team responsibilities and would be motivated to find out answers to questions and solutions to problems!

While reviewing workshop standards, the members of the National Policy and Performance Council in the U.S. had difficulty reaching agreement about professional services to be offered.\textsuperscript{19} Practitioner's functions such as intake, counseling,
and placement are normal counseling functions. Research involvement helps the counsellor understand the purpose and value of research, the research process, and helps him develop a more critical ability in appraising the total agency practice. These skills are needed by most agencies.

Beyond developing these skills and their accompanying resources (including videotape, film, group techniques, and reference material), other agency needs can best be met by professional upgrading or development of needed skills in the agency setting.

Versatility is an important quality to develop; not the versatility of the dilettante, but versatility evolving from broad experience and ability to relate and apply learning to practice. With additional agency support such as case aides, the counsellor would be relieved of many time consuming clerical duties and would be able to devote more time to using his knowledge and training appropriately in the service of his clients.20

Both education and the helping professions work within processes having various stages through which a person moves. Knowing when to help a person to prepare for each new stage is important.21 This sense of timing has been referred to as recognizing "the propitious moment" and "job readiness".22

If a client is moved too quickly from one phase to another, he may fail and not be rehabilitated. If he is able to complete a phase and isn't moved on, he may stagnate. Great sensitivity on the part of professionals is needed to minimize
these effects through better performance of this function.

The following recommendation incorporates many needed features for training helping professionals: A training and research centre should be established in Canada for the helping professions utilizing modern technology, simulated learning experiences and research. On-the-job training could be a major focus in both clinical and research work. Selection criteria should consider the ability or potential of each applicant to develop empathy with others as an important training prerequisite.

The student should be involved in clinical training in a field setting and research training as a team member of an actual research project. He should participate in both endeavours from start to finish and work in every team capacity.

Course work should be carefully integrated into these work experiences and much of the student's interaction with advisors would be on a NEED TO KNOW basis. The advisors should act as guides and resource specialists.

There should be supervision during the clinical and research training from supervisors working as team members. Simulation of actual conditions in research and clinical work would be one of the objectives of this kind of program. This training approach may have important implications for teachers.

The program graduate would be generally familiar with counseling procedures and social research procedures. He would also have learned the operation of any necessary technical equipment such as videotape, computers, etc.
Versatility would be encouraged and with this general training, a base for advanced specialist training or agency specialization would be established. This program avoids the narrow specialist training and provides the student with the tools of intelligent inquiry necessary to do effective counseling, research, and teaching.

Each student would become something of a specialist on his own particular research project because he would be expected as a team member to become very knowledgeable and understand at an experience level, the problem he is researching.

In rehabilitation, much follow-up information is gathered hastily, in a naive manner, often to satisfy funding agencies who want quantitative results to justify their program to donators.

Progress in rehabilitation is advanced by selecting the best outcome possibilities, not the most expedient! Unless research proceeds along the path of genuine inquiry, services will continue to be measured by a head count as the dead are in Vietnam. The result is pressure to rehabilitate the most easily helped people rather than those most in need. This narrow service approach, based on expediency rather than research, helps to create and perpetuate an entire section of society occupying a marginal status. 23

The outcome of research is intimately connected to its methodology. By setting outcome objectives which can be realistically measured with reliable and valid measures, many of the current difficulties can be resolved.
Establishing a set of measurement criteria is also crucial to effective research. Unless these intimate connections between methodology, criteria, and outcome exist, fruitful research doesn't seem probable.24

These intimate associations need to be socially acceptable and meaningful to those involved in the research. This involvement is necessary to establish a social consensus regarding the criterion or criteria for the measurement of outcome.25 The days of the laboratory scientist toiling away on his own esoteric projects are waning and the time for more research involving entire subsystems of society in a co-operative effort is beginning.

Outcome determination in the counseling relationship is a particularly difficult task. Much research has been very vague regarding outcome criteria. Carl Rogers says that "the degree to which I can create relationships which facilitate the growth of others as separate persons is a measure of the growth I have achieved in myself."26

Because research judgements are made on the basis of behavior (i.e., verbal behavior or questionnaires, surveys, tests), such statements are experimentally useless. How can professionals determine, in any measureable sense, their growth in relation to the client's growth? This kind of abstraction doesn't lead to the development of valid outcome criteria.

Previously, counseling has been evaluated in terms of working relationship, talk ratio, responsibility taking,
statements of insight, and expressions of feeling. This evaluation is unsatisfactory because it doesn't establish goals or relate counseling experience to any established goals.

Because individual counseling takes place in an artificial setting, group counseling is probably a more realistic learning setting. Psychodrama, role playing, and milieu therapy may be the most realistic settings because research in the setting in which the client interacts normally might reveal more genuine patterns in his life than does the artificial setting of the counseling office. Counseling in the work or social setting with the client enables the counsellor to work more effectively with the client on his vocational and interpersonal problems.

Traditionally, guidance has used more concrete outcome criteria such as academic grades, income after a number of years, frequency of job change, stability of life goals, and the extent to which educational plans are completed. These criteria still need to be related to the client goals and are not relevant in and of themselves.

Not only is research needed on outcome criteria, but more studies are needed also on ways of measuring different research approaches to investigating outcome criteria. These developments will open up many productive avenues of research.

Successful rehabilitation outcome criteria have been defined as understanding disability and being able to plan realistically for the future. Family, personal, and community
strengths are necessary; communication and teamwork are crucial. Although these criteria do encompass important aspects of the rehabilitation process and supply important predictors of success, they don't set up any specific goals.

Rehabilitation success has also been based on a person's ability to function continually in an effective manner. Restored effectiveness or functional effectiveness needs to be carefully defined, measured and related to the goals of the process.

Some research findings which have important implications for rehabilitation practice and development of predictive outcome criteria include one study which found that success or failure in a rehabilitation program was predictable from the information obtained from the client at the time of hospital admission. These predictions could indicate the appropriate treatment for the client. Continued research in this vein will provide assistance in the selection of the client and the prediction of client success in the program.

A similar study examining the vocational success of clients discovered that the most important predictors were ego strength and ability to maintain an independent social and personal role. Ego strength seems to be related to a person's perception of his role because clients who saw themselves as meeting other's demands successfully saw themselves as effective people; unsuccessful clients saw themselves as ineffective people. Helping the client to achieve success in his rehabilitation program may be the first step in helping
him achieve success on his job.

Research on the process of vocational adjustment indicates that 68 per cent of the clients considered unemployable by referring agencies were placed in employment after leaving vocational adjustment with 35 per cent working most of the twelve month period and 16 per cent working half to three-quarters of the period.

Most predictions of the staff for future employability of the clients were upheld, i.e., clients rated as employable tended to be employed for a longer time. While age, disability, and previous employment didn't influence outcome, family attitudes toward the client did, both positively and negatively.  

Other research evaluating treatment approaches found when comparing the individual performance by two counsellors with the performance by a team of specialists, that there was no difference between the number of closures by individual counsellors versus the closures by the specialist team.  

(Closures are clients successfully employed, usually over three months.) The specialist team included two rehabilitation counsellors, a psychologist, a social worker, an intake counsellor aide, a physical restoration services counsellor aide, a training-placement counsellor aide, and four secretarial staff.

This team did obtain better results with the more severe mental cases and the marginal clients, finding on-the-job training placements, placing clients in training, getting
clients higher wages, more wage increases, greater job retention and promotions.

The cost difference for the specialist team was less than ten per cent greater than the cost of two counsellors with two secretarial staff. Similar comprehensive rehabilitation approaches have dynamic implications for improving the quality of the rehabilitation process and building a solid foundation for related research.

Motivational research suggests that motivating factors stimulate improvement in overall job performance. Another study found that staff relationships with the clients, the challenge and novelty of the tasks, the grouping of the clients for effective interpersonal interaction, and the range of tasks for growth sufficient to sustain the interest of the clients, all had motivating components to them.

A related study reveals no correlation between successful completion of the rehabilitation program and disability, age, or employment. Important factors seem to be better personality integration and consistent motivation.

These studies all add support to optimizing motivational aspects of the learning process for more effective rehabilitation.

In a recent study, controlled workshop evaluation was considered to be the most important single aspect of the overall evaluation for the rehabilitation of epileptics. This finding generalizes to almost every disability because for nearly every client, accurate simulation of a task to be learned appears to be one of the most efficient ways of learning
One of the most important studies relating to establishing valid rehabilitation outcome criteria came from the field of corrections. This study found that success was indicated when the patient in a prison hospital "doubted whether he was really cured, showed increased tolerance for frustration and stress, accepted appropriate responsibility for past misconduct, and was able to make realistic plans for the future." There is some correspondence between this definition and the previously defined criteria for successful rehabilitation.  

Failure was indicated by evidence of the patient embracing some kind of cure-all (e.g. religion, psychiatry, etc.), manifesting defense mechanisms, overemphasizing past wickedness and positiveness that he is cured, and overconforming to the rules and becoming a model patient. 

This study provides possible outcome criteria for rehabilitation periods by analyzing the outcomes of unsuccessful rehabilitation clients and determining what outstanding features these people share that are not shared by the successful clients; research may help establish valid outcome criteria. 

Doubts about being rehabilitated, increased tolerance for frustration and stress, accepting responsibility for personal actions, making realistic plans, and general absence of defense mechanisms and overconforming behavior may be good predictors of successful rehabilitation. 

As goals to work towards, many of these criteria
can be established in counseling situations involving groups, work groups, psychodrama, role playing, and other kinds of situations. Simulation of work tasks, on-the-job experience, and temporary placement are additional ways of getting an evaluation to determine current progress being made and to plan for the future.

These studies exemplify some of the current significant rehabilitation research which provides guides for improving practice, directions for future research, and establishes a basis for a theory of rehabilitation.

An overview of rehabilitation research points to a number of areas which need considerable development. One study indicates the need for retraining and sheltered workshop facilities, new job opportunities in line with the abilities of the disabled, greater interagency co-operation, and better procedures for disseminating information about services. 45

Another study states that the research and development projects (R & D Projects) have been mainly involved in evaluation of tests, facilities, prostheses and new milieus.

The greatest lag is in follow-up and evaluation of client success and adjustment on the job and in the community. Basic research is needed with testing of hypotheses to develop a body of principles or theories. 46

Establishment of a U.S. VRA Information Service communicating these findings to the various agencies is a major advance. Dr. Howard A. Rusk, one of the pioneers in the field of rehabilitation, believes this service is one of the most
important developments in the past several years and will effectively advance rehabilitation.\textsuperscript{47}

A recent Guidance, Training, and Placement Workshop (GTP), sponsored by the U.S. VRA in 1961, surveyed their committee members regarding problem areas. The members indicated the following research needs:

- Characteristics of counselor performance and the counselor's use of effective techniques in providing client services, characteristics of vocational rehabilitation clients, including motivation and vocational choice, and methods of organization for getting counselor service to clients.\textsuperscript{48}

The committee members recommended that rehabilitation research reflect and initiate changes in program emphasis by taking inventories and gathering data (a function of accreditation), engaging in continuous self-examination (a function of accreditation), and responding to the research needs of other agencies and the community (a function of social innovative research).\textsuperscript{49} This GTP committee also stressed the need for better communication of research and more effective implementing of research results.

By determining specific organizational objectives, how they will be implemented at an organizational and service level, knowledge of clients, area served, and studies needed, research can be conducted utilizing the above criteria, employing the social innovative research method.\textsuperscript{50}

Because of the appropriateness of the social innovative method to the helping professions, and rehabilitation in particular it is recommended that social innovative research be conducted in rehabilitation facilities to: 1. measure the success of
accreditation procedures, and 2. help to develop and measure valid outcome criteria.

With careful specification of objectives, careful selection of representative subsystems, and careful development and implementation of appropriate measuring tools, these experiments will represent a major breakthrough for rehabilitation research and, ultimately, for rehabilitation practice.

The 1962 GTP Workshop looked at the need for facilitating research by consumer agencies, difficulties of planning and executing research projects, evaluation of the projects, need for trained personnel and need for improved communication. Griswell has urged that research be undertaken to discover more specific and precise methods of identifying problems and imparting effective knowledge, particularly in the areas of the handicapped person's perception of himself, others, and his understanding of the work.

Systematic observation should be made of what occurs during training and of the behavior of persons working and dealing with the handicapped (i.e., more studies are needed on counsellor-client, staff-client interaction).

The creation of R & D projects by the VRA has resulted in significant accumulation of information on rehabilitation programs and ways to improve the quality and efficiency of services. This knowledge must also be communicated if rehabilitation counseling is to become more professional:

The study of the handicapping effects of various disabilities - the way they develop, what causes them and how to cope with them - is basic to advancing
the rehabilitation program. But the knowledge gained from such studies produces results only if it is appropriately used in the rehabilitation of the disabled individual. The time has arrived to apply the new knowledge that is becoming available, if the benefits of research are to reach the people who need them.52

Information from research is accumulating all over the world. With computers and modern technology available, there is no reason why current findings can not be communicated immediately to professionals, follow-up studies carried out to determine how professionals are using the information, and an evaluation system developed to ascertain how new findings are being utilized or why they are not. Unless these findings are implemented, the contribution that research makes is very limited.

Because of this need to facilitate the implementation of these research findings quickly and effectively, it is recommended that an information service be established in Canada to disseminate research findings to professionals in the helping professions and encourage implementation of these findings.

Present practice in the helping professions will only be improved through diligent, comprehensive application of relevant research findings and closer co-ordination and interaction of research and practice. But research alone is not the panacea for all human problems:

Progress does not wait upon research effort alone. Existing values, concepts, and factual information can go far in relieving suffering, in aiding social and psychological rehabilitation, if only they are applied more genuinely and generally in the ordinary
affairs of life as well as among the many special enterprises that society as a whole needs to undertake.
Notes

Section Three - Part Two


14 Carkhuff and Truax, op. cit.

15 Letta Vicelli, G.F. Strong Centre Interview, (Vancouver, 1970).


25 Fairweather, op. cit., p. 32.


31 Vicelli, loc. cit.


33 M.B. Sussman, op. cit.


43 Vicelli, loc. cit.

44 Andriola, loc. cit.


47 Loc. cit.

48 Loc. cit.

49 Loc. cit.


51 Rehabilitation Research, loc. cit.
52. Mary E. Switzer, Vocational Rehabilitation Administration Commissioner on Research and Demonstration Projects, (1965).

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Switzer, Mary. Address by Vocational Rehabilitation Administration Commissioner on Research and Demonstration Projects. 1965.


# APPENDIX A

## ANALYSIS OF CARF SURVEYS

Conducted from November 1, 1967 through December 31, 1969

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APPENDIX A

ANALYSIS OF CARF RE-SURVEYS

Conducted from November 1, 1967 through December 31, 1969

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