This is to certify that the

thesis entitled

A STUDY OF THE IMPACT OF VOCATIONAL REHABILITATION SERVICES ON WORK DISINCENTIVES: A CLIENT, COUNSELOR, ADVOCATE PERSPECTIVE

presented by

Burt J. Danovitz

has been accepted towards fulfillment of the requirements for

Ph.D. degree in Counseling and Educational Psychology

Major professor

Date 10/2/80

A STUDY OF THE IMPACT OF VOCATIONAL REHABILITATION SERVICES ON WORK DISINCENTIVES: A CLIENT, COUNSELOR, ADVOCATE PERSPECTIVE

By

Burt J. Danovitz

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Counseling and
Educational Psychology

1980

ABSTRACT

A STUDY OF THE IMPACT OF VOCATIONAL REHABILITATION SERVICES ON WORK DISINCENTIVES: A CLIENT, COUNSELOR, ADVOCATE PERSPECTIVE

By

Burt J. Danovitz

In recent years, vocational rehabilitation as administered through the state vocational rehabilitation agency has greatly expanded services. This expansion has allowed for the eligibility for vocational rehabilitation services to persons with severe disabling characteristics. Prior to this legislative change, many severely handicapped persons applied for and received Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI) and remained in a beneficiary status for life. With the increase of services, SSI/SSDI beneficiaries have a greater opportunity to become rehabilitated and participate in gainful employment, yet many still choose not to work. For them, the basis of this decision is closely tied to rules and regulations in the Social Security Act which terminate cash and in-kind benefits to recipients when they participate in employment. This phenomenon is referred to as work disincentives.

The intent of this study was to respond to the need for further investigation into the work disincentives problem. Intending to complement previous findings, which primarily focused on Social Security legislation and/or the demographic or psychological characteristics of beneficiaries, this study researched the Federal-State Vocational Rehabilitation Program's activities which affect SSI and SSDI recipients. Additionally, the intent of this study was to acknowledge and support the spirit of recent rehabilitation legislation which encourages and mandates substantial consumer involvement in all aspects of the rehabilitation program.

The primary purpose of this research was to investigate the questions:

1. To what extent do the activities of the state vocational rehabilitation program assist SSI and SSDI beneficiaries in overcoming existing work disincentives?

2. Are there certain rehabilitation activities, such as diagnostic services, vocational counseling, rehabilitation services, the agency-client relationship, and follow-up and placement services that have a greater impact on assisting beneficiaries to overcome work disincentives than other activities?

3. Is there a difference of perceptions among counselors, clients, and advocates as related to the extent that the state vocational rehabilitation agency assists beneficiaries in overcoming existing work disincentives?

4. Do vocational rehabilitation counselors, clients, and advocates, in fact, perceive certain provisions of the Social Security Act as disincentives to work?

To examine these questions, vocational rehabilitation counselors employed by the Michigan Bureau of Rehabilitation, advocates working in Michigan, and former clients of vocational rehabilitation services who were receiving SSI and/or SSDI at the time of their rehabilitation activities were selected as subjects for the research. Each subject was administered the Structured Telephone Interview Protocol (STIP), a questionnaire developed specifically for this study.

The STIP was designed to examine the major activities of the state vocational rehabilitation agency as they relate to assisting beneficiaries overcome work disincentives. To do this, the STIP consisted of six subscales, five of which related to major vocational rehabiliation activities, and one subscale comprised of questions concerned with benefits and their importance to SSI/SSDI recipients.

As a result of the analyses performed, the following was found:

1. Vocational rehabilitation counselors, clients, and advocates do differ in their perceptions of facts and activities as related to the extent that vocational rehabilitation services assist clients in overcoming work disincentives.

2. The differences in perceptions of facts and activities generally were due to counselors viewing rehabilitation services as more helpful in assisting beneficiaries to overcome work disincentives than was viewed by clients and advocates.

3. Overall, the subjects believed that rehabilitation services has a negligible effect on assisting beneficiaries to overcome disincentives to work.

4. Of all the activities commonly conducted by the state vocational rehabilitation agency, the working relationship between the agency (primarily the counselor) and the client was perceived as being more helpful than other activities in assisting beneficiaries in overcoming existing work disincentives.

5. Benefits provided by Social Security, especially the financial payments and medical insurance, are very important to beneficiaries. The importance of these benefits is so paramount that some beneficiaries do not work in order to continue receiving them. The conclusion is that disincentives to work do exist.

Dedicated to all the people whose lives are made worse by a political economy that de-emphasizes the maximization of human growth and development.

ACKNOWLEDGMENTS

The notion of interdependence is greatly experienced in a process such as writing a dissertation. The illusion of independence is quickly tossed aside and replaced with the reality of community. This was certainly the case in this experience. My community was of great help. Hoping not to sound like an Oscar recipient, I would like to recognize several people for their role in this effort.

The co-chairmen of my committee, Jim Engelkes and Don Galvin, were quite helpful. They assisted in areas ranging from conceptualization to research "nuts and bolts." My third committee person, John Aycock, provided enthusiasm and a source of reality throughout the endeavor. Bill Ewens, the fourth member of the committee, provided inspiration and the constant reminder to make global connections.

Several agency persons played a crucial role in coordinating the selection of interviewees. Without their help, this research would have been an N of one study, that one being myself. For their help, I would like to thank Duncan Wyeth from the Center for Handicapper Affairs, Pat Dufort from the Ann Arbor Center for Independent Living, and John King from the Detroit Center for Independent Living. Also, I greatly appreciate Harry Smith from the

Michigan Bureau of Rehabilitation, for all of his efforts related to this study.

The two men who "got me into this mess," Huss Malik and Greg Miller, served to convince me that life and careers are controlled by the dice. Certainly this must explain why they are both floating around somewhere in the Atlantic.

Very close to me throughout my studies were a few people who were always available. George Frassa provided assistance, comments, and a friendship that was unquestionable. My father maintained a sincere interest and understanding of the entire process. My family, Lynda, Joshua, and Malaika, were consistently supportive and loving through late night typings, trips to the computer center, and other "fun" family activities.

My greatest amount of appreciation goes to the beneficiaries who agreed to be interviewed for this study. Their honesty and openness touched me in each interview. It is my intention to continue work in this area so as to not let their time given to this study go in vain.

TABLE OF CONTENTS

LIST OF TABLES

Page

Page

Page

LIST OF FIGURES

CHAPTER I

INTRODUCTION

Introductory Statement

The Rehabilitation Act of 1973 (Public Law 93-112) comprised a total legislative revamping of the Federal-State Rehabilitation Program. The Act and accompanying 1978 amendments (Public Law 95-602, Rehabilitation, Comprehensive Services and Developmental Disabilities Legislation) mandated that individuals with "severe handicaps" be given special emphasis and priority for rehabilitation services. Despite the broadening of the scope of rehabilitation programs as exemplified by Title VII - Comprehensive Services for Independent Living, the major purpose of the act remained the "comprehensive and coordinated programs of vocational rehabilitation" (Public Law 95-602, p. 3).

A rethinking of the appropriateness and feasibility of employment for an increased number of severely handicapped persons has been stimulated by the expansion of vocational rehabilitation services. One potential group of severely disabled vocational rehabilitation clients who have received increased attention as a result of legislative prioritization in rehabilitation is Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) beneficiaries. Severely disabled candidates

for vocational rehabilitation face the prospect of losing their benefits upon successful completion of a rehabilitation program. The anticipation of being terminated from a beneficiary status is what constitutes the work disincentives problem (Berkowitz, 1979). A person receiving Social Security Disability Insurance and/or Supplemental Security Income may choose to avoid or prematurely terminate a vocational rehabilitation program in order to maintain their current level of economic or "social security."

Masters and Garfinkel (1977) stated, "almost everyone agrees that the structure of economic incentives to work is affected by a variety of policies--income taxes, social insurance, food stamps, housing subsidies, etc.--in addition to the public assistance categories that fall under the rubric of 'welfare'." Resulting from this assistance system, a myriad of ramifications arise.

Rather than losing benefits, many individuals with disabling conditions choose to remain unemployed. This results in a reduction of labor supply which increases the financial burden to the employed. With some programs, if beneficiaries do work, they may limit their earnings and pay less taxes. In order to maintain the same level of all governmental services, not to mention service expansion, nonbeneficiaries' taxes must increase. In addition to placing a greater financial strain on workers who already feel the effects of an inflationary economy, this crisis

in taxation intensifies feelings of resentment toward noncontributors.

The Federal/State Vocational Rehabilitation Program's efficacy is also affected by these benefit programs that transfer income from one segment of the population to another. Section 1615 of the Social Security Act makes provisions for vocational rehabilitation services to blind and disabled persons who receive Supplemental Security Income payments. Section 222 of the Social Security Act authorizes payments from the trust fund to cover the costs of these rehabilitation services. A Government Accounting Office (GAO) report issued on May 13, 1976, emphasized the need for improved program effectiveness. Subsequently, Health, Education, and Welfare Secretary Califano requested Rehabilitation Services Administration Commissioner Robert R. Humphreys and the Social Security Administration Bureau of Disability Insurance Director, William Rivers, to identify problems, and recommend solutions which would improve the performance of the SSDI and SSI vocational rehabilitation programs (Annual Report to the President and Congress, 1978).

Their investigation took place during the period from August to November, 1978. One of their major findings was that, "Certain provisions in Titles II and VII of the Social Security Act regarding SSDI and SSI programs, intended to be incentives for vocational rehabilitation, have become disincentives" (Annual Report, 1978, p. 40). These

provisions have resulted in a reduced cost effectiveness for the vocational rehabiliation program, a discouragement of recipients from returning to gainful employment, and a growth in the frustration of the vocational rehabilitation counselor.

There is a fundamental problem resulting from the work disincentives issue that impacts directly on the SSI/SSDI recipient. Being immersed in the bureaucracies of income transfer programs, the person with a disabling condition is forced to make decisions regarding his/her life which prohibits the maximization of potential, isolates himself/herself from the mainstream of society, and creates an environment that is alienating and humiliating (Lasch, 1979). Optimization of human development may be possible, but, as Jochheim stated (1978), it is very difficult to be rehabilitated to an economic disadvantage.

The severity of this crisis was poignantly exemplified in 1978. A young California woman with the characteristic of quadraplegia desperately wanted to live a life of independence and self-sufficiency. Confronted with rules and regulations that would reduce her benefits in excess of what she could ever hope to earn in the labor market, she became frustrated and despondent. Prior to her death, she made a tape-recorded message recounting her problems with the assistance programs and expressing her rationale for suicide. Rather than being trapped in a dependency situation, she chose to end her life (60 Minutes, CBS: 1979).

This destruction of life is an extreme example of what the work disincentives issue causes, for certainly not all beneficiaries are at this end of the continuum; nevertheless, it is a reasonable premise that, in varying degrees, the structure of certain benefit programs has a negative effect on the quality of human growth and development.

Need for the Study

The need for increased attention and research regarding the problem of work disincentives recently has been cited by several highly reputable groups. The most notable sources stating this need are the Urban Institute in the Report of the Comprehensive Service Needs Study (1975), the White House Conference on Handicapped Individuals, and the Rehabilitation, Comprehensive Services and Developmental Disabilities Legislation (1978).

The Report of the Comprehensive Service Needs Study (1975) in a discussion of benefit programs, cited the need for greater flexibility in the Social Security system for persons who have intermittent or recurring problems. The report further asserted that without basic reform in Medicaid, or the establishment of a truly comprehensive public health service, disabled people with excessively high medical expenses are penalized from becoming employed. The study summarized its discussion on this issue by calling for research that would examine strategies for lessening the disincentives effect.

The Report of The White House Conference on Handicapped Individuals (1977) also addressed the problem of work disincentives. Included in the list of recommendations were suggestions for amendments to the Social Security Income legislation for the removal of current work disincentives. The Report also advised that a task force of consumers and relevant agency representatives be created for the purpose of reviewing and recommending necessary actions to reduce and eventually eliminate disincentives to employment.

Members of the United States Congress also demonstrated their cognizance of the disincentives problem by authorizing a "Special Study Concerning Disincentives to Employment" (Section 403, the Rehabilitation Act, 1978):

> Sec. 403. In consultation with appropriate Federal departments and agencies, the Secretary shall conduct a study of possible ways to structure Federal programs providing benefits to handicapped individuals in order to eliminate any disincentives for individuals receiving benefits under such programs to obtain and continue employment.

Accompanying each of the three documents' discussion of work disincentives, and the need for further study, were a series of policy statements either emphasizing or mandating the active participation of consumers; that is, persons with disabling characteristics, in the reviewing and recommending of policies affecting handicapped persons. This was expressed in several ways. The Report of the Comprehensive Service Needs Study (1975) called for further research to determine the benefit and impact of consumer

involvement in the areas of: (1) technology, (2) rehabilitation delivery systems, and (3) policy analysis (p. 577). The report which summarized the White House Conference on Handicapped Individuals recommended that it should be "ensured that all agencies affecting handicapped individuals have at least 50% consumer and/or parent/guardian membership elected to agency advisory or governing boards" (p. 65, Volume 2, Final Report, Part A). The 1978 Rehabilitation Act, along with the proposed Regulations for implementing the Act (November 29, 1979), provided for "substantial consumer involvement in policy planning and development" in the Federal/State Rehabilitation Programs.

The intent of this study was to respond to the need for further investigation into the work disincentives problem. The plan was to enhance existing research, which will be discussed in the Review of the Literature, Chapter II. Intending to complement previous findings, which primarily focus on Social Security legislation and characteristics of beneficiaries, this study researched the Federal/State Vocational Rehabilitation Program's activities which affect Supplemental Security Income and Social Security Disability Insurance beneficiaries. In keeping with the intent and spirit of consumer involvement, this study included substantial consumer input.

The focus of this investigation was significant in view of the fact that under Social Security legislation individuals receiving either Supplemental Security Income

and/or Social Security Disability Insurance are automatically referred to the State Vocational Rehabilitation Agency. The purpose of this referral is to determine eligibility for rehabilitation services. Once eligibility is determined, the provision of rehabilitation services for the purpose of placement into gainful employment begins.

Since previous research on work disincentives has been directed towards Social Security legislation and beneficiary characteristics, resulting policy changes have taken place primarily within the Social Security Administration. For the most part, these changes have been minor adjustments to the Social Security system. An example of this would be a change in the amount of earnings allowed before benefits would be terminated. It is important, though, to realize the potential that the vocational rehabilitation program has in aiding beneficiaries in overcoming work disincentives. Through careful study of the vocational rehabilitation program, data was generated that identified activities which aid beneficiaries in overcoming work disincentives. It is anticipated that the results of this study may be useful in the analysis and promulgation of future policies geared towards combating disincentives to employment.

Purpose

The purpose of this study was to examine the activities of the vocational rehabilitation program as they relate to assisting beneficiaries in overcoming existing work

disincentives. As a result of the automatic referral process of Supplemental Security Income and Social Security Disability Insurance recipients for vocational rehabilitation services, the state rehabilitation agency is an important variable in aiding people to ultimately overcome the fear of losing benefits. This reduction or elimination of apprehension allows for the successful completion of a rehabilitation program and return to gainful employment.

This study examined the activities of the Michigan Bureau of Rehabilitation program by partitioning the flow of rehabilitation services into five distinct components. These categories were as follows:

1. Diagnostic services
2. Vocational counseling
3. Rehabilitation services provided after acceptance and prior to job placement
4. Placement and follow-up services
5. The agency-client relationship

Furthermore, a sixth category identified as "miscellaneous" was studied. This category consisted of questions related to benefits received by SSI and SSDI beneficiaries.

Five of the areas follow the flow of services commonly provided by the state rehabilitation agency. Diagnostic services and establishing a vocational goal are part of the eligibility process which takes place after referral and prior to acceptance. Upon acceptance to the rehabilitation

program, a rehabilitation plan is developed and rehabilitation services are provided to attain the goal of the plan. Examples of services provided during this phase of the program are vocational training, maintenance, education, counseling, and physical/mental restoration. When the services are completed, the job placement process is initiated. Upon satisfactory placement, follow-up and post-employment services are provided to the client to assist with any problems that may arise during the beginning phases of employment. Encompassing all rehabilitation activities is the agency-client relationship.

Subjects from three different groups were interviewed. The first group was vocational rehabilitation counselors whose primary responsibility is to provide services to Supplemental Security Income and Social Security Disability Insurance beneficiaries. The second group was SSI and/or SSDI beneficiaries who had received rehabilitation services. This group was divided into two sections according to whether the beneficiary had been either successfully rehabilitated to a wage-earning job, or closed unsuccessfully by the state vocational rehabilitation agency. The third group consisted of representatives from organizations whose primary purpose is to provide advocacy services for individuals with disabling characteristics. The use of clients and advocacy organizations, which in many cases are consumer controlled, provided an opportunity for consumer involvement in reviewing programs

which affect their lives. The interviewing of all three groups provided for a multidimensional perspective.

The subjects were administered one of three parallel interviews designed for this study. Each interview elicited comments relating to the subjects' experience with the rehabilitation program and Social Security benefits. There was a client interview, a counselor interview, and an advocate interview. These interviews were developed through a rational process reflecting the vocational rehabilitation system and the research literature. The validity and reliability of the interview, the research instrument, also was examined as part of the study.

In addition to providing information regarding the perceptions of counselors, clients, and advocacy organizations, this study generated data that may be useful in the future evaluation, planning, and development of new policies to increase the general effectiveness of the state rehabilitation agency. Also, the study has provided information that may be beneficial in the analysis of Social Security legislation and its role in creating and maintaining work disincentives.

Research Questions

The major research questions answered by this study were as follows:

1. To what extent do the activities of the State Vocational Rehabilitation Program assist Supplemental

Security Income and/or Social Security Disability Insurance beneficiaries in overcoming existing work disincentives?

2. Are there certain rehabilitation activities, such as diagnostic services, vocational counseling, and follow-up services, that have a greater impact on assisting beneficiaries to overcome work disincentives, than other activities?

3. Is there a difference of perceptions among counselors, clients, and advocates as related to the extent that the activities of the state rehabilitation agency assists beneficiaries in overcoming existing work disincentives?

4. Do vocational rehabilitation counselors, SSI/SSDI beneficiaries and advocates, in fact, perceive certain provisions of the Society Security Act as disincentives to work?

Definition of Terms

Beneficiary: An individual with a disabling characteristic(s) receiving assistance from Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI).

Cash benefits: Monthly cash payments provided to SSI and SSDI beneficiaries.

In-kind benefits: Non-financial assistance provided to beneficiaries. Medicare and Medicaid are the major

in-kind benefits, that is, a government-subsidized health insurance.

Rehabilitation client: An individual with a disabling characteristic(s) receiving services from the state vocational rehabilitation agency.

Work disincentives: Certain provisions of the Social Security Act that terminate SSI and SSDI benefits when a beneficiary participates in paid employment.

Overview

Presented in the following chapters is a detailed explanation of this study. A review of the theories, research, and existing policies pertinent to work disincentives and the rehabilitation process is incorporated in Chapter II. Contained in Chapter III is the methodology that was used for conducting this study. A discussion of the selection of research participants, research agreements, instrumentation, research questions in testable form, and the statistical models used for the data analysis are included in Chapter III. After the methodology for the study is presented, the focus of this report turns to data analysis and the interpretation of the results. This is detailed in Chapter IV. The final chapter, Chapter V, is the conclusion of the research report. This chapter contains a discussion of the research results, a macro view of work disincentives, implications of the research, recommendations for future study, and conclusions.

With the need for and purpose of this study explained in the first chapter, research relevant to this area of investigation provides the content for the next chapter.

CHAPTER II

SURVEY OF THE LITERATURE

Introductory Statement

The purpose of this study was to investigate the impact of the state vocational rehabilitation agency on assisting rehabilitation beneficiary clients in overcoming existing work disincentives. This study expands the available knowledge in the area of work disincentives. Such knowledge may be useful in the analysis and change of rehabilitation policy and practice in assisting persons with disabling conditions who receive Social Security Disability (SSDI) or Supplemental Security Income (SSI) to obtain paid employment. In accord with this purpose, literature relevant to five topics was reviewed. The topics presented include: income transfer programs, medical insurance, recent disincentives research, economic theory, and rehabilitation philosophy and practice. The survey of the literature provides the knowledge and theoretical base for this study.

Income Transfer Programs

To understand work disincentives it is necessary to understand Social Security legislation. It is within the legislation that the laws and regulations are found which

reflect compromises between ideologies that believe in providing assistance to individuals in need, and a Darwinian approach which subscribes to a "survival-of-the-fittest" position. Noble (1979) aptly pointed out:

> Rehabilitation takes place within a matrix of disability policies and is, in fact, one subset of the whole. Thus, variations in the structure of the set of disability policies can influence the outcomes of rehabilitation service technologies. Some combinations of policies and politico-economic conditions may be mutually reinforcing and prove productive; other combinations may simply cancel each other out; still others may be positively harmful to individuals and society. (p. 229)

In 1935, Social Security legislation was enacted. This law provided coverage to insured workers only upon retirement. Although meager by today's standards, it was landmark legislation establishing a national policy to provide for the elderly. In 1939, the law changed, allowing the payment of benefits to families of deceased workers. The 1939 legislation also extended coverage to certain dependents of retired workers. Disability insurance became part of Social Security legislation for the first time in 1954. This insurance was intended to protect workers against a loss of earnings due to total disability (Goldenson, 1978). The 1954 legislation laid the groundwork for disability insurance as it now exists.

The two types of public assistance that are of primary concern in this study are Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). This in no way exhausts the scope of available benefits

allowed to a vocational rehabilitation client. In fact, Walls (1977) listed 76 Federal programs in which an individual with a disability may participate, a few of which are represented by such programs as Aid to Families with Dependent Children, Food Stamps, Workers Compensation, and rent supplements.

Walls (1977) classified these programs into four categories. The first category has no income rules. That is, the person receives benefits with a disregard for their current financial status. An example of this type of assistance is found in the Veterans Administration. If while serving in the armed forces persons become disabled, they are entitled to lifetime benefits. The second category provides benefits contingent upon the amount of wages an individual earns. Social Security programs such as Old Age, Survivors, and Disability Insurance are examples of benefits limited by an individual's income. In the third category are programs which are limited not only by wages but also by public benefits. In this category Walls (1977) included Railroad Retirement, Disability and Survivors' benefits, Unemployment Insurance, and Black Lung benefits for miners, dependents and survivors. The fourth category consists of programs with limits on wages, certain public benefits, and unearned private income. This is a very broad category in which people are subjected to a general means test (Berkowitz, 1980). Examples of these programs are Food stamps, Aid to Families with Dependent Children, and Supplemental Security Income (SSI).

The SSI and SSDI programs mandate that a referral be made to the state vocational rehabilitation agency. Rehabilitation services provided by the state agency are totally financed by the Social Security Administration. The purpose of this funding is to reduce the number of individuals receiving benefits. An in-depth understanding of the SSI/SSDI programs helps to provide a clearer understanding of the disincentives problem. Two major components of each program are financial and medical benefits. Following is an explanation of these programs.

Supplemental Security Income (SSI). As its name implies, SSI is available as a supplement to income from other sources, including other Social Security benefits (A Guide to SSI, 1977). It is designed to provide a floor of income for the aged, blind, or disabled; therefore, it is based on economic need (Burton, 1979). SSI is a Federal program, and each state has the option to supplement the Federal payments. Administered through the Social Security Administration, the Federal government makes payments to eligible recipients; determines eligibility; and maintains a "master record" (A Guide to SSI, 1977). The funding for the SSI program is generated from the coffers of the United States Treasury, e.g., personal income taxes, corporation taxes, and other taxes. This differs from Social Security, which is funded by workers, employers, and the self-employed. In addition to Federal participation, each state provides Medicaid, Food Stamps, and various

social services. Also, some states provide interim assistance while eligibility is being determined at the federal level. It should be noted that SSI is the first federal-administered cash assistance program in this country available to the general public (Social Security Handbook, 1978).

There are two factors which affect eligibility for SSI benefits. The first is related to income. In order to qualify for SSI, the disabled person must have an income below $282.30 a month, and for a couple the total income must be below $413.40 a month (Social Security Amendments, 1972, Section 301, as amended Section 1612A).* In the initial financial determination, a person can retain ownership of his/her house and may own a car worth less than $1,200. They may have life insurance with a total face value less than $1,500 and savings less than $1,500 (Goldenson, 1978).

The second criterion is that a person be disabled. The definition of disability as used in determining eligibility states that, "A person 18 or older is considered 'disabled' if a physical or mental impairment prevents him or her from doing substantial, gainful work, and is expected to

---

*These figures reflect the Congressional increase which became effective on July 1, 1980. Prior to this date, the amounts were $242.29 a month for an individual and $363.44 for a couple (SSI for the aged, blind, and disabled in Michigan, 1979). It should be noted that data for this study was collected while the reduced rate was in effect.

last at least twelve months." (A Guide to SSI, 1977, p. 6) Also mandated as a criterion of eligibility is that a disabled person must accept vocational rehabilitation services if offered. If the disability is that of drug addiction or alcoholism, the individual also must accept treatment if offered.

Once the claimant has been allowed benefits, his/her earned income becomes subject to certain guidelines. The first $20 a month of any income, regardless of source, is disregarded. In addition, if the beneficiary works, the first $65 a month of all earnings does not count against the SSI payment. After $65 a month is earned, though, one half of any monthly income is not counted. This continues until the beneficiary earns a net amount of $300 a month. When this level is reached, the individual is considered to be engaged in "substantial gainful activity" (SGA) and benefits are terminated. In essence, the person is no longer considered disabled.

Table 2.1 shows the number of persons receiving SSI and the average monthly amount of their payment.

Social Security Disability Insurance (SSDI). Where SSI has an economic needs test, SSDI is awarded to individuals who are insured and then become disabled. A person is insured if he or she has a sufficient number of work quarters credited to his/her Social Security earnings record (Social Security Handbook, 1978). The amount of

Table 2.1.--Number of SSI Recipients and Average Monthly Income

Type of Payment	Total*	Aged	Blind	Disabled
Number of Persons	4,156,812	1,889,736	76,974	2,190,102
Average Monthly Income	$142.31	$109.03	$179.75	$169.72

*This includes Federal SSI payments and State supplementation.
Monthly Benefit Statistics, Nov. 13, 1978

work needed depends on the age of the claimant when the disability occurs. If the disability occurs before age 24, 1½ years of work in the three-year period before the disability is needed. From age 24 through 30, the claimant needs credit for having worked half the time between 21 and the time of disability. All workers disabled at 31 or older, except the blind, need the amount of credit shown in Table 2.2.

In order to receive SSDI a person must be disabled.* In defining disability, the Social Security Handbook (1978) states that "a person must be not only unable to do his or her previous work, or work commensurate with the previous work in amount of earnings and utilization of

*It should be noted that Worker's Compensation is another form of disability insurance. A worker injured while performing activities related to the job is eligible. SSDI differs in that the disability does not have to be work-related. Since there is not a national policy for mandatory referral to vocational rehabilitation by Worker's Compensation, this type of insurance was not included in this study.

Table 2.2.--Work Credits Needed to Qualify for SSDI Benefits

Born after 1929, become disabled at age	Born before 1930, become disabled before 62 in	Years of work credit you need
42 or younger	1971	5
44	1973	5½
46	1975	6
48	1977	6½
50	1979	7
52	1981	7½
54	1983	8
56	1985	8½
58	1987	9
60	1989	9½
62 or older	1991 or later	10

If you become disabled, August, 1979

capacities, but cannot, considering age, education, and work experience, engage in any other kind of substantial, gainful work which exists in the national economy. It is immaterial whether such work exists in the immediate area, or whether a specific job vacancy exists, or whether the worker would be hired if he or she applied for work" (p. 95). The Social Security Handbook (1978) also states that "A medically determinable physical or mental impairment is one that results from anatomical, physiological,

or psychological abnormalities which are demonstrated by medically acceptable clinical and laboratory diagnostic techniques" (p. 102). The furnishing of this information to the Social Security Administration is the claimant's responsibility.

In addition to becoming unemployed due to the occurrence of a disability, the claimant must demonstrate that the disability is expected to last for a period of not less than twelve months. During this twelve-month period, the person must be unable to perform any substantial gainful work. SSDI is also made available for individuals with disabilities who are unmarried and disabled before the age of 22, and who are likely to continue with a severe disability. Also, disabled widows or widowers are eligible for disability benefits upon the death of an insured worker (Goldenson, 1978).

Unlike SSI, the SSDI program requires a five-month waiting period before benefits can be received. And if the beneficiary returns to work, he/she has a nine-month trial work period (TWP). If the individual is successful during this trial work period, benefits can be received for three more months before SSDI is terminated. This allows for a total of twelve months in trial work.

For the disabled worker, the average monthly award under SSDI is $321.27 (Monthly Benefit Statistics, 1978).

Provided in Table 2.3 is a comparison of the SSI and SSDI programs. It should be understood that a person

Table 2.3.--A comparison of the SSI and SSDI Programs

Variables for Comparison	SSI	SSDI
Administrative headquarters	Social Security Administration	Social Security Administration
Funding source	General Funds of the U.S. Treasury	Contributions of workers, employers, and self-employed people
Requirement for financial need	Yes	No
Requirement for work history	No	Yes
Disability requirements	Aged, blind, or unable to engage in substantial, gainful activity	Unable to perform substantial, gainful work and disability is expected to last (or has lasted) at least 12 months, or is expected to result in death
Waiting period before benefits are payable	None	5 full calendar months
State contributions	Yes	No
Limit on ownership of personal property	Yes	No
Effect of work on benefits	Immediately reduced or terminated	Benefits continue for a 9-month trial work period
Health insurance	Medicaid	Medicare

may qualify for both, but being a beneficiary of one program does not provide for automatic entitlement to the other.

Medical Insurance

For many individuals who receive either SSI or SSDI, the financial part of the benefits are not as important as the accompanying medical insurance. Individuals with disabilities often require ongoing medical supervision. Clearly, with skyrocketing health care costs, the loss of medical benefits becomes an important consideration when an individual is faced with the prospects of returning to substantial, gainful work. The two primary medical programs that have a significant effect on the clients of this study are Medicare and Medicaid.

Medicare is an insurance program that is financed by monthly premiums paid jointly by the insured person and the federal government. Practically everyone 65 or older is eligible. Individuals with disabilities qualify if they have received SSDI for two or more consecutive years, or if they need dialysis treatment and/or a kidney transplant. Special attention should be given to the requirement for the two-year waiting period prior to receiving Medicare. If an individual returns to substantial gainful activity, he/she is no longer considered disabled and benefits, including medical ones, are terminated. If for any reason the individual terminates employment, the two-year waiting period must be reestablished.

The types of coverage available under Medicare are categorized in two parts:

Part A

1. Up to 90 days of inpatient care per each eligible benefit period
2. Up to 100 days of care in a nursing home or rehabilitation facility
3. Home health care benefits, such as nurses and/or physical therapists

Part B (this covers outpatient treatment)

1. Physician services
2. Outpatient hospital services
3. Various medical and health services, e.g., X-rays, braces, artificial limbs, wheelchairs, and ambulance services (Goldenson, 1978)

The claimant is responsible for paying the first $60 of bills incurred each year. After this is paid, Medicare will pay for 80% of the rest of the bills. Medicare does not pay for routine physical examinations, prescriptions, glasses, hearing aids, immunizations, dentures, dental care, and orthopedic shoes. Medicare also does not provide coverage for strictly custodial care.

For individuals unable to meet the cost of medical services not covered by Medicare, Medicaid is available. Persons receiving SSI are automatically eligible for Medicaid. Services covered by Medicaid are:

1. Necessary services provided by physicians, optometrists, podiatrists, chiropractors, and other professional personnel
2. Dental services

3. Home health care services

4. Drugs, sickroom supplies such as bedpans, bandages, etc., eyeglasses, and prosthetic appliances (Goldenson, 1978)

Again, it should be noted, that as in the case of Medicare, coverage is only available as part of the total benefit package allowable to individuals not involved in substantial, gainful activity.

Given the overview of the rules and regulations governing SSI/SSDI and the accompanying medical programs, an illustration of a specific case study will highlight the disincentives issue. This example comes from a study conducted by Rehabilitation Facilities of Wisconsin (1978).

Larry, needing to use a wheelchair as a result of bruising his spinal cord in an automobile accident, has been a recipient of SSDI since 1973. He and his daughter received $705 each month in SSDI payments. As a result of receiving rehabilitation services, he was hired by an electronics company to assemble computer boards. After only one month on the job, his employer gave Larry a very positive evaluation. The electronics company also said that they would like to have Larry work more than 19 hours a week, which had been his work level, and increase his hourly wage from $2.65 to $2.85. Larry was quite pleased with this until he learned that as a result of increasing his wages and gross income earned, he would experience a decrease of $484 in his total net monthly income.

Larry's wage was $215 a month. After Social Security taxes were deducted, he took home $202. With the $705 received from SSDI, none of which was taxable, the total cash income each month was $907. In addition, Larry was covered by Medicare.

Working full time at the proposed $2.85 per hour level would have given Larry $490. After FICA, federal, and state withholding taxes, his take-home pay would have been $423. And as a result of the Social Security Administration's earning test, Larry and his daughter would have no longer been eligible for SSDI, for his earned income would have exceeded the $280 a month limit. Larry, as a result of earning $423 a month take-home pay, would no longer be considered disabled; therefore, all benefits would have been terminated. In order to maintain his current cash income, disregarding medical insurance, Larry would need to obtain employment yielding $1230 in gross monthly wages, and $907 in take-home pay. Given his capabilities at that time and work history, Larry encountered a considerable disincentive and obstacle to work and independence.

Disincentives Research Studies

In this section research studies related to work disincentives are reviewed. As stated in Chapter I, the previous research has as its primary focus Social Security legislation and characteristics of beneficiaries. There have been several short narratives attesting to the reduced

motivation towards successfully completing a rehabilitation program for persons in a beneficiary status (Comptroller General, 1976; Walls, Mason, and Werner, 1977; Wise, 1974). A number of investigators reported individuals with disabilities, who were SSI/SSDI recipients, as having a below average rehabilitation rate (Fowler, 1969; Greenblum, 1976; Grigg, Holtman, and Martin, 1969; Micek and Bitter, 1974; Nagi, 1969; Walls, Stewart, and Tseng, 1974). Recently, Better et. al., (1979) in examining a 15% random sample of nationwide fiscal year 1975 vocational rehabilitation case closures, found that disabled individuals receiving SSDI or SSI were rehabilitated less frequently than nonbeneficiaries. Although often found in sheltered employment, rehabilitated beneficiaries were less often self-employed or working in the competitive labor market. Their findings suggested that reduced work motivation attributable to SSDI/SSI programs contributed to this situation.

The Indiana Rehabilitation Services (1976) conducted a study which had rehabilitation counselors in the state agency rank six factors, in order of importance, that were disincentives to the rehabilitation of SSI and SSDI beneficiaries. The major problems listed by the counselors were: fear of returning to work because of the loss of benefits, and decreased income. Fear of losing Medicare was perceived as less of a disincentive to complete a rehabilitation program.

The Alabama Counselor Perceptions Study

With a variety of proposals for lessening or eliminating the disincentives effect, the Department of Rehabilitation Medicine at the University of Alabama (1979) believed that it ". . . would be enlightening to systematically examine one group's view on rehabiliation disincentives. Rehabilitation counselors, by virtue of their relationship with clients, are in a unique position to comment upon the various proposals for modifying the SSDI system and indicate those most likely to achieve the desired outcome" (Better, Fine, Simison, and Doss, 1979, p. 646).

Counselors within the Alabama Division of Rehabilitation and Crippled Children Services, assigned to serve clients in North Central Alabama, were the subject of the study. Thirty-four counselors were randomly selected to participate in a personal interview to evaluate the absolute and relative efficacy of several proposals for reducing disincentives to the rehabilitation of beneficiaries, including:

1. Continuation of Medicare coverage after the trial work period
2. Immediate renewal of Medicare coverage for former beneficiaries who terminate employment
3. Deductions for work-related expenses in deciding whether a beneficiary is able to engage in substantial, gainful activity
4. Raising the amount of money a beneficiary may earn before benefits are terminated

5. Permitting partial payments of benefits
6. Extending the trial work period to 24 months
7. Renewing benefit eligibility every two years
8. Lowering disability benefits

The researchers found that 91% of the counselors believed changes relating to Medicare coverage would be effective. Eighty percent reacted positively to the proposals that work-related expenses be considered in determining whether a client is performing at the substantial, gainful activity level; partial benefits be granted to beneficiaries with limited earnings; and SGA be increased to $500 from the current $230 a month. The most effective changes perceived by the counselors were related to the continuation of Medicare coverage after the trial work period is completed, increasing the substantial gainful activity level, followed by the continuation of partial benefits to be granted beneficiaries with limited earnings.

The findings suggested a moderate degree of counselor consensus on proposed changes in the SSDI programs intended to reduce or eliminate disincentives to vocational rehabilitation. A major criticism of the beneficiary programs was that benefits are completely terminated, even when a beneficiary's earnings are quite modest. Three of the proposals mentioned received considerable counselor support and would partially rectify this situation.

There was some counselor support for attacking the perceived attitude of some beneficiaries, that benefits have been awarded for life. Counselors felt that by reviewing cases every two years, beneficiaries would not settle in to an "out-of-work-for-life" mind set.

In summary, the counselors' perceptions implied that both the benefit programs and the attitude of the beneficiaries contributed to the low level of vocational rehabilitation clients returning to work. As a result, their recommendations included proposals for dealing with provisions within the Social Security Administration along with the establishment of a more comprehensive system for auditing the health and activities of beneficiaries.

The West Virginia Study

The University of West Virginia Research and Training Center initiated a research project, "Negative Incentives: Contingencies which Discourage Disabled Individuals from Seeking or Completing Rehabilitation Services and Subsequent Employment" (Project R-34, 1976). Although the project has not yet been completed, some findings were made available in an interim progress report.

The objectives of the West Virginia study were to " . . . determine which types and amounts of cash and in-kind benefits discourage eligible individuals from engaging in and completing VR services. Further, to what extent is this a problem in VR, and, if it is a substantial problem, what are some possible remediating actions" (p. 168).

The investigators used 76 different programs to cover the range of benefits that eligible vocational rehabilitation clients may receive. The project leaders recognized that the disincentives problem becomes increasingly complex when an individual receives more than one type of benefit: "A particularly insidious arrangement may occur if workers receiving multiple benefits actually reduce the total income when they work; that is, they may lose more than they gain" (p. 173).

The plan in the West Virginia study was similar to the Better et. al., (1979) study--to compare beneficiaries to nonbeneficiaries, both of whom were eligible clients for vocational rehabilitation services. The dependent variable was the closure status of the individuals, and factors associated with it, such as: whether the person was in competitive employment or homemaker employment, and the earnings received. Unlike the Better (1979) study, which reviewed R-300s (a federal reporting form used by the state vocational rehabilitation agencies), this study assigned full-time interviewers to collect data in the Charleston-Huntington, West Virginia and the Baltimore, Maryland area.

During the intake process of the state agency, the potential clients were interviewed by the "disincentives" interviewer. During the interviews the investigators attempted to report the person's motivation for work, since it was felt that this variable was significant in terms of obtaining gainful employment. Similar to a study

reported by Cain and Watts (1977), which attempted to assess a person's desire to work by examining how assets were accumulated in the past, West Virginia accomplished this by classifying people as having either an internal or external orientation. Of the 304 potential clients, 64% had an external orientation in that they agreed or strongly agreed that " . . . a great deal that happened to you is probably just a matter of luck, fate, breaks, or other more powerful people." Thirty-six percent had an internal orientation inasmuch as they disagreed or strongly disagreed with the same statement. It seems reasonable to assume that the researchers were inferring that individuals with an "internal orientation" were more "self-directed" and hence more "motivated" to secure employment.

The person's progress in vocational rehabilitation was then monitored through agency records. At the time of vocational rehabilitation closure, regardless of outcome, the investigators noted the pattern of benefits received and their relationship to vocational rehabilitation outcome.

In the interim report (1979), five specific objectives were listed:

1. To determine the amount of benefits vocational rehabilitation clients were receiving at referral
2. To determine benefit reductions that occur if the person is rehabilitated
3. To examine the relationship between a person's progress in vocational rehabilitation and their benefit reductions

4. To specify the scope of disincentives
5. To generate legislative and programmatic recommendations increasing rehabilitation incentives

The interim report showed that the most important program, as viewed by the clients, was the SSDI, followed by SSI. After these programs, the category of benefits providing medical care was determined to be significant. The only other in-kind program that was quantitatively important was the Food Stamp program..

The Recovery of Disabled Beneficiaries--The Treitel Study

Treitel (1979) reported the results of his examination of the recovery, that is, the termination from beneficiary status, by individuals who were allowed benefits in 1972. Treitel then studied the same beneficiaries in 1975. Stimulating his research was the rapid increase of new claimants. New benefits were awarded to 350,000 claimants in 1970, and in 1975 the number of new claimants rose to 592,000. This occurred while the number of recoveries remained at approximately 40,000 annually. Treitel's study involved the tracing of 413,000 beneficiaries.

He found that only 7% of the 413,000 beneficiaries who were awarded benefits in 1972 had recovered. Around 42% were still receiving benefits, and the remainder had either died or attained the age of 65.

Treitel further analyzed the characteristics of the 7% who left the rolls and those who stayed in a beneficiary status. He found that the significant variables related to recovery were fairly predictable. Twenty-three percent of those who were under 40 years of age recovered, as compared to 4% of those aged 50 or older. Ten percent of the men and 6% of the women recovered. Beneficiaries with more dependents recovered at a greater rate than those with fewer dependents. With certain primary diagnoses, the recovery rate was greater than for others: fractures, 33%; disc displacement, 16%; tuberculosis, 34%; blindness, 10%; heart disease or osteoarthritis, 3%; emphysema, less than 1%; neoplasms, 1%. Education was significant. With more schooling, there was an increased recovery rate. Predisability earnings were also significant, with higher earnings prior to disability showing the greater recovery rate. Interestingly, it was found that beneficiaries with larger amounts of benefits ($300 or more) recovered more often than individuals with lesser benefits. However, when this last finding was analyzed with other characteristics, such as age, education, and primary disability, it was considered to be of less importance than when considered individually.

Treitel believed that for most beneficiaries recovery was not possible. In order to be allowed benefits, a claimant must have a severe disabling condition that is

long-term; therefore, program changes creating incentives would have a minimal effect on "most" beneficiaries.

To determine the factors related to recovery and to determine the extent of existing disincentives, Treitel employed the Automatic Interaction Detector program (AID 3). As explained by Sonquist et al. (1971), this involved an analysis of variance technique which identifies those variables with the greatest variance. The AID 3 was used for all persons who recovered by 1975 and an equivalent group randomly selected from those who remained in a beneficiary status.

In analyzing the data, Treitel maintained his findings suggested that some workers who had a great potential for medical improvement may have exercised manipulation over their medical history in order to maintain a beneficiary status. Nevertheless, Treitel concluded that most beneficiaries apply for assistance and remain on the rolls due to the traumatic effects of their disabling conditions, and that frequently these disabling characteristics lead to premature death. Treitel further postulated that the younger beneficiaries with a potential for improvement, i.e., recovery was possible, could be engaged in substantial, gainful activity if it were not for the disincentives in the benefit program.

A Study of the Beneficiary Rehabilitation Program--the Rutgers Study

A study conducted by Berkowitz, Horning, McConnell, Rubin, and Worrall (1979) attempted to determine whether the Beneficiary Rehabilitation Program was cost beneficial. Further, the study suggested alternative methods for financing the program.

The Beneficiary Rehabilitation Program is funded from the payments of the prior year's total Social Security Disability Insurance payments. For fiscal year 1976, that amount was $102.6 million. The amount of available money reflects the significance of the program, for in 1976 the $102.6 million represented 9.2% of the total vocational rehabilitation expenditures (Berkowitz, 1980). Also, in 1976, the Beneficiary Rehabilitation Program served 88,449 clients, or 7% of the total number of clients served by the vocational rehabilitation agencies.

In studying 8,286 beneficiaries who were rehabilitated during fiscal year 1973, it was found that 35% of those rehabilitated left the SSDI rolls at least once by January, 1977. In agreement with Treitel, Berkowitz, et al. (1979) found that age was one of the factors associated with termination, that is, the likelihood of termination from SSDI decreased as the rehabilitant became older: "Over 40% of the rehabilitants in the prime age group 25-34 terminate, and more than one-third of those in the 35-44 years age group also leave the rolls. In contrast,

only 14% of those age 55-66 terminate" (Berkowitz, 1980, p. 89).

Berkowitz, et al. (1979), in looking at the wage that a rehabilitant was earning at successful closure, found the expected. When the wage increased, the termination or recovery rate also increased. Once the benefit ratio equaled or exceeded 1, the rate of termination from beneficiary status increased dramatically.* This was further illustrated by an example from the "Wage/Benefit Ratio and the Rate of Termination Table." When a wage/benefit ratio was somewhere between 0.51-0.75, the rate of termination was 22.2%. However, when the ratio increased to between 1.51-1.75, the rate of termination rose sharply to over 61%.

The study also focused on the SGA limit of the Social Security Act. In examining SGA, the researchers paid special interest to the 24.4% of the Beneficiary Rehabilitation Program's rehabilitants who had not terminated from SSDI in 1977, but had some participation in the labor market. This group, whose "double status" consisted of wage earners and beneficiaries, was studied to see why they were not terminated. The researchers hypothesized two explanations for the lack of termination:

---

*To arrive at the wage-benefit ratio, the reported wage is divided by the actual benefit. Therefore, when the ratio is equal to 1, the wages and benefits are equal. As the wage increases, the ratio increases.

(1) the extent of this group's impairment made them incapable of earning more than the SGA amount; or (2) the prospects of losing benefits stopped these individuals from working more. The second explanation serves as the basis for the disincentives issue.

The researchers maintained that for some rehabilitants, the data suggested that the SGA limit acted as a disincentive; that is, some individuals were capable of earning enough income to be terminated from SSDI, but instead chose to use the SGA provision to limit their income and remain in a benefit status.

The conclusions of the study provided recommendations for reducing the disincentives problem. The researchers suggested that the provisions governing the trial work period should be liberalized, along with improving the overall performance of rehabilitation counselors. These two changes would lead to an increase in the wages earned, raising the wage/benefit ratio, therefore increasing the probability of recovery. Other recommendations included reforms in the program management, financing, and monitoring of the Beneficiary Rehabilitation Program. Although none of the recommendations provided for an elimination of disincentives, the researchers felt that their proposals would greatly reduce the desire of some rehabilitants to limit their earnings.

Economic Theory and Disincentives: A Theory of Labor Supply

Public policies which involve a transfer of income from one group to another group require considerable consultation from economists (or, at least, economists are normally solicited for their input). The overall goal of this study was to gain a better understanding of the work disincentives problems related to income transfer programs. Therefore, a brief overview of an economic theory of labor supply, as viewed by the economists directly involved in work related to the disincentives issue, provides a helpful background.

In 1930, Lord Robbin simplified a theory of labor supply. He saw a worker as having a finite amount of time which could either be spent at work or in pursuing leisure activities. The purpose of work was to earn a wage so that goods could be purchased. In the process of working, the amount of leisure time is reduced. Robbin believed that, given the opportunity, people preferred to be involved in nonwork activities. Therefore, all income transfer programs contributed to a person not working, for if a person can be financed for not working there is no reason to work. Although discounting the need to feel a sense of usefulness and belonging, or the significance of work in relation to the healthy personality and positive human development, as expressed by Erikson (1950), Robbin maintained that work was only significant in relation to obtaining a wage.

Berkowitz (1980), commenting on the theory of labor supply, included the viewpoint of Robbin in establishing four basic assumptions related to work disincentives and vocational rehabilitation:

1. The purpose of vocational rehabilitation is to prepare people with disabilities for work.
2. The purpose of work is to acquire money.
3. Benefit programs are allowed to people who do not work.
4. Thus, benefit programs cause disabled persons to refrain from work preparation provided by vocational rehabilitation.

Simply put, given the nature of people, as viewed from this economic vantage point, it is the benefit, not the disabling condition, in conjunction with the nature of people, that restrains people from working.

These assumptions exclude a macro view of a political economy which is basic to developing a comprehensive understanding of the dynamics of any particular system within a social structure (Ollman, 1978). Nevertheless, other theorists concurred with the labor supply theory.

Rejda (1976) expanded on the purpose of work and included "economic security." Economic security, which is a part of a person's total welfare, is "a state of mind or sense of well-being whereby an individual is relatively certain he can satisfy his basic needs and wants, both present and future" (p. 2). For most people, Rejda maintained, economic security is an income that is above

the poverty level, i.e., above the minimum level a person needs to obtain basic material goods and services.

Lack of economic security is experienced by many in this country, including individuals with disabilities. In 1973, Rejda stated that the poverty income threshold for a four-member nonfarm family was $4,540. Twenty-three million Americans, or about 11% of the total population, were living below this level. Many of the 11% were individuals with disabilities.

Berkowitz, Johnson, and Murphy (1976) claimed that a causal relationship between disability and poverty exists. One out of five families on the welfare rolls receive assistance because the head of household is disabled (Turem, 1976). The probability of an adult from a low-income family becoming disabled is twice that of a middle-class person. Nearly two-thirds of poor families consisting at least of husband and wife, include a disabled adult; and, of the currently poor at least 30% owe their economic status to their health condition (Luft, 1972). This all translates into economic insecurity.

The lack of economic security consists of one or any combination of the following:

1. Loss of income
2. Additional expenses
3. Insufficient income
4. Uncertainty of income (Rejda, 1976, p. 3)

The reasons for people being in any of these four categories may be due to old age, injury and disease, unemployment, substandard wages, and inflation (Wilcox, 1969). A person with a disabling condition may be forced to leave a job; therefore, a loss of income results and much uncertainty is created. In addition, other family workers may be affected, giving rise to considerable extra expenses.

Needless to say, the individual looks for economic security and may find it within the benefit system. Once benefits are allowed, the beneficiary gains some certainty in his/her life, despite the fact that in many cases they are worse off financially than before the disabling characteristic occurred. Through benefits a steady income is present. Thereafter, when faced with the option of entering a rehabilitation program and returning to gainful employment it is reasonable that the beneficiary becomes reluctant.

It is also reasonable to expect that the problems faced by the beneficiary appear overwhelming. In testimony before the House Ways and Means Sub-Committee on Public Assistance and Unemployment Compensation (1979), Joseph Califano cited a few of the problems plaguing the current system. He estimated that 25 million people were living below the poverty level; there were inadequate job opportunities; supplements for the working poor were

unacceptably low; and that the current system was demeaning and bewildering to recipients.

The theory of labor supply maintains that work is not a preferred activity. Given a choice, people would rather participate in nonwork activities. Because benefits are only given to individuals for not working, the theory maintains that income transfer programs provide a vehicle to carry out preferred nonwork-related activities. The theory does not consider the degradation and confusion resulting from being a beneficiary. The theory also does not include the notion that work activities provide a variety of contributions to a person's life.

Unlike the economic proponents of the theory of labor supply who believe that work is drudgery, offering only financial remuneration, other theorists maintain that work provides several other dimensions to an individual's life. Dunn (1979) and Levinson et al. (1978) stated that for some people work is just one part of a total growth and developmental process. This lifelong process frequently enhances an individual's ability to cope, adapt, plan, and take risks (Dunn, 1979, in referencing Kroll et al., 1970). This point of view sees work as an integral part of a person's total life. The emphasis is on the interconnectedness of varied aspects of a person's activities, rather than a compartmentalizing or separation of activities into isolated categories. Theorists holding this viewpoint have not specifically addressed the whole issue of work

disincentives; nevertheless, in order to obtain a critical analysis of the problem the concept of work must be viewed in its entirety. This means the inclusion of such notions as work as a social relation (Ollman, 1978); an extension of the personality (Holland, 1973); an enhancer of human growth and development.

Rehabilitation Philosophy and Practice

A theory, according to Burks and Stefflre (1979) is a conceptual model. In a conceptual model there are elements of reality and belief. "Reality is the data or behavior that we strive to explain. Belief is the way that we try to make sense out of the data by relating what we see to conceivable explanations of it" (p. 2). Although not comprising a formal theory, per se, the rehabilitation philosophy is grounded in a set of principles or laws of a field of knowledge (DiMichael, 1969).

The value of the human being is a basic tenet commonly expressed by rehabilitation professionals. This principle serves as a constant throughout the three major beliefs which form a philosophical foundation for the practice of rehabilitation in the United States. These principles are:

1. Equality of opportunity should exist for everyone. This means that there is an obligation to provide specialized services to afford individuals with disabilities the same privileges and responsibilities as able-bodied persons (Garrett, 1969).

2. A person is holistic, not just a combination of separate parts. The physical, mental, social, vocational, and economic aspects of a person all interact to form a whole (Jacques, 1970).

3. Each person is unique: reacting differently, having different needs, potentials, assets, ways of coping, and goals (Bitter, 1979).

Given the complexity of the individual, rehabilitation must take an interdisciplinary approach in order to provide comprehensive services and insure quality outcomes. Done properly, rehabilitation can lead to self-respect and elimination of despair, frustration, and grief (Bitter, 1979). Basic to all of this " . . . is self-rehabilitation, for what disabled persons learn to do for themselves is more important than what others do for them. The reasons are clear. Self-dependence, even in small measure, helps individuals preserve their sense of dignity and personal worth, while dependence tends to deprive them of initiative, self-esteem, and hope for the future" (Goldenson, 1978, p. 36). Given a program with these ideals, what has been its impact in assisting SSI/SSDI beneficiaries overcome existing work disincentives?

As was previously stated, SSDI/SSI claimants are automatically referred to the state vocational rehabilitation agency. Despite improvements in the system since 1954, inadequate rehabilitation remains a problem. "Rehabilitation services are provided to only about one-fifth of those who receive Old Age, Survivors, Disability Insurance benefits" (Treitel, 1971, p. 22). The present

system for determining eligibility for SSI/SSDI conflicts with the goals of rehabilitation. To obtain beneficiary status, a person must prove that his/her disability is of considerable severity, yet in order to receive rehabilitation services the disabling condition cannot be so severe that the person lacks a feasibility for participating in gainful activity. This seemingly "Catch-22" promotes an understandable dilemma to the rehabilitation client and the rehabilitation agency. These conflicting policies, in conjunction with the 1973 legislative mandate to give priority to those individuals with the most severe handicapping conditions, partially explain the relatively small numbers of beneficiaries that the state vocational rehabilitation agency is able to successfully assist. In 1975, clients referred by the Social Security Administration and public welfare agencies accounted for 51.7% of the total cases not accepted. Additionally, persons referred by the Social Security Administration, the largest single source of referrals to the state vocational rehabilitation program, comprised only 3.7% of the total rehabilitants (Information Memorandum RSA-IM-77-37, 1977). It was also found that approximately two-thirds of the applicants for vocational rehabilitation services were closed unsuccessfully for failure to cooperate, refusing services, and having an undetermined location (Information Memorandum RSA-IM-77-7, 1977). This may be due, in part, to the disincentives effect.

In a general study of "The effect of vocational rehabilitation services on the earnings of disabled persons" (Greenblum, 1977), it was found that the higher the family income at time of referral, the more often clients were rehabilitated and the more favorable their subsequent earnings picture. However, consistent with Berkowitz and Treitel, Greenblum (1977) found that the state vocational rehabilitation agency was less likely to rehabilitate a beneficiary. If successful rehabilitation did occur, earnings of the beneficiary rehabilitant were lower than those of nonbeneficiaries. Again, the disincentives effect must be taken into account. Table 2.4 further illustrates the activities of the state vocational rehabilitation program in relation to rehabilitating beneficiaries. The low rehabilitation rate for beneficiaries as reflected in Table 2.4 compares quite unfavorably with the 15% rehabilitation rate experienced in the general vocational rehabilitation agency caseloads.

Given the quality of the rehabilitation, coupled with the effect of existing disincentives, it becomes exceedingly clear why some beneficiaries do not respond positively to the offer of vocational rehabilitation services. In 1975, the average earnings of a successful rehabilitant at closure was $95 a week (Adams, 1975), as compared to $185 a week earned by the nondisabled worker (Statistical Abstracts, 1978). For a large percentage of rehabilitated clients, job placement resulted in semiskilled/unskilled positions,

Table 2.4.--Rehabilitation of SSI/SSDI Beneficiaries

1977

	Total Expenditures*
SSA Trust Fund Budget	$ 80,901,318
SSI Service Fund	44,100,523
Section 110 General Agencies	800,342,098

	No. of Persons Rehab	Rehabilitation Rate	Average Cost per Rehabilitation	Average Cost per Case Served
SSDI	11,056	8 percent	$7,600	$684
SSI	5,977	7.7 percent	7,378	547
Section 110	262,239	15.4 percent	3,357	525

State VR Agency Fact Sheet Booklet, 1978, and State Vocational Rehabilitation Agency Program Data, 1978

*Costs and statistics from agencies serving the blind are not included in these figures.

service occupations, and clerical jobs (see Table 2.5), partially explaining the low salaries.

In another study by Greenblum (1979), it was found that rehabilitation was more effective with clients who were not considered disadvantaged. Return to work occurred less often among groups frequently disadvantaged in the labor market, such as ethnic minorities and those at low educational and other socioeconomic levels. Obviously, many factors contribute to this situation. Many of the experts discussed in this chapter believe that in addition to the myriad of problems associated with being disabled, certain

Table 2.5.--Vocational Rehabilitation Job Placement Summary

	In thousands				
	1973	1974	1975	1976	1977
Professional, technical, & managerial[1]	33.8	35.4	36.4	36.8	34.4
Clerical & sales	48.9	50.5	46.3	43.0	41.2
Service	69.7	68.0	64.6	59.9	54.8
Agriculture, fishing, etc.	10.5	9.8	9.5	9.2	7.9
Industrial:					
Skilled	31.9	31.6	28.4	27.1	25.8
Semi-skilled & unskilled	80.4	81.1	66.8	60.6	58.4
Homemakers[2]	52.0	50.1	53.7	53.3	46.2
Others & not reported	33.5	34.5	18.2	13.5	22.4

Statistical Abstracts, 1978, p. 349

[1] Includes vending-stand personnel

[2] Includes unpaid family workers

provisions of income transfer programs serve to substantially reduce the number of people participating and successfully completing a vocational rehabilitation program.

Implications

Certain provisions of the Social Security Act serve as obstacles to work for many individuals with handicapping characteristics. For some, these roadblocks are so enormous

that SSI and/or SSDI beneficiaries frequently choose to not work. This is the basis for the work disincentives issue. The problem of work disincentives has become the concern of many, including such reputable organizations as: the Urban Institute, as presented in the Report of the Comprehensive Needs Study (1975); the White House Conference on Handicapped Individuals' Report (1977); and the United States Congress, as expressed in Section 403, "Special Study Concerning Disincentives to Employment" in the Rehabilitation, Comprehensive Services, and Developmental Disabiliities Act (1978).

The review presented in this chapter provided information needed to understand the complexities of the Social Security system. Several research studies investigating the work disincentives problem were also described. The current economic theory commonly used for analyzing work disincentives, and the rehabilitation philosophy were outlined. Through this review, it can be seen how the state vocational rehabilitation agency has a crucial role in assisting SSI and SSDI beneficiaries in obtaining employment.

With such knowledge, this research was developed to study the effect vocational rehabilitation services has on assisting SSI and SSDI beneficiaries in overcoming existing work disincentives. To provide for a multi-dimensional perspective of this research area, along with providing significant consumer involvement, former SSI

and SSDI clients of the Michigan Bureau of Rehabilitation agency, vocational rehabilitation counselors employed by the state agency, and advocates for the rights of disabled persons were surveyed with a structured telephone interview designed specifically for this study. This study was an attempt at providing information and knowledge related to the work disincentives problem in an area in which, at this point, they have been lacking.

Summary

In developing this study, the issues discussed in the survey of the literature were given great consideration. The studies conducted by Treitel, Berkowitz, et al., West Virginia, Alabama, and Greenblum, have all provided greater insights into those provisions of the Social Security Act which create an inhibitory effect on beneficiaries when it comes to considering their return to work. The studies have also addressed the characteristics of people most likely to be affected by work disincentives. Given the existing problems, the studies also spoke to the accomplishments of the state vocational rehabilitation agency. By investigating the specific services provided by the state vocational rehabilitation agency, along with obtaining considerable input from consumers of rehabilitation services, this study expanded the knowledge related to work disincentives in order to contribute to future

changes in relevant policies and practices affecting beneficiaries with disabling characteristics.

CHAPTER III

METHODOLOGY

Introductory Statement

Emphasized in Chapter One, the need for more information and research on the work disincentives problem experienced by vocational rehabilitation clients who receive benefits from the Social Security Administration was presented. This issue was explored in more detail in Chapter II, where the need for research examining the specific activities of the state vocational rehabilitation agency in relation to assisting beneficiaries overcome existing work disincentives was discussed. Although much of the research either emphasized the beneficiary client or the policies of the Social Security Administration, there was virtually no research that examined the activities of the state vocational rehabilitation agency. Expounded upon in this chapter is the research methodology that was used in conducting this study. The purpose of this study was to facilitate an understanding of the disincentives problem as it relates to the activities of the state vocational rehabilitation agency.

Included in this chapter is the procedure used for selecting all the research subjects. The characteristics

of the subjects are described, and an explanation of the agreements made with the Bureau of Rehabilitation and the three independent living centers is provided. The specific procedure for conducting the research is presented. The development of the research instrument is detailed with an explanation for how content validity and reliability were established. Also presented in this chapter are the research hypotheses and questions, and the statistical techniques used to perform the analyses.

Selection of Research Participants

Subjects selected for this study came from three distinct groups:

1. Vocational rehabilitation counselors providing services to SSI/SSDI beneficiaries. All of the counselors selected for this study were employed by the Michigan Bureau of Rehabilitation.

2. Representatives from organizations whose primary purpose is to advocate for individuals with disabling conditions. All advocates worked in the state of Michigan.

3. Former vocational rehabilitation clients who were receiving SSI and/or SSDI during their participation in a vocational rehabilitation program. All of the clients selected for this study were closed from rehabilitation services provided by the state vocational rehabilitation agency. The analysis of this group took place in two ways:

   (1) The clients were analyzed as a total client group.

   (2) The clients were analyzed in separate groups depending on whether the individual was closed from rehabilitation services as successfully rehabilitated to employment earning a wage, or unsuccessfully rehabilitated, that is, not employed at the time of closure.

These three groups of subjects were selected for the study in order to:

1. Allow for considerable consumer involvement, the importance of which was highlighted in Chapter I.
2. Provide for a comparison among three groups who were closely involved in the work disincentives problem.
3. Allow for the participation of persons who were knowledgeable of the activities of the state vocational rehabilitation agency.

Selection of Subjects: Procedures

The three groups of subjects interviewed for this study were selected using three different procedures. The counselors were randomly selected from a pool of appropriate vocational rehabilitation counselors, the advocates were randomly selected from a pool of Michigan advocacy organizations, and the client subjects were obtained through the independent living centers in Michigan. What follows in this section are the specific details for subject selection.

Selection of Vocational Rehabilitation Counselors.

Subjects for this group were selected with the cooperation of the Michigan Bureau of Rehabilitation. Upon receiving administrative approval (Appendix A) for interviewing the counselors, the Counselor Data File, a computer printout of all counselor activities, was reviewed. Included on the Counselor Data File is a report on each counselor as to the percentage of SSI and SSDI clients served for the

month reported. The Counselor Data File reviewed for this study was dated May 15, 1980, covering activities of the previous month.

At the time of the review, 451 caseloads were listed as having client activity. Nearly 80% of all caseloads indicated some SSI/SSDI clients. For 201 counselors, the SSI/SSDI caseload consisted of less than five individual cases. Therefore, counselors having a minimum SSI/SSDI caseload size of five or more were initially selected to make up a pool of counselor subjects. This was done to assure the interviewing of counselors with more than a superficial exposure to the vocational rehabilitation of SSI/SSDI beneficiaries. This initial screening resulted in an n of 139 counselors working throughout the state of Michigan.

From this population of counselors (n = 139) a random sample was selected. A table of random numbers, the best method of achieving a random sample (Glass & Stanley, 1970), was used. Each of the 139 counselors was assigned a three-digit number from 001 to 139. A starting point in a table of random numbers was selected by chance. Moving along the rows, digits were grouped into groups of three. When a number above 139 appeared in the row, or if a number appeared twice, it was simply disregarded. This procedure continued until a random sample of 25 was obtained. Two counselors from this sample were not used in the study.

One counselor was on vacation while the interviews took place, and one counselor was repeatedly unavailable. This left a total n of 23 for this group.

Selection of Advocates. A comprehensive list of Michigan advocates was compiled with the assistance of personnel from the Michigan Bureau of Rehabilitation, the Center for Handicapper Affairs in Lansing, and the University Center for International Rehabilitation at Michigan State University. The total list consisted of 43 organizations. Similar to the random sampling process that took place with the counselors, a table of random numbers was used to select 30 advocate organizations for inclusion into the study. Of the 30 organizations randomly selected, five were no longer operational and two organizations did not participate due to their lack of knowledge and contact with SSI/SSDI beneficiaries and the state vocational rehabilitation agency. Therefore, the total number of subjects for this group was 23.

Selection of Clients. Subjects for this group were obtained through the three independent living centers in Michigan: the Center for Handicapper Affairs in Lansing, the Ann Arbor Center for Independent Living, and the Detroit Center for Independent Living. The Lansing and Detroit centers each provided a list of people who had received SSI and/or SSDI benefits while they were receiving services from the Michigan Bureau of Rehabilitation. These lists were developed through a telephone request.

Individuals known to have received SSI and/or SSDI while they were clients of the state vocational rehabilitation agency were telephoned by the Center staff. The prospective interviewees had the study explained to them, were given assurances of anonymity and confidentiality, and were told that their participation was to be on a totally voluntary basis. All individuals provided by the two centers were used in this research study.

Due to an unfamiliarity with the benefit and rehabilitation history of the Ann Arbor Center users, a letter explaining the research study and soliciting volunteers was mailed to the entire mailing list of the Ann Arbor Center for Independent Living. The letter sent is included in Appendix B. To assure confidentiality, the Center was in charge of the mailing. Included with the letter was a postcard that could be returned if the individual met the criteria of being a subject and wanted to participate in the study (Appendix C). It should be noted that the letter sent through the Ann Arbor Center was a duplication of the verbal request that took place through the Lansing Center for Handicapper Affairs and the Detroit Center for Independent Living.

A total of 220 letters were mailed. Thirty-eight persons responded. Seven of those respondents did not wish to participate, but did have comments concerning the research. Of the remaining 31 respondents, four did not meet the criteria established for being a subject

(a recipient of SSI/SSDI while receiving vocational rehabilitation services). Two of those respondents had never received SSI or SSDI, and two respondents had never participated in a rehabilitation program through the state vocational rehabilitation agency. Of the remaining 27 respondents, 26 were interviewed and one was not available.

Summarizing, this group consisted of subjects from three areas. Voluntary participation for the study consisted of 18 subjects from Lansing, 26 subjects from Ann Arbor, and seven subjects from Detroit. This provided for a total n in this group of 51. All subjects in this group were recruited with the assistance of the three independent living centers in Michigan.

Subject Characteristics

Vocational Rehabilitation Counselors. In order to test the research questions and hypotheses for this study, it was necessary to ascertain the primary type of caseload which the interviewed counselors carried. This was determined in Item 1 of the counselor interview. Table 3.1 gives this information.

Advocates. As stated in Chapter 1, Congress has mandated that there be substantial consumer involvement in policy planning, development, and management of Independent Living Centers. Not all advocacy organizations are managed by consumers, though. With this in mind, this study investigated the difference, if any, of advocacy

Table 3.1.--Michigan Bureau of Rehabilitation Counselor Primary Caseload Characteristics

Type of Caseload	Number of Counselors
SSI	5
SSDI	4
SSI/SSDI	6
General and SSI/SSDI	8
Total	23

organizations based on whether they were consumer-managed or not consumer-managed. Table 3.2 illustrates the number of advocates in each category who were interviewed.

Table 3.2.--Type of Organizational Management found in Advocacy Organizations in Michigan

Type of Management	Number
Consumer-Managed	20
Not Consumer-Managed	3
Total	23

Clients. The demographic data on clients necessary for testing the research questions and hypotheses appears in Table 3.3. The data indicated that the varied solicitation

Table 3.3.--Client Subjects' Demographic Data

Area	Men	Women	Rehabilitated	Not Rehabilitated
Lansing	11 (61%)	7 (39%)	10 (55%)	8 (45%)
Ann Arbor	14 (53%)	12 (47%)	16 (61%)	10 (39%)
Detroit	3 (43%)	4 (57%)	3 (43%)	4 (57%)
Total	28 (54%)	23 (46%)	29 (57%)	22 (43%)

N = 51

(%) denotes percentage of subjects in each area

procedure used for Lansing and Detroit versus Ann Arbor did not produce a meaningful difference in relation to sex or rehabilitation closure status.

Research Agreements

During the proposal-writing stage of this research study, preliminary discussions took place with the Michigan Bureau of Rehabilitation, the Lansing Center for Handicapper Affairs, the Ann Arbor Center for Independent Living, and the Detroit Center for Independent Living. These meetings provided an opportunity to explain the study thoroughly and to discuss the feasibility of providing assistance in obtaining the research subjects. Upon approval of the research proposal by the Guidance Committee, a formal research contract was signed (Appendix A) with the Michigan Bureau of Rehabilitation. Reflecting the more informal

atmospheres of the Independent Living Centers, the formal research agreement developed with these organizations was a verbal one. The verbal research agreement with the three centers provided for the following:

I. The Centers would provide access to their users for the purpose of requesting voluntary participation in the study. The Lansing and Detroit Centers agreed to do this via telephone with their own staff, and the Ann Arbor Center agreed to perform this task through a mailing.

II. The Centers agreed to allow the use of the data obtained during the process of the study for the purpose of performing analyses for any and all subsequent research reports.

III. The researcher agreed to take full responsibility for protecting the confidentiality of the individuals who were selected to be interviewed.

IV. The researcher agreed to prepare a final report of the results of the study for each of the centers.

Procedure

Two individuals were recruited to assist in the collection of data. One of the interviewers was a doctoral student in Counseling at Michigan State University and a former rehabilitation counselor. The other interviewer was a coordinator of services at a rehabilitation facility. Both interviewers were well qualified to work for the study, due to their previous experiences in research and rehabilitation.

Prior to conducting the interviews, the interviewers were thoroughly trained in the interviewing process that was used in the research. The interviewers were provided

with some general comments about the nature of the survey and its ultimate purpose as suggested by Babbie (1973). The two interviewers were then administered the research instrument as if they were one of the subjects. Then, the interviewers conducted a practice interview with someone other than a selected research subject. Finally, a question-and-answer session was held with the interviewers to provide any necessary clarification. A detailed description of the training is located in Appendix D.

Data Collection Time Schedule

The amount of time it took to conduct the interviews ranged from 15 minutes to 75 minutes, with 25 minutes being the average. Although the interview was primarily a structured one, there were opportunities for the subjects to respond in an open-ended manner. Data collection for the study began May 19, 1980, and continued until completion on June 10, 1980.

Data Collection Procedure

All interviews were conducted in a prescribed manner by the interviewers. The data collection procedure for the clients was as follows:

I. All clients who volunteered to participate in the study had their names, area of residence, and telephone numbers compiled into a list.

II. The list was divided among the interviewers.

III. The interviewers called the subjects and read an introductory statement (Appendix E). The introductory statement in the appendix referred

the subjects to a letter that was sent to them. This only applied to subjects in the Ann Arbor area. For subjects in the Lansing and Detroit areas, the sentence starting with "Several days ago . . . " was changed to reflect that they had been telephoned by one of the independent living center staff.

IV. After the introductory statement was read, the question segment of the interview began.

V. In the case where a subject was not available, an interviewer called back at another time.

The data collection procecure for the vocational rehabilitation counselors was as follows:

I. Counselors selected for the study were sent a memorandum letting them know that the research study had been approved by the Bureau and that they might be contacted to be interviewed (Appendix F).

II. A list of counselors selected for the study was developed and divided among the interviewers.

III. The interviewers telephoned the counselors, reminded them of the memo they received regarding the study, and then asked if they would like to volunteer to be interviewed.

IV. When the counselor consented, the formal interview began. If the counselor was unavailable at the time of the telephone call, an alternative time was scheduled for conducting the interview.

The data collection procedure for the advocates was as follows:

I. The list of advocates developed for this study were mailed a letter describing the research, asking for their participation, and informing them that an interviewer would be calling them in the near future (Appendix G).

II. The list of advocates was divided among the interviewers.

III. The interviewers began the interview in a procedure similar to that described in Step III of the procedure used with the vocational rehabilitation counselors.

IV. When the advocate consented, the formal interview began. If the advocate was not available at the time of the telephone call, an alternative time was scheduled for conducting the interview. If the advocate felt that there was someone else in the organization who was more knowledgeable regarding the content of the research study, the call was transferred to the recommended person.

During all interviews, the Structured Telephone Interview Protocol (STIP) was administered. Although differing slightly in order to have face validity to the group being interviewed, all three STIPs were parallel. The Client, Counselor, and Advocate STIP are located in Appendices H, I, J. For every interview conducted, the interviewers recorded the respondent's answers on a separate STIP.

Instrumentation

The instruments used to collect data for this study were structured telephone interviews. This type of survey research " . . . can be used profitably in the examination of many social topics" (Babbie, 1973, p. 45). Babbie (1973) also asserted that through the use of survey research, empirical verification can be provided. Kerlinger (1965) maintained that research interviews can help to identify variables and relations for future research, as well as serving as a main instrument in research.

The structured Telephone Interview Protocol (STIP) was developed specifically for this research project. The interviews were initially developed through a rational process rather than an empirical one. In the development of the STIP, previous research, the flow of the rehabilitation process, and rehabilitation surveys previously used were all considered. Additionally, two items from Vandergoot's (1975) The Structured Interview were modified for use in the STIP.

Comprising the research interview are six subscales (Appendix K). These subscales relate to the activities and services normally carried out by the state vocational rehabilitation agency and the Social Security Administration. The subscales are as follows:

1. The Diagnostic Subscale
2. The Vocational Counseling Subscale
3. The Rehabilitation Services Subscale
4. The Agency-Client Relationship Subscale
5. The Placement and Follow-up Services Subscale
6. The Miscellaneous Subscale

Content Validation

In order to determine whether the content of the interview " . . . covers a representative sample of the . . . domain to be measured" (Anastasi, 1976, p. 135), the examination of content validity was part of the research study. To do this, ten expert raters were asked to review all the items developed for the STIP. The instructions

given to the raters are located in Appendix L. The ten raters were selected due to their diversity of expertise in rehabilitation, research, and survey construction. These raters were:

1. Two rehabilitation researchers
2. One educational psychologist specializing in measurement
3. Two rehabilitation administrators
4. Two rehabilitation counselors
5. One former rehabilitation client
6. One reading specialist
7. One rehabilitation counseling doctoral student with over four years experience as a rehabilitation counselor

The original STIP consisted of 53 items. After reviewing the results of the ratings and the raters' comments, the following changes, additions, and eliminations were made:

1. Fourteen question stems were modified.
2. One item was eliminated.
3. The foils of four items were changed.
4. Three items were added.
5. One item was expanded into 5 items.

When the content validity study was completed, the STIP consisted of 60 items.

Pre-Testing

When the content validity study was completed, pre-testing of the STIP took place. This was done to determine the ease of administration, clarity of the instructions, and for the purpose of generating data for reliability and item analysis computation. It was also important to do, for as Raj (1972) points out, " . . . there are many aspects of the survey on which a rational decision can only be made if a pilot survey is conducted before the main survey is begun" (p. 153). The subjects used during the pre-testing were picked for their similarity to the subjects that were to be interviewed on a large scale. The pre-testing subjects were as follows:

1. Four former SSI/SSDI beneficiaries who had received rehabilitation services
2. Four advocates
3. Four vocational rehabilitation counselors

Pre-Testing Results. The reliability or accuracy of the measurement instrument (Magnusson, 1967) was studied using Cronbach's coefficient alpha. This form of estimating reliability is useful in tests or ratings where the items are given weighted scores (Magnusson, 1967) as in the STIP. Table 3.4 gives the results of the reliability for the pre-testing.

Based on the pre-testing, item-analysis, and reliability study, nine items were slightly modified to provide greater clarity and increase the reliability. In addition,

Table 3.4.--Reliability of Structured Telephone Interview Protocol Total Score and Subscale Scores

N = 12	Alpha Reliability Coefficient
Diagnostic Subscale	.289
Vocational Counseling Subscale	.603
Rehabilitation Services Subscale	.745
Agency-Client Relationship Subscale	.759
Placement & Follow-up Services Subscale	.919
Miscellaneous Subscale	.348
All Items (Total STIP)	.906

one item was dropped. The changes made as a result of the pre-testing proved to be beneficial. Table 3.5 provides the reliability coefficients for the STIP for all the data collected for this study. Although the Diagnostic and Miscellaneous Subscales were .463 and .461, respectively, the overall reliability of .922 was quite high and therefore adequate for this study.

Coding of Scores for Data Analysis

Warwick and Lininger (1975) pointed out that, "The essential task in coding is to have the data represented with numerical or other symbols permitting rapid and flexible storage, retrieval, and tabulation" (p. 238). With this in mind, a system for coding the data obtained through the STIP was designed. As can be seen by examining the

Table 3.5.--Structured Telephone Interview Protocol Reliability Estimates for Total Score and Subscale Score

N = 97	Alpha Reliability Coefficient
Diagnostic Subscale	.463
Vocational Counseling Subscale	.837
Rehabilitation Services Subscale	.820
Agency-Client Relationship Subscale	.854
Placement & Follow-up Services Subscale	.932
Miscellaneous Subscale	.461
All Items (Total STIP)	.922

STIPs located in the appendices, nearly all of the items were developed to give the subjects a choice of three foils. The scoring of the foils was either 1, 2, or 3. The foils were mutually exclusive of each other, and only one foil was acceptable for each item.

For all responses, the weight of scores was placed on a continuum from 1 to 3, with 3 being on the high side and 1 on the low side. This was in relation to the major hypothesis of this study, which was to determine the extent to which state vocational rehabilitation services assist SSI and/or SSDI beneficiaries in overcoming existing work disincentives. Therefore, if a subject gave a 3 response to an item, the score was translated into supporting the statement that vocational rehabilitation services assisted

beneficiaries in overcoming work disincentives. If a subject gave a 1 response to an item, the score was translated into a lack of support for the belief that vocational rehabilitation services assisted beneficiaries in overcoming work disincentives. The coding format for all the items is located in Appendix M.

Research Questions and Hypotheses

The research questions and hypotheses that were tested in this study were as follows.

Overall Hypothesis

There is no difference in perceptions of facts and activities between rehabilitation counselors, rehabilitation clients, and advocates as related to the extent that vocational rehabilitation services assist clients in overcoming existing work disincentives. Scores from the Client, Counselor, and Advocate STIP provided data to test this hypothesis.

Statistical Hypothesis:

$H_o: \mu_1 = \mu_2 = \mu_3$

$H_1: \mu_1 \neq \mu_2 \neq \mu_3$

Legend: μ_1 = client group mean

μ_2 = counselor group mean

μ_3 = advocate group mean

In addition to the overall hypothesis, several sub-hypotheses were tested. They were the following:

1. There is no difference in perceptions of facts and activities between rehabilitation counselors, clients, and advocacy organizations as related to the extent that diagnostic services assist clients in overcoming existing work disincentives. Scores from the diagnostic subscale will provide data to test this hypothesis.

2. There is no difference in perceptions of facts and activities between rehabilitation counselors, clients, and advocacy organizations as related to the extent that the process of establishing a vocational goal assist clients in overcoming existing work disincentives. Scores from the vocational counseling subscale will provide data to test this hypothesis.

3. There is no difference in perceptions of facts and activities between rehabilitation counselors, clients, and advocacy organizations as related to the extent that rehabilitation services provided from status 10 to status 22 assist clients in overcoming existing work disincentives (see Appendix N for description of statuses). Scores from the rehabilitation services subscale will provide data to test this hypothesis.

4. There is no difference in perception of facts and activities between rehabilitation counselors, clients, and advocacy organizations as related to the extent that the agency-client relationship assists clients in overcoming existing work disincentives. Scores from the

agency-client subscale will provide data to test this hypothesis.

5. There is no difference in perception of facts and activities between rehabilitation counselors, clients, and advocacy organizations as related to the extent that placement and follow-up services assist clients in overcoming existing work disincentives. Scores from the placement and follow-up services subscale will provide data to test this hypothesis.

In addition to the hypotheses, there were several research questions explored:

1. Does any difference exist in the perceptions of facts and activities between type of vocational rehabilitation counselors, e.g., SSI, SSDI, SSI/SSDI, Generalist and SSI/SSDI, in regard to the extent that vocational rehabilitation services assist clients in overcoming existing work disincentives?

2. Does any difference exist in the perceptions of facts and activities between consumer-managed advocacy organizations and nonconsumer-managed advocacy organizations in regard to the extent that vocational rehabilitation services assist clients in overcoming existing work disincentives?

3. Does any difference exist in the perceptions of facts and activities between clients who were rehabilitated and clients who were not rehabilitated in regard to the

extent that vocational rehabilitation services assist clients in overcoming existing work disincentives?

4. Do counselors, advocates, and clients in fact perceive certain provisions of the Social Security Act as disincentives to work?

Research Designs and Statistical Analyses

For the overall hypothesis, the research design was as shown in Figure 3.1.

G_1 (Clients)	G_2 (Counselors)	G_3 (Advocates)
n = 51	n = 23	n = 23

N = 97

Figure 3.1.--Overall ANOVA, Research Design for the 3 Groups (Clients, Counselors, Advocates)

To test the Overall Hypothesis, the statistical technique of Univariate Analysis of Variance (ANOVA) was used. This technique was used because it is efficient in obtaining a single result that is made up of several dependent variables; as was the case with the STIP, which consisted of six subscales.

The testing of the five sub-hypotheses was performed using Multivariate Analysis of Variance (MANOVA). The multivariate model was used because it is most appropriate

when a study contains multiple dependent measures (Finn, 1974). The multivariate approach attends to the data as a whole, rather than to isolated aspects of the research. For the Overall Hypothesis and the five sub-hypotheses, an alpha level of .05 was chosen to indicate significant differences. When significance was found with any of the hypotheses, post-hoc tests were performed. The post-hoc procedure used was the Scheffé method. The .05 alpha level also was chosen to indicate significant differences in the post-hoc tests.

The STIP was designed to distinguish between clients who were rehabilitated to gainful employment and clients who were not. This determination was made in Item 34. For those clients answering "no" to Item 34, that is, they did not enter into employment as a result of receiving rehabilitation services, placement questions were not asked. Those questions were items 35, 36, 37, 38, 39, 41, 42, 43, and 44. Therefore, all analyses were performed twice. One analysis included all of the clients and excluded the aforementioned items. The other analysis included all of the items, but excluded the clients who answered "no" to Item 34.

Summary

Vocational rehabilitation counselors serving beneficiaries; advocates; and former vocational rehabilitation beneficiaries comprised the subjects for this study.

Each subject was administered the STIP, an instrument developed specifically for this study.

The STIP was designed to measure the extent to which services provided by the state vocational rehabilitation agency assisted SSI/SSDI beneficiaries in overcoming existing work disincentives. The work discincentives under study are related to the rules and regulations which govern the administration of Social Security benefits to individuals with disabling characteristics. Comprehensive content validation and reliability procedures were performed to generate a clear and precise instrument. The STIP, the instrument produced, was the major research instrument used in this study.

The data obtained through the administration of the STIP was used to test the overall research hypothesis, the five sub-hypotheses, and the four research questions. The main statistical procedures used to test the hypotheses and research questions were the univariate and multivariate analysis of variance procedures. When significance was indicated, post hoc procedures were used. The research questions and hypotheses were all related to the services provided by the state vocational rehabilitation agency and Social Security benefits. Presented in Chapter 4 are the results of all analyses performed.

CHAPTER IV

ANALYSIS OF RESULTS

Introductory Statement

Presented in this chapter are the analyses of the data generated by this study. Significant differences were found for the overall research hypothesis and the five sub-hypotheses. To determine the areas contributing to significance, post hoc procedures, as outlined in Chapter III, were performed and are presented here. The analyses of the data pertaining to the four research questions are also provided in this chapter.

The results of data analysis for the overall hypothesis are presented. Results of the five sub-hypotheses tested are then presented. Next are the data analyses for the four research questions. Concluding this chapter is a summary of all the results.

Overall Hypothesis

> There is no difference in perceptions of facts and activities between rehabiliation counselors, rehabilitation clients, and advocates as related to the extent that vocational rehabilitation services assist clients in overcoming existing work disincentives.

Scores from the Client, Counselor, and Advocate Structured Telephone Interview Protocol (STIP) provided data to test this hypothesis.

Statistical Ho: $\mu_1 = \mu_2 = \mu_3$

H_1: $\mu_1 \neq \mu_2 \neq \mu_3$

Tables 4.1 and 4.2 provide the results of the tested overall hypothesis. The statistical procedure used was univariate analysis of variance. Tables 4.1 and 4.2 represent data collected on the total sample of counselors and advocates. The clients used in this analysis are those subjects who answered "yes" to item 34, that is, they did enter into employment as a result of receiving rehabilitation services. Therefore, this analysis comprises those clients who answered all of the items.

Based on the analysis, the overall hypothesis was rejected. It was determined that counselors, clients, and advocates do have a significant difference in perceptions of facts and activities as related to the extent that vocational rehabilitation services assist clients in overcoming existing work disincentives. When signific found, the Scheffe post hoc procedure was performed. The results of the Scheffe identified the counselor group as differing significantly from the client and advocate groups. This procedure was performed using a .05 alpha level.

Tables 4.3 and 4.4 present the analysis for the counselors, advocates, and all the clients. These tables reflect data generated with the placement items excluded.

Table 4.1.--Analysis of Variance for Overall Hypothesis: Comparison of Counselors, Advocates, and Rehabilitated Clients*

Source of Variation	df	Sum of Squares	Mean Square	F Ratio	F Prob
Between Groups	2	1.920	.960	10.476	.0001
Within Groups	72	6.599	.092		
Total	74	8.519			

*Nonrehabilitated clients excluded

Table 4.2.--Groups Statistics of Clients, Counselors, and Advocates for the Overall Research Hypothesis*

Group	N	Mean	Standard Deviation	Standard Error
Client	29	1.84	.423	.079
Counselor	23	2.06	.179	.037
Advocate	23	1.65	.201	.042
Total	75	1.85	.339	.039

*Nonrehabilitated clients excluded

Based on the analysis that included all of the subjects and excluded the placement items, the overall hypothesis was rejected. It was determined that a difference in perceptions regarding the activities of the state vocational

Table 4.3.--Analysis of Variance for Overall Hypothesis: Comparison of Counselors, Advocates, and All Clients*

Source of Variation	df	Sum of Squares	Mean Square	F Ratio	F Prob
Between Groups	2	1.83	.916	9.965	.0001
Within Groups	94	8.64	.092		
Total	96	10.47			

*Placement items excluded

Table 4.4.--Group Statistics of Clients, Counselors, and Advocates for the Overall Research Hypothesis*

Group	N	Mean	Standard Deviation	Standard Error
Client	51	1.83	.377	.053
Counselor	23	2.06	.176	.037
Advocate	23	1.66	.195	.041
Total	97	1.84	.330	.034

*Placement items excluded

rehabilitation agency relating to assisting beneficiaries overcome work disincentives does exist. The Scheffé post hoc procedure identified the Counselor group as differing

significantly from the Advocate and Client groups. This procedure was performed using a .05 alpha level.

Upon finding significance between the groups, the Wilks multivariate test of significance was performed to determine whether the groups differed significantly on any of the STIP subscales. The results of this analysis were:

Approximate F = 2.49

Significance of F = .008

This test was performed on all the subjects with the placement items excluded. With the nonrehabilitated clients excluded and all the items analyzed, the following results were found using the same statistical test:

Approximate F = 2.43

Significance of F = .007

These levels of significance suggested that the groups not only differed on the total STIP, but that they also had significant differences on at least one of the STIP subscales. The five sub-hypotheses were then tested to discern which subscales showed significant differences between the three groups of subjects.

Sub-Hypothesis 1

There is no difference in perceptions of facts and activities between rehabilitation counselors, clients, and advocacy organizations as related to the extent that diagnostic services assist clients in overcoming existing work disincentives.

Scores from the diagnostic subscale provided data to test this hypothesis. Tables 4.5 and 4.6 provide the results of the first tested sub-hypothesis. These tables represent data using all the research subjects. Univariate analysis of variance was the statistical technique performed.

Table 4.5.--Analysis of Variance for Sub-Hypothesis 1 comparing Clients, Counselors, and Advocates on the Diagnostic Subscale*

Source of Variation	df	Sum of Squares	Mean Square	F Ratio	F Prob
Between Groups	2	.984	.492	3.286	.0417
Within Groups	94	14.067	.150		
Total	96	14.051			

*All subjects included

The analysis detailed in Tables 4.5 and 4.6 led to a rejection of the first sub-hypothesis. It can be stated that there is a significant difference between the three groups on the Diagnostic Subscale. To determine which group(s) differed, the Scheffé post hoc procedure was performed at the .05 alpha level. This test showed that there was no significant difference between the advocates and the clients. Also, it was found that there was no significant difference between the clients and the

Table 4.6.--Group Statistics of Clients, Counselors, and Advocates for the Diagnostic Subscale*

Group	N	Mean	Standard Deviation
Client	51	1.81	.419
Counselor	23	1.99	.293
Advocate	23	1.70	.395
Total	97	1.83	.396

*All subjects included

counselors. A significant difference was found between the counselors and the advocates, though.

Tables 4.7 and 4.8 provide the data for the same sub-hypothesis (Diagnostic Subscale) excluding the non-rehabilitated clients. This diagnostic sub-hypothesis excluding the nonrehabilitated clients produced similar results. Significance was found. The counselors and advocates were found to differ significantly, while the client and advocate groups and the client and counselor groups did not.

Table 4.7.--Analysis of Variance for Sub-Hypothesis 1 comparing Clients, Counselors, and Advocates on the Diagnostic Subscale*

Source of Variation	df	Sum of Squares	Mean Square	F Ratio	F Prob
Between Groups	2	.977	.488	3.442	.037
Within Groups	72	10.217	.142		
Total	74	11.194			

*Nonrehabilitated clients excluded in this analysis

Table 4.8.--Group Statistics of Clients, Counselors, and Advocates on the Diagnostic Subscale*

Group	Mean	Standard Deviation	N
Client	1.82	.419	29
Counselor	1.99	.293	23
Advocate	1.70	.395	23
Total	1.83	.389	75

*Nonrehabilitated clients excluded in this analysis

Sub-Hypothesis 2

The second sub-hypothesis consisted of items from the vocational counseling subscale. That hypothesis was:

There is no difference in perceptions of facts and activities between rehabilitation counselors, clients, and advocacy organizations as related to the extent that the process of establishing a vocational goal assists clients in overcoming existing work disincentives.

Tables 4.9 and 4.10 represent the analyzed data for this hypothesis including all the subjects. Tables 4.11 and 4.12 are the analyses for the vocational counseling subscale hypothesis which excludes the clients who were not rehabilitated. As with the preceding hypothesis tested, univariate analysis of variance was the statistical procedure utilized.

Table 4.9.--Analysis of Variance for Sub-Hypothesis 2 comparing Clients, Counselors, and Advocates on the Vocational Counseling Subscale*

Source of Variation	df	Sum of Squares	Mean Square	F Ratio	F Prob
Between Groups	2	2.71	1.35	7.39	.001
Within Groups	94	17.24	.18		
Total	96	19.95			

*All subjects included

Table 4.10.--Group Statistics of Clients, Counselors, and Advocates on the Vocational Counseling Subscale*

Group	Mean	Standard Deviation	N
Client	1.90	.501	51
Counselor	2.25	.293	23
Advocate	1.80	.357	23
Total	1.96	.456	97

*All subjects included

Table 4.11.--Analysis of Variance for Sub-Hypothesis 2 comparing Clients, Counselors, & Advocates on the Vocational Counseling Subscale*

Source of Variation	df	Sum of Squares	Mean Square	F Ratio	F Prob
Between Groups	2	2.66	1.33	6.53	.003
Within Groups	72	14.65	.20		
Total	74	17.31			

*Nonrehabilitated clients excluded from this analysis

Analysis of variance performed with all the subjects and excluding the nonrehabilitated clients showed significant differences which resulted in rejecting this hypothesis. When the Scheffé post hoc procedures were performed, it was

Table 4.12.--Group Statistics of Clients, Counselors, and Advocates on the Vocational Counseling Subscale*

Group	Mean	Standard Deviation	N
Client	1.89	.596	29
Counselor	2.25	.293	23
Advocate	1.80	.357	23
Total	1.97	.484	75

*Nonrehabilitated clients excluded from this analysis

found that in both analyses the counselor group differed significantly from the client and advocate groups.

Sub-Hypothesis 3

> There is no difference in perceptions of facts and activities between rehabilitation counselors, clients, and advocacy organizations as related to the extent that rehabilitation services provided from status 10 to status 22 assist clients in overcoming existing work disincentives (see Appendix N for description of statuses).

Scores from the rehabilitation services subscale provided data for the testing and analysis of this hypothesis. As Tables 4.13, 4.14, 4.15, and 4.16 reflect, this hypothesis was rejected in all analyses. The post hoc procedures had different results, though, depending on whether the nonrehabilitated subjects were included or excluded. When all the subjects were analyzed at once, the Scheffé test identified the counselor group as differing

Table 4.13.--Analysis of Variance for Sub-Hypothesis 3 comparing Clients, Counselors, and Advocates on the Rehabilitation Services Subscale*

Source of Variation	df	Sum of Squares	Mean Square	F Ratio	F Prob
Between Groups	2	5.38	2.69	10.506	.0001
Within Groups	94	24.06	.26		
Total	96	29.44			

*All subjects included

Table 4.14.--Group Statistics of Clients, Counselors, and Advocates on the Rehabiliation Services Subscale *

Group	Mean	Standard Deviation	N
Client	1.82	.601	51
Counselor	2.20	.383	23
Advocate	1.52	.356	23
Total	1.84	.554	97

*All subjects included

Table 4.15.--Analysis of Variance for Sub-Hypothesis 3 comparing Clients, Counselors, and Advocates on the Rehabilitation Services Subscale*

Source of Variation	df	Sum of Squares	Mean Square	F Ratio	F Prob
Between Groups	2	5.37	2.69	11.13	.0001
Within Groups	72	17.38	.24		
Total	74	22.75			

*Nonrehabilitated clients excluded

Table 4.16.--Group Statistics on the Rehabilitation Services Subscale*

Group	Mean	Standard Deviation	N
Client	1.91	.637	29
Counselor	2.20	.383	23
Advocate	1.52	.356	23
Total	1.88	.555	75

*Nonrehabilitated clients excluded

significantly from the client and advocate groups. Excluding the nonrehabilitated subjects from the analysis made the advocate group differ significantly from the counselor and client groups.

Sub-Hypothesis 4

The fourth sub-hypothesis concerning the relationship between the client and the vocational rehabilitation agency was as follows:

> There is no difference in perception of facts and activities between rehabilitation counselors, clients, and advocacy organizations as related to the extent that the agency-client relationship assists clients in overcoming existing work disincentives.

Univariate analysis of variance was performed on the data generated from the agency-client relationship subscale scores. The testing of the hypothesis led to rejections for analyses including and excluding the nonrehabilitated subjects. The Scheffé post hoc procedures were also similar for both analyses. The advocate and client groups did not differ significantly, nor did the client and counselor groups. Significant differences did occur, though, between the counselor and advocate groups. The analysis of the data generated to test this sub-hypothesis is located in Tables 4.17, 4.18, 4.19, and 4.20.

Table 4.17.--Analysis of Variance for Sub-Hypothesis 4 comparing Clients, Counselors, and Advocates on the Agency-Client Relationship Subscale*

Source of Variation	df	Sum of Squares	Mean Square	F Ratio	F Prob
Between Groups	2	3.78	1.90	6.98	.0015
Within Groups	94	25.57	.27		
Total	96	29.37			

*All subjects included

Table 4.18.--Group Statistics of Clients, Counselors, and Advocates on the Agency-Client Relationship Subscale*

Group	Mean	Standard Deviation	N
Client	1.96	.635	51
Counselor	2.28	.282	23
Advocate	1.71	.409	23
Total	1.98	.553	97

*All subjects included

Table 4.19.--Analysis of Variance for Sub-Hypothesis 4 comparing Clients, Counselors, and Advocates on the Agency-Client Relationship Subscale*

Source of Variation	df	Sum of Squares	Mean Square	F Ratio	F Prob
Between Groups	2	3.77	1.88	7.353	.0012
Within Groups	72	18.45	.26		
Total	74	22.22			

*Nonrehabilitated subjects excluded

Table 4.20.--Group Statistics of Clients, Counselors, and Advocates on the Agency-Client Relationship Subscale*

Group	Mean	Standard Deviation	N
Client	1.99	.682	29
Counselor	2.28	.282	23
Advocate	1.71	.409	23
Total	2.00	.548	75

*Nonrehabilitated subjects excluded

Sub-Hypothesis 5

There is no difference in perception of facts and activities between rehabilitation counselors, clients, and advocacy organizations as related to the extent that placement and follow-up services assist clients in overcoming existing work disincentives.

Scores from the placement and follow-up services subscale were used to test this hypothesis. The subjects in the client group who answered item 34, "no," that is, they did not enter into employment as a result of rehabilitation services, did not respond to the remainder of the items in this subscale. Therefore, unlike the other hypotheses analyzed, there is only one analysis for this subscale. That analysis reflects the data generated by the subjects with the nonrehabilitated clients excluded. Based on the analysis of this data, as reported in Tables 4.21 and 4.22, this hypothesis was rejected. Upon performing the post hoc procedures, it was determined that advocates and clients did not differ from each other, nor did the clients and the counselors. It was found, though, that the counselors and advocates differed significantly from each other.

Research Questions

Four research questions were explored in this study. Following is the analysis of data related to these questions.

Table 4.21.--Analysis of Variance for Sub-Hypothesis 5 comparing Clients, Counselors, and Advocates on the Placement and Follow-up Services Subscale*

Source of Variation	df	Sum of Squares	Mean Square	F Ratio	F Prob
Between Groups	2	2.14	1.07	8.27	.0006
Within Groups	72	9.30	.13		
Total	75	11.44			

*Nonrehabilitated clients excluded

Table 4.22.--Group Statistics of Clients, Counselors, and Advocates on the Placement and Follow-up Services Subscale*

Group	Mean	Standard Deviation	N
Client	1.78	.414	29
Counselor	2.01	.314	23
Advocate	1.59	.325	23
Total	1.80	.393	75

*Nonrehabilitated clients excluded

1. Does any difference exist in the perceptions of facts and activities between type of vocational rehabilitation counselors, e.g., SSI, SSDI, SSI/SSDI, Generalist and SSI/SSDI, in regard to the extent that vocational rehabilitation services assist clients in overcoming existing work disincentives.

The univariate analysis of variance as reported in Table 4.23 shows that no significant differences between counselor types does exist.

Table 4.23.--Analysis of Variance for Research Question 1 comparing Michigan Bureau of Rehabilitation Counselor Primary Caseload Types

Source of Variation	df	Sum of Squares	Mean Square	F Ratio	F Prob
Between Groups	3	.005	.002	.043	.988
Within Groups	19	.697	.037		
Total	22	.702			

The Wilks multivariate test of significance was performed on the counselor data. The findings were that no statistically significant differences existed between types of counselors on any of the subscales. The Wilks multivariate test of significant outcomes was:

Approximate F = 1.467
Significance of F = .155

Table 4.24 provides the results of the analysis of variance for each subscale, and Table 4.25 presents the results of the group data generated for this question.

Table 4.24.--Analysis of Variance for STIP Subscales for the Different Types of Vocational Rehabilitation Counselors*

Subscale	F Ratio	Prob of F
Diagnostic	.648	.594
Rehabilitation Services	1.370	.282
Client-Agency Relationship	1.262	.316
Placement and Follow-up	1.369	.283
Vocational Counseling	.040	.989
Miscellaneous	.803	.507

*The counselor types were: SSI, SSDI, SSI/SSDI, Generalist and SSI/SSDI

2. Does any difference exist in the perceptions of facts and activities between consumer-managed advocacy organizations and nonconsumer-managed advocacy organizations in regard to the extent that vocational rehabilitation services assist clients in overcoming existing work disincentives?

Univariate analysis of variance procedures showed that no statistically significant differences exist between

Table 4.25.--Group Statistics of SSI, SSDI, SSI/SSDI, and Generalist & SSI/SSDI Counselors

	SSI		SSDI		SSI/SSDI		Generalist & SSI/SSDI		Total	
Subscale	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Diagnostic	2.10	.190	1.83	.236	2.03	.414	1.96	.278	1.99	.293
Rehabilitation Services	2.47	.361	2.25	.441	2.17	.447	2.04	.278	2.20	.383
Client-Agency Relationship	2.37	.274	2.04	.438	2.33	.258	2.31	.188	2.28	.282
Placement and Follow-up	1.80	.200	2.10	.294	1.98	.366	2.14	.316	2.02	.314
Vocational Counseling	2.22	.342	2.23	.239	2.26	.305	2.27	.333	2.25	.293
Miscellaneous	1.68	.137	1.88	.308	1.72	.240	1.81	.177	1.77	.211
	n = 5		n = 4		n = 6		n = 8		N = 23	

types of advocates when compared on the total STIP scores. Table 4.26 outlines these results.

Table 4.26.--Analysis of Variance for Research Question 2: Comparison of Advocate Organizational Management Structures in Michigan on the STIP

Source of Variation	df	Sum of Squares	Mean Square	F Ratio	F Prob
Between Groups	1	.045	.045	1.12	.302
Within Groups	21	.847	.040		
Total	22	.892			

Wilks multivariate test of significance was:

Approximate F = 1.99

Significance of F = .123

Table 4.27 provides the results of the analysis of variance procedures for each subscale, and Table 4.28 contains the results of the group data analyzed in this study for this question.

3. Does any difference exist in the perceptions of facts and activities between clients who were rehabilitated and clients who were not rehabilitated in regard to the extent that vocational rehabilitation services assist clients in overcoming existing work disincentives?

Table 4.27.--Analysis of Variance for STIP Subscales of Different Types of Advocacy Organizational Management*

Subscale	F Ratio	Prob of F
Diagnostic	.633	.435
Rehabilitation Services	2.994	.098
Client-Agency Relationship	1.128	.300
Placement and Follow-up	.067	.798
Vocational Counseling	4.154	.053
Miscellaneous	.003	.958

*Organizational management was either consumer-managed or not consumer-managed

Univariate analysis of variance procedures showed that no significant differences existed between the rehabilitated and nonrehabilitated groups. Tables 4.29 and 4.30 show that significance was found on the STIP for the main effect of geographic area. The clients did differ on their perceptions from one geographical area to the next. The Scheffé post hoc procedure performed at .05 alpha level showed that clients interviewed in Lansing differed from the clients interviewed in the two other areas--Ann Arbor and Detroit.

Table 4.28.--Group Statistics for Advocacy Organizational Management Structure: Consumer-Managed or Not Consumer-Managed

	Consumer-Managed		Not Consumer-Managed		Total	
Subscale	Mean	SD	Mean	SD	Mean	SD
Diagnostic	1.70	.454	1.50	.289	1.67	.401
Rehabilitation Services	1.48	.339	1.83	.289	1.52	.349
Client-Agency Relationship	1.68	.415	1.94	.192	1.72	.401
Placement and Follow-up	1.59	.337	1.53	.208	1.58	.320
Vocational Counseling	1.75	.331	2.17	.300	1.81	.350
Miscellaneous	1.58	.116	1.58	.167	1.58	.119
	n = 20		n = 3		N = 23	

Further analysis of the client subjects by area revealed that the three groups differed on the Diagnostic, Rehabilitation Services, and Client-Agency Relationship subscales. Tables 4.31 and 4.32 provide these results. It can be seen that on the three subscales where significance was found, clients in the Lansing area consistently had the lowest mean scores.

Table 4.29.--Analysis of Variance for Research Question 3 Comparison of Rehabilitated and Nonrehabilitated Subjects

Source of Variation	df	Sum of Squares	Mean Square	F Ratio	F Prob
Main Effects	3	1.439	.480	3.872	.015
Area	2	1.388	.694	5.600	.007
V34*	1	.043	.043	.349	.558
2-Way Interact	2	.177	.089	.716	.494
Area-V34	2	.177	.089	.716	.494
Explained	5	1.617	.323	2.610	.038
Residual	45	5.452	.124		
Total	50	7.069	.144		

*V34 was the item that identified the client subjects as either employed or not employed as a result of receiving vocational rehabilitation services.

Table 4.30.--Group Statistics of Lansing, Ann Arbor, and Detroit Client Subjects for Research Question 3 comparing Clients on the STIP*

Area	Mean	Standard Deviation	N
Lansing	1.61	.329	18
Ann Arbor	1.94	.349	26
Detroit	2.01	.389	7
Total	1.83	.377	51

*Placement items excluded

Table 4.31.--Analysis of Variance for Subscales comparing Client Subjects according to the Geographical Areas of Lansing, Ann Arbor, and Detroit*

Subscale	F Ratio	Prob of F
Diagnostic	4.164	.022
Rehabilitation Services	4.460	.017
Client-Agency Relationship	6.238	.004
Placement and Follow-up**	1.042	.367
Vocational Counseling	2.834	.070
Miscellaneous	2.258	.117

*All client subjects included
**For rehabilitated clients only

4. Do counselors, advocates, and clients, in fact, perceive certain provisions of the Social Security Act as disincentives to work?

This research question was analyzed using simple measures of central tendency, e.g., mean and standard deviation, for the subjects' responses to items 48, 51, 52, 53, 54, and 56. As was explained in Chapter 2, most items had three foils that were weighted on a continuum from 1 to 3, with 3 being a high or positive score, and 1 representing a low or negative score. In relation to the items used for analysis in this research question, low scores reflected that the provisions of the Social Security Act did, in fact, serve as disincentives to employment,

Table 4.32.--Group Statistics of Client Subjects in Lansing, Ann Arbor, and Detroit for Research Question 3*

Subscale	Lansing Mean	Lansing SD	Ann Arbor Mean	Ann Arbor SD	Detroit Mean	Detroit SD	Total Mean	Total SD
Diagnostic	1.61	.342	1.94	.436	1.98	.378	1.83	.412
Rehabilitation Services	1.52	.584	1.96	.486	2.12	.685	1.83	.605
Client-Agency Relationship	1.57	.495	2.15	.603	2.26	.745	1.96	.641
Vocational Counseling	1.68	.412	1.99	.513	2.12	.530	1.90	.506
Placement and Follow-up**	1.63	.411	1.86	.400	1.87	.513	1.78	.414
Miscellaneous	1.61	.284	1.78	.291	1.77	.266	1.72	.300
Total	1.60	.421	1.94	.455	2.02	.519	1.83	.479
	n = 18 (10)		n = 26 (16)		n = 7 (3)		n = 51 (29)	

* All clients included

** Rehabilitated clients only

while scores of three translated into there not being a disincentives effect. A score of two represented a neutral effect.

Table 4.33 shows that for items 48, 51, 52, and 56 the mean scores were low. Summarizing, these items were as follows:

Item 48: The concern beneficiaries have regarding losing benefits.

The scores show that clients, counselors, and advocates believe there is concern by beneficiaries.

Item 51: The importance of Social Security financial payments.

All three groups felt that this was very important, with the counselor group expressing unanimity on this item.

Item 52: The importance of Medicare and Medicaid.

All three groups felt that this benefit was an important one, with the counselor group again expressing unanimity.

Item 56: Asked if more people would return to work if benefits would not be terminated.

All three groups believed that more people would return to work if benefits would not be terminated.

For items 53 and 54, the groups had more favorable responses, especially the clients. These items concerned

Table 4.33.--Group Statistics of Clients, Counselors, and Advocates for Research Question 4: Are Social Security Provisions Disincentives to Work?

Item	Client		Counselor		Advocate		Total	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
48	1.61	.802	1.30	.559	1.17	.491	1.43	.706
51	1.22	.503	1.00	.000	1.04	.209	1.12	.389
52	1.47	.783	1.00	.000	1.04	.209	1.26	.617
53	2.17	.910	1.74	.810	1.74	.864	1.97	.900
54	2.22	.901	1.96	.976	1.35	.647	1.95	.928
56	1.22	.541	1.21	.600	1.09	.288	1.19	.507
	n = 51		n = 23		n = 23		N = 97	

the importance of food stamps (item 53) and rent supplements (item 54). It can be said that the loss of these benefits is not of as great concern to beneficiaries and, therefore, does not have the disincentives effect that the other benefits carry. It should be noted that these two benefits are not administered by the Social Security Administration, although SSI and SSDI beneficiaries commonly receive them. These benefits stand to be reduced or terminated upon entering into gainful employment. Table 4.33 shows the results of the analysis for this research question.

Summary of Results

For this study, data was generated to test an overall hypothesis and five sub-hypotheses, and to answer four research questions. The results of the data analysis are:

1. Significant differences were found between vocational rehabilitation counselors, clients, and advocates as to their perceptions of facts and activities related to the extent that vocational rehabilitation services assist clients in overcoming existing work disincentives. This resulted in the rejection of the overall hypothesis.

2. Overall, vocational rehabilitation counselors believed that vocational rehabilitation services had a slightly better than neutral effect on assisting beneficiaries in overcoming disincentives to work. This contrasted with the client and advocate groups whose

perceptions showed that vocational rehabilitation services did not assist beneficiaries in overcoming existing work disincentives.

3. Significant differences were found on all five sub-hypotheses. These sub-hypotheses related to the different subscales of the STIP: diagnostic services, vocational counseling, rehabilitation services, agency-client relationship, and placement and follow-up services. These results led to the rejection of the five sub-hypotheses.

4. Four research questions were explored in this study. The analysis of the data showed that:

a. No differences exist in the perceptions of facts and activities between type of vocational rehabilitation counselors: SSI, SSDI, SSI/SSDI, Generalist and SSI/SSDI, in regard to the extent that vocational rehabilitation services assist clients in overcoming existing work disincentives.

b. No differences exist between advocates from consumer-managed or nonconsumer-managed advocacy organizations on the overall hypothesis.

c. No differences exist between rehabilitated and nonrehabilitated clients on the overall hypothesis, although significant differences were found according to geographic location of the client subjects. Post hoc procedures showed that clients from the Lansing area consistently had lower scores on the STIP, representing more negative results.

d. Counselors, advocates, and clients do, in fact, perceive certain provisions of the Social Security Act as disincentives to work.

CHAPTER V

DISCUSSION

Summary

In recent years, vocational rehabilitation, as administered through the state vocational rehabilitation agency, has greatly expanded services. This expansion has allowed for the eligibility for vocational rehabilitation services to persons with severe disabling characteristics. Prior to this legislative change, many severely handicapped persons applied for and received Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI) and remained in a beneficiary status for life. With the increase of services, SSI/SSDI beneficiaries have a greater opportunity to become rehabilitated and participate in gainful employment, yet many still choose not to work. For them, the basis of this decision is closely tied to rules and regulations in the Social Security Act which terminate cash and in-kind benefits to recipients when they participate in employment. In short, beneficiaries who want to work are faced with work disincentives that are contributed to by Social Security legislation. Therefore, despite rehabilitation legislation, which on the surface seems to be totally positive, conflicting laws have resulted with the potential

rehabilitation client being placed in a bureaucratic process that appears to be even more confusing and irrational than ever before.

Many reputable individuals and organizations, along with beneficiaries themselves, have recognized the magnitude of this problem. With this recognition, there have been calls for investigations and further research to study the issue and to develop suggestions for rectifying policies and regulations. The intent of this study was to respond to the need for further investigation into the work disincentives problem. Intending to complement previous findings, which primarily focused on Social Security legislation and/or the demographic or psychological characteristics of beneficiaries, this study researched the Federal-State Vocational Rehabilitation Program's activities which affect SSI and SSDI recipients. Additionally, the intent of this study was to acknowledge and support the spirit of recent rehabilitation legislation which encourages and mandates substantial consumer involvement in all aspects of the rehabilitation program.

The primary purpose of this research was to investigate the questions:

1. To what extent do the activities of the state vocational rehabilitation program assist SSI and SSDI beneficiaries in overcoming existing work disincentives?

2. Are there certain rehabilitation activities, such as diagnostic services, vocational counseling, rehabilitation

services, the agency-client relationship, and follow-up and placement services that have a greater impact on assisting beneficiaries to overcome work disincentives than other activities?

3. Is there a difference of perceptions among counselors, clients, and advocates as related to the extent that the state vocational rehabilitation agency assists beneficiaries in overcoming existing work disincentives?

4. Do vocational rehabilitation counselors, clients, and advocates, in fact, perceive certain provisions of the Social Security Act as disincentives to work?

To examine these questions, vocational rehabilitation counselors employed by the Michigan Bureau of Rehabilitation, advocates working in Michigan, and former clients of vocational rehabilitation services who were receiving SSI and/or SSDI at the time of their rehabilitation activities were selected as subjects for the research. Each subject was administered the Structured Telephone Interview Protocol (STIP), a questionnaire developed specifically for this study.

The STIP was designed to examine the major activities of the state vocational rehabilitation agency as they relate to assisting beneficiaries overcome work disincentives. To do this, the STIP consisted of six subscales, five of which related to major vocational rehabilitation activities, and one subscale comprised of questions concerned with benefits and their importance to SSI/SSDI recipients.

Upon completing all the interviews, the subjects' responses to the STIP were coded and scored. This data was then analyzed to test the major research hypotheses and questions. The primary statistical procedure used in the analyses was the multivariate analysis of variance. When statistically significant differences were found, the Scheffé post hoc procedure at the .05 alpha level was performed.

As a result of the analyses performed, the following was found:

1. Vocational rehabilitation counselors, clients, and advocates do differ in their perceptions of facts and activities as related to the extent that vocational rehabilitation services assist clients in overcoming work disincentives.

2. The differences in perceptions of facts and activities generally were due to counselors viewing rehabilitation services as more helpful in assisting beneficiaries to overcome work disincentives than was viewed by clients and advocates.

3. Overall, the subjects believed that rehabilitation services had a negligible effect on assisting beneficiaries to overcome disincentives to work.

4. Of all the activities commonly conducted by the state vocational rehabilitation agency, the working relationship between the agency (primarily the counselor) and the client was perceived as being more helpful than other

activities in assisting beneficiaries in overcoming work disincentives.

5. Benefits provided by Social Security, especially the financial payments and medical insurance, are very important to beneficiaries. The importance of these benefits is so paramount that some beneficiaries do not work in order to continue receiving them. The conclusion is that disincentives to work do exist.

Discussion of Results

As shown previously and now in this study, work disincentives exist, and the result is that people do not maximize their potential, nor function to the extent of their capabilities. The state vocational rehabilitation agency has the responsibility for rehabilitating to gainful employment SSI and SSDI recipients, but, as found in this study, work disincentives impose too great a barrier. The impediments to work are not easily eliminated or reduced by rehabilitation counselors, who function under tight budgetary constraints.

Due to the nature of rehabilitation services which necessitates a short-term finite process, comprehensive rehabilitation services generally do not take place. This, in part, may explain the consistently low scores on the STIP. Highlights from a few of the items elucidate the negative effects of short-term services in overcoming work disincentives.

Seventy-two percent of all respondents either reported or perceived earnings of rehabilitated beneficiaries to be less than $125 a week. This finding supports national averages detailed in the second chapter. This dollar amount, when computed for a 40-hour work week, does not reach the minimum wage level. Not only were the wages low, but 52% of the subjects said that the jobs that beneficiaries are rehabilitated to allow for very little advancement. Consistent with this finding is the type of jobs into which beneficiaries are commonly rehabilitated. Fifty-nine percent of the respondents stated that beneficiaries are usually rehabilitated to jobs in either the services occupation (janitor, housekeeper) or other semi-skilled occupations. SSI and SSDI benefits, being at the levels they are, although not high by any standard, still provide a degree of economic security that may be lacking in low-level jobs with little or no advancement and below minimum wage salaries.

Despite these seemingly gloomy figures, 71% of the clients, 91% of the counselors, and 95% of the advocates all expressed the view that beneficiaries should be given the recommendation to apply for vocational rehabilitation services. This suggests that although the state vocational rehabilitation agency does not necessarily assure beneficiaries that they will overcome disincentives and obtain high level employment at a good wage, the subjects

still believed that rehabilitation services were worth giving consideration.

A significant finding of this study was that the respondents saw the agency-client relationship as the most helpful area in assisting beneficiaries to overcome disincentives. This finding should be considered in light of a discussion regarding caseload size. It is extremely common to sit down with a group of vocational rehabilitation counselors any place in the United States and have the topic of caseload size emerge. The complaint is that with caseloads of 100 plus, a quality job just cannot be done. Di Michael (1973) discussed this quality-versus-quantity issue, as had Newman (1972) the former Commissioner of Rehabilitation Services Administration, to name just a few. As Commissioner of Rehabilitation Services Administration, in speaking of the vocational rehabilitation/public assistance programs, it was Newman's feeling that successful rehabilitation is more likely to take place when counselors have a maximum caseload size of 50. With smaller caseloads, the relationships, which in this study were seen as helpful, could be enhanced. It is also interesting to note that with the plethora of services that can be provided through the state vocational rehabilitation agency, the personal contact, which usually takes place on a one-to-one basis between the counselor and the client, was seen as the most beneficial service. The implications of this finding may be worth noting in future policy decisions

regarding the allocation of money and personnel. At least in terms of the rehabilitation of SSI and SSDI beneficiaries, money may be better spent in the personnel area than on case service line items. It should also be noted that when emmersed in a bureaucratic and complex system, as beneficiaries often find themselves, the human contact with counselors may have great significance on the beneficiary's desire to continue in a rehabilitation program.

Making counselors more available en masse is not enough to assure the overcoming of work disincentives. Rehabilitation professionals must be competent, knowledgeable, and communicatively clear. This study found that vocational rehabilitation counselors were knowledgeable as to the rules that govern trial work period and substantial, gainful employment. Ninety-one percent of the counselors correctly described what a trial work period was, and 85% of them knew what substantial, gainful activity was. This compared favorably to the advocate group, where 79% could correctly define these two regulations. The knowledge that counselors have is not clearly reaching the clients, though. Forty-four percent of all the subjects stated that rehabilitation counselors did not explain the effects of work on benefits very clearly, while only 28% said that it was explained "very clearly."

It is important to recognize that vocational rehabilitation counselors do not have the only responsibility for informing beneficiaries of the rules and regulations that

affect their benefits when they become rehabilitated. Certainly, the Social Security Administration has a duty to inform beneficiaries as to the rules and regulations in a clear and simple manner. Unfortunately, as was the experience of this researcher in attempting to understand the myriad of complex laws and regulations governing benefits, this is not routinely done.

Another finding of this study involved the difference in perceptions of facts and activities that exist between counselors, clients, and advocates as related to the extent that vocational rehabilitation services assist beneficiaries in overcoming work disincentives. Counselors felt that rehabilitation services provided more assistance than was perceived by the clients, and the advocates perceived rehabilitation services as providing the least amount of assistance to beneficiaries' attempts at overcoming disincentives. These differences could be attributable to many reasons, such as:

1. It is reasonable that counselors take pride in their work and see what they and the agency do in a more positive light than people outside of the agency. It seems to be a natural human trait to feel what is being done is significant. This is similar to the phenomenon that results in loyalty to a school, community, geographical location, or nation.

2. The advocates consistently had the lowest scores. This could be due to the fact that it is the nature of their

job to be critical and find problems with the system in the interest of increasing the quality of services.

3. Advocate organizations were established as part of the consumer and self-help movements. This was in response to a dissatisfaction with the existing professional agencies (DeJong, 1979). As a result of these movements, there has emerged a long history of seeing state agencies in a negative light. This attitude may influence their perceptions of all areas of state agency activity.

4. Advocates are usually called upon when there are problems. This may account for the differences in perceptions between counselors and advocates. While advocates see the negative side of what is going on and, therefore, have reason to be negative, it is not the viewpoint of counselors who have access to all types of agency activities, some of which result in positive outcomes.

5. Some of the low client scores may be due to the nature of asking for help. In this society, autonomy and independence are appaluded, while recipients are demeaned. The denigrating experience of being a client may have negatively affected the clients' overall perceptions of human service agencies.

6. The final reason causing the differences may be due to counselors not being sensitive enough to the unmet needs of their clients. With large caseloads, pressures from the agency, and forever-changing policies, counselors may not be taking the necessary time to reflect upon and

critique what they do, and what the existing service gaps are. In addition to this, they may not feel powerful enough to do anything about the problems which they feel exist in the agency. In a way, they feel as bureaucratized (Lasch, 1979) and controlled as do the clients.

The other significant finding of this study supported what has been researched and expressed by many, that is, the structure of the SSI and SSDI benefit system does create disincentives to work. It was found in this study that nearly 70% of all respondents felt that beneficiaries become very concerned about losing benefits when they are involved in a rehabilitation program. Of the benefits received, 52% felt that the financial assistance was the most important one, while 37% said that the medical coverage provided was the most important benefit. The counselors and advocates saw medical benefits as being the most important to beneficiaries. This was demonstrated statistically, along with an informal assessment done by the interviewers, who noted that when asked the importance of Medicare or Medicaid many respondents replied with an emphatic "very important." It was interesting to find, though, that clients felt that the financial payments were more important to them than the medical coverage.

To further emphasize the disincentive nature of the benefit system, 87% of all respondents stated that it was their feeling that more people would return to work if all benefits would not be terminated. The significance of

this finding may help explain the overall low national level of rehabilitations with SSI and SSDI beneficiaries, as was pointed out in Chapter Two. Given the notion that economic security is so crucial to people and compound that with the provisions of the Social Security Administration, it may very well be that no matter what the quality of rehabilitation services is, the disincentives are just too great for some people to want to risk returning to work.

The final item of the STIP was an open-ended question asking the respondents if they would like to make any additional comments about the vocational rehabilitation of beneficiaries. Seventy-eight (80.4%) of the 97 respondents had comments to make. Although there was no coding of these comments nor any statistical analysis of the response to this question, some summary statements related to this item may prove to be quite elucidating. What follows are a few such summary statements.

1. There are huge gaps in the system with no real transition between government dependence, government support, and independence and self-sufficiency.

2. A sentiment expressed repeatedly by vocational rehabilitation counselors was that a beneficiary works very hard, sometimes for years, to convince Social Security that they are permanently and totally disabled. When they (the claimant) finally receive benefits, they are referred to vocational rehabilitation where the goal is to get them to work and have their benefits terminated. This

immediately establishes an adversary relationship between the vocational rehabilitation counselor and the beneficiary. The counselor is seen as a threat to all the effort expended by the beneficiary.

3. Counselors also expressed the concern that beneficiaries, while applying for SSI and SSDI have spent a lot of time convincing everyone that they cannot work. By the time they get referred to vocational rehabilitation, they are certain that work is just not feasible. The counselor then must spend a lot of time trying to reverse that mind set. Frequently, counselors say, they are unsuccessful in doing so.

4. It was not uncommon for clients to state that they had been assigned to several counselors over the time of their rehabilitation. Twelve clients reported that they had been assigned to five or more counselors. The client subjects felt that this was confusing because they would have to retell their "story," frequently there would be large gaps of time elapsing between counselor assignments, and the policies of the agency would seem to change with the counselors.

5. As demonstrated by their scores on the STIP, the advocates generally did not have many positive comments to make about vocational rehabilitation services. The competence and commitment of counselors was repeatedly questioned by the advocates. Advocates were concerned that in-depth career counseling did not take place. In fact, one advocate

working for an organization that primarily is involved with a single disability group was incredulous that 13 of her last 14 referrals to vocational rehabilitation had been rehabilitated to be accountants.

6. Counselors were of the general sentiment that they did as good a job as could be expected given all the problems and constraints. Many counselors felt that if they only had more time with clients they could rehabilitate a lot more people.

7. Frequently expressed by counselors, advocates, and clients was the feeling that reliable and precise information was exceedingly difficult to get from the Social Security Administration.

8. For some clients, participating in a vocational rehabilitation program was a positive experience. They felt a real caring from the counselors, and believed that they were much better off as a result of their rehabilitation program. Other clients, though, did not distinguish rehabilitation services from other "government" agencies. They felt as if they were treated as a number, and that no one really cared what happened to them.

9. There were several client reports which this researcher classified as "horror stories." It was not uncommon for the client subjects to relate experiences where governmental agencies acted unethically, if not illegally. In one case a beneficiary tried to return money to Social Security, because she felt that her trial

work period was over. For 18 months, despite her continued efforts to have Social Security stop her checks, the over-payments continued. When Social Security finally accepted their mistake, the woman no longer had the money, and the beneficiary's widowed mother had her Social Security check reduced in order for the Social Security Administration to recoup for its mistake.

Disincentives: A Macro View

All societal laws, rules, and regulations stem from beliefs that women and men hold as important. The ideologies that stimulate and support laws may be religious, non-sectarian, or economic, and as is in most cases, there is great overlap. More frequently than not, laws which stem from ideologies represent great compromises. As an outcome, society has become filled with contradictions. The Manson murders were seen as horrifying to all, yet soldiers returning with Viet Cong teeth made into necklaces were treated as heroes. Small businesses have steadily declined since the turn of the century due to a seemingly free-to-choose, free-to-survive, and free-to-fail economic system; yet a major American corporation was recently rescued, with the help of the Federal government, from bankruptcy with funds amounting to nearly 45% of the total Supplemental Security Income budget. President Carter (1980) recently proposed providing guaranteed loans to car dealers ($600,000,000), equaling approximately two-thirds the

amount budgeted for the administration and execution of the Rehabilitation Act. The same government which provides large subsidies to the tobacco industry also mounts a national campaign to alert people to the dangers of smoking.

The laws and policies which affect SSI and SSDI recipients are no exception to these contradictions. Human services do exist in this country. This originates from the belief that it is appropriate and morally right to insure individuals in society some basic standard of living. This enables the often-experienced alienation from others, the environment, and the self to be minimized. Human services theoretically has as its aim the provision of services that provide for feelings of security, comfort, belonging, usefulness, meaning, and competence, which are important in all areas of existence, including politics, culture, leisure, personal encounters, and work (Pearls, 1973). Simultaneously, the political debates which generate laws and policies give consideration to economics and "fiscal responsibility." This was exemplified in a recent letter from Russell B. Long, Chairman of the Senate Committee on Finance (1980). In discussing bills relating to Social Security Act disability programs, Senator Long stressed that, "One element of both versions (of Social Security legislation) is designed to assure that the benefits disabled persons receive are not substantially more than the wages they earned when employed." These types of assurances come into direct conflict with the rehabilitation philosophy.

Townsend (1966) reported that in 1943 the National Council on Rehabilitation defined rehabilitation as "the restoration of the handicapped to the fullest physical, mental, social, and economic usefulness of which they are capable." Consistent with this mission statement is the Rehabilitation, Comprehensive Services and Developmental Disabilities Legislation (1978) which exists "to meet the current and future needs of handicapped individuals, so that such individuals may prepare for and engage in gainful employment to the extent of their capabilities." Both of these expressions concern the maximization of human potential, the particiaption of handicapped people into the mainstream of society, and the right of handicapped people to live a productive and contributing life.

This philosophy of maximization has the potential of affecting large numbers of people. Studies conducted by Nagi (1976) and Krute and Burdette (1978) showed that nearly 10% of all adults in the United States were considered to be severely or substantially limited in physical performance. It was also found that more than 15 million people were limited in their ability to work because of chronic health conditions and impairments (HEW, 1977). Despite these large numbers of people and a humanistic rehabilitation philosophy, the provisions found in the Social Security Act place great limitations on individuals' ability to grow. Therefore, instead of participating in productive and meaningful activities, people with

disabilities maintain the demeaning role of being a recipient at an annual public expenditure of $11.5 billion for SSDI and $3.4 billion for SSI (Berkowitz, 1980).

The remediation of the disincentives problem has not come easily. In his summary of recent Congressional initiatives relating to Social Security Act programs, Nelson (1980) pointed out that there have been over 70 bills introduced recently to change some part of the Social Security disability programs. Nelson grouped these proposed changes into three categories:

1. Funding: These proposals were in response to the increase in Social Security payroll taxes enacted in 1977.

2. Administration: These proposals addressed the five-month waiting period for disability insurance benefits, eliminating gender-based distinctions in benefit awards, and requirements for better qualifications and training for disability examiners.

3. Payments: In this area proposals related to either increasing or decreasing benefit payments.

In summarizing all these Congressional proposals, Nelson stated that, "Legislation may neither improve work disincentives nor reduce Federal expenditures" (p. 123). In short, there would be great bureaucratic transferring of responsibilities, yet no substantive changes.

As a result of the Humphreys-Rivers evaluation activity (1978) described in Chapter Two, several corrective initiatives in the rehabilitation programs for SSI and SSDI

beneficiaries were made. A few of the initiatives were:

1. Plans for joint training of Social Security Administration (SSA) and Rehabilitation Services Administration (RSA) workers.

2. RSA and SSA will ensure that claimants have a thorough understanding of Rehabilitation Services.

3. RSA will evaluate the administrative functioning of the SSI/SSDI coordinators in the state vocational rehabilitation agencies.

4. RSA will evaluate the utilization of SSI/SSDI rehabilitation counseling staff.

5. RSA will perfect data measurement capabilities.

6. An RSA task force will improve certain reporting systems, such as the R-300. (HEW, 1978)

As with the Congressional proposals summarized by Nelson (1980) these corrective initiatives appear to address some minor alterations in the SSA and RSA system rather than major systemic changes.

One type of legislation that could do more than transfer programs and responsibilities throughout the Federal government would be the enactment of a comprehensive national health insurance program. As was shown in this study, medical benefits are very important to beneficiaries. When a chronic condition exists, the beneficiary knows that medical attention, supplies, and hospitalization will always be a great expense. Out of fear of losing this

benefit, a decision to not work may take place. With a guaranteed national health insurance program, one concern and disincentive would be eliminated.

Rejda (1976) pointed out that, "the United States is one of the few advanced nations in the world that does not have some form of national health insurance covering its citizens" (p. 253). In stating the reasons for a national health insurance policy, Rejda pointed out that:

1. It is a basic right of all to have medical care.

2. The present health care delivery system is in need of reform.

3. The poor in this country should not be subjected to inferior medical care.

4. A national health insurance could contribute to a general redistribution of income (p. 253).

Dorken and LaRocca (1977) joined Rejda in calling for a national health insurance policy. They saw the mandating by Congress for vocational rehabilitation to serve persons with severe handicaps as being closely tied to the need for a national health insurance policy. Not only would a national health insurance policy be of great relief to the vocational rehabilitation client, Dorken and LaRocca believe that it would free up some state vocational rehabilitation funds customarily used for medical expenses. They saw a comprehensive plan such as advocated by Kennedy, which is a truly comprehensive program, as making available the $100 million for physical and mental restoration and the

$75 million that was used for diagnostic and evaluation in FY '76 for other rehabilitation services. With these additional funds, services could be truly expanded and beneficiaries could participate in a rehabilitation program with less fear of losing their economic security.

Another solution that has been expressed most recently by Berkowitz (1980) involves the better selection of potentially successful rehabilitants. In this way, the beneficiary rehabilitation program would become more cost effective. This "backing the winner" philosophy should be met with great skepticism. Not only does it disregard the causes of work disincentives, it goes against what many disabled persons have worked for in recent years. For years, the rehabilitation program has been accused of "creaming the top," or, picking the easiest people or least disabled with whom to work. In response to this, consumers forcefully lobbyed for the expansion of vocational rehabilitation services to severely handicapped individuals and the creation of comprehensive independent living rehabilitation services. To do what is proposed by Berkowitz would be a step backwards for the rights of handicapped persons and the integrity of the rehabiliation program.

Other changes suggested affect the substantial, gainful activity (SGA) level and the trial work period (TWP). As was pointed out by Nelson (1980), different manipulations of SGA or TWP will not result in the elimination of disincentives. What is needed, though, is careful and critical

analysis which penetrates to the roots of the problem. Future legislative changes must assure that all people, disabled or not, who are able to work have the opportunity to do so without worrying about being less able to take care of their basic human needs.

In conducting the study, this researcher became critically aware of the work disincentives problem. In so doing, certain suggestions and viewpoints were developed. The following represents these thoughts:

1. The definition of disability needs to be changed. As was pointed out, if an individual earns over $300 a month and is able to work for more than nine months, she/he is no longer considered disabled by the Social Security Administration. This definition totally negates the ongoing problems that accompany many disabling conditions. A wheelchair user may be able to work, but may also require personal attendant care, specially-equipped vans, and frequent hospitalizations. All of these services are expensive and should be considered in determining whether a person no longer needs SSI and/or SSDI.

2. In order for handicapped persons to successfully complete a rehabilitation program, comprehensive services must be provided. It is not enough to send someone to a short vocational training program and expect the person to be "rehabilitated." Comprehensive rehabilitation is a long, complex process that takes place with an interdisciplinary team made up of competent professionals working jointly

with the client. Functioning in this manner, a total package of social, psychological, and physical rehabilitation can take place. As a result, clients will not be routinely rehabilitated to low-paying, menial jobs; rather, persons will have the opportunity to work at a fulfilling job, earn an acceptable wage, and maximize their potential.

3. The enactment of legislation providing for a national health insurance program that provides medical care to all members of society will significantly reduce the level of work disincentives. The requirement of a two-year waiting period prior to becoming eligible for Medicare disregards a person's immediate medical needs. The fear of losing health care is a justifiable one in a society where one major hospitalization can place an individual in debt for a significant portion of his/her life. With a national health insurance program, the beneficiary will not have to speculate as to what his/her condition may be in the future. Instead, the beneficiary will be able to make a decision about working as it relates to his/her present situation.

4. The political economy of the United States precludes social services as a priority. Benefit programs that do exist are viewed as a drain on the economic system and hence fail to respond to the comprehensive needs of beneficiaries. As long as the priority of amassing profits remains, the quality of human growth and development will be minimized. In order to fully meet the needs of persons with disabling characteristics, a commitment to develop and

implement complementary social service policies must take place.

Limitations of the Study

The limitations of this study and the considerations of them are as follows:

1. The client subjects who were selected through the independent living centers may not be representative of SSI and SSDI beneficiaries nationally. Data generated from this study reflected that there was a similarity between the clients interviewed in this study and clients rehabilitated nationally in regard to wages earned at the start of a job and type of job into which they had been rehabilitated.

The client subjects were not selected to control for age, sex, marital status, and education. Findings of this study are limited to the subjects unless the Cornfield-Tukey Bridge Argument (1956) is used, in which case populations and type of client, counselor, advocate subjects are judged to be similar enough to allow the findings of this study to be generalized to them.

2. Unemployment was extremely high at the time of this study. The unemployment rates existing during the interviews were: Ann Arbor--10%; Detroit--14.7%; Lansing--13% (Michigan Employment Security Commission, June, 1980). In severe recessionary times, it is reasonable to assume that the economic security obtained through the benefit system becomes more attractive when there is an

unavailability of jobs. Hope for obtaining a job lessens especially when the beneficiary is cognizant of the fact that even those jobs which once appeared to be secure and permanent are no longer that. Therefore, benefits become more attractive, and the disincentives barrier increases, making the efforts of vocational rehabilitation less successful.

3. As with the client subjects, the counselor subjects were selected through the Michigan Bureau of Rehabilitation. Generalizability may be affected, but it should be considered that the Michigan Bureau of Rehabilitation has the same funding, congressional mandate, and federal regulations that every other state in the United States has. Although states do differ on certain policies, overall the procedures, services, and clients served are quite similar. Therefore, as with the client subjects, certain reasonable assumptions can be made despite the question of inductive inference or generalizability never being completely answered (Campbell and Stanley, 1963).

4. The total number of subjects interviewed for this study was 97. If in future study stratification according to other variables, such as disability, is done, an increase in sample size would be necessitated.

5. As with all types of survey interviews, subjects frequently want to provide a socially acceptable response (Payne, 1973). This appeared to be especially true for the client subjects. Despite all efforts that were made to

assure the client subjects that the interviews were being done anonymously and that all results would be kept confidential, the researcher and interviewers noticed that some clients were clearly reticent to talk. This was expressed by one respondent who used a false name when she returned the postcard. Another client wanted to meet the interviewer in person "to check him out" before consenting to be interviewed. Seven other subjects expressed concern over what they said and what might happen to them as a result. It is difficult to say how many other clients felt suspicious of the interview process. Some may not have verbalized strong feelings that they felt for fear of losing benefits and services.

Implications of Future Research

Future research in the area of disincentives could take place at least on two levels. The first level relates to this study. As was noted in the limitations section, all subjects were selected from Michigan. Although certain assumptions were made using the Cornfield-Tukey Bridge Argument in order to generalize, future research may want to increase the sample size and select subjects from a more nationally representative population. For the selection of client subjects, it is suggested that the subjects be randomly selected from each regional federal office. The R-300, a federal reporting form accounting for all rehabilitation clients, could be used for this selection.

In this procedure, variables such as sex, age, geographic location, disability, benefit income, and rehabilitation closure status could be controlled. This type of research would give a more precise estimate of how rehabilitation services affect specific client populations.

The second level of suggested research has to do with the manipulation of different services and benefits. The first step in this type of research would be to develop an instrument which would measure the level of the disincentives effect. Then with the use of control groups for comparison, the experimental group could be provided a different service or benefit. The disincentives effect could then be measured. Examples of this type of research could involve one of the findings of this particular study. It was determined that the agency-client relationship was most helpful in assisting beneficiaries to overcome disincentives. An experiment could be set up where this relationship is heavily emphasized. The experimental group could receive frequent visits by counselors, paraprofessionals, and placement specialists. This could be similar to a vocational rehabilitation/public assistance project directed by this researcher (Perry, 1974). In this project, each client was visited three times a week by a paraprofessional, and once a week by the vocational rehabilitation counselor and placement specialist. Additionally, several clients were involved in general education classes which met daily.

Another system manipulation could involve the Social Security Administration. Similar to experiments in New Jersey which changed regulations governing benefits (Berkowitz, 1980), this type of research could manipulate the trial work period or the substantial, gainful activity level. Medical insurance and financial payments are variables which could be controlled. As was demonstrated in this study, these are the most important benefits to beneficiaries. Future research could arrange either to continue providing medical insurance once the beneficiary is working, or guarantee that if a former beneficiary ever leaves employment and needs medical coverage, beneficiary status, which would include the providing of medical insurance, would begin immediately. As in the previously proposed study, the instrument measuring the disincentives effect would be used to obtain the dependent variable.

Conclusions

The vocational rehabilitation of SSI and SSDI beneficiaries is exceedingly difficult due to the laws, regulations, and policies which comprise the Social Security Act. Despite statistically significant differences among counselors, clients, and advocates in perceptions of facts and activities related to the state vocational rehabilitation agency, all subjects generally saw the state agency as not being able to provide a great deal of assistance to beneficiaries in overcoming disincentives to work. This is

partly due to the constraints placed on the state rehabilitation agency which necessitates the short-term rehabilitation of large numbers of people. The result is that clients are rehabilitated to low-level, low-paying jobs with few chances for advancement. Also at issue is the Social Security Act, which frequently places beneficiaries into decision-making situations where work or economic security make up two distinct choices.

If the notion that work is important to obtain a feeling of usefulness, meaningfulness, belonging, and a way to express oneself is accepted, then it is clear that the ability to grow and develop is extremely limited for beneficiaries.

APPENDICES

APPENDIX A

Administrative Agreement with the Michigan Bureau of Rehabilitation

ADMINISTRATIVE AGREEMENT

This document indicates the agreement of the Michigan Bureau of Rehabilitation (BR) to allow research (to be conducted by Burt Danovitz, researcher, Michigan State University) with vocational rehabilitation counselors employed by BR.

The following list of responsibilities constitutes an agreement between BR and Burt Danovitz to insure the continuity of this study and the protection and confidentiality of the counselors to be interviewed.

The Bureau of Rehabilitation agrees to:

1. Provide access to vocational rehabilitation counselors serving Social Security beneficiaries, for the purpose of a telephone interview. It is understood that vocational rehabilitation counselors will participate in the study on a voluntary basis only.

2. Allow the use of said information for the purpose of performing analyses for any and all subsequent research reports.

The researcher from Michigan State University agrees to:

1. Take full responsibility for protecting the confidentiality of the individuals who are selected to be interviewed.

2. Maintain the physical integrity and security of the files and their content when working with them.

3. Prepare a final report of the results of the study for the Michigan Bureau of Rehabilitation.

These agreements shall be in force until the final report is written.

SIGNED:

Harry R. Smith, Michigan Bureau of Rehabilitation	Date
Burt Danovitz, Michigan State University, Researcher	Date

APPENDIX B

LETTER TO POTENTIAL ANN ARBOR CLIENT SUBJECTS

Letter to Potential Ann Arbor Client Subjects

Hello:

I am writing to you to ask for your participation in a research study. The study has to do with work disincentives, that is, certain rules and regulations within the Social Security Administration that stop benefits to Social Security Disability Insurance (SSDI) beneficiaries and Supplemental Security Income (SSI) beneficiaries when they return to work. People receiving SSI and SSDI who are involved with the Michigan Bureau of Rehabilitation face this problem. The goal of the Bureau of Rehabilitation is to assist people in getting a job, yet, if someone goes to work, they may lose their benefits. The possibility of this happening may affect a person's desire to continue in a rehabilitation program. This is what this research is all about; to what extent do vocational rehabilitation services assist people in overcoming existing work disincentives?

To do this study, I would like to talk to as many people as possible about their experiences with receiving SSI and/or SSDI while they were involved with the Bureau of Rehabilitation. If you were ever involved with the Bureau of Rehabilitation while receiving SSI and/or SSDI, I would like to interview you regarding your experiences. The interview will last about 15 minutes and will be done over the telephone. What you say in the interview will be strictly confidential. Your name will not be used in the research report, or be given to any other person or agency.

Enclosed with this letter is a postcard to fill out if you agree to be interviewed. If you are interested, please return this postcard to me by May 14, 1980, or as soon as you can.

It is my hope that this study will contribute to the changing of policies and laws that serve as obstacles to people with disabling conditions who want to return to work, and live independently.

If you have any questions about the study, feel free to call me. My number is (517) 394-6674 or (517) 355-1824.

I hope to hear from you.

Sincerely,

Burt Danovitz
Researcher
Michigan State University

APPENDIX C

RETURN POSTCARD FOR ANN ARBOR CLIENT SUBJECTS

Return Postcard for Ann Arbor Client Subjects

YES, I AGREE TO BE INTERVIEWED.

My name is _____
(first name only)

My telephone number is (____) _____
area code

The best time to call me is: (circle one)

morning afternoon evening

APPENDIX D

INTERVIEWER TRAINING SESSION

Interviewer Training Session

May 12, 1980

9:00 - 9:45	Overview of the problem of disincentives and the purpose of this research study.
9:45 - 10:30	The interviewers were each administered the Structured Telephone Interview Protocol (STIP)
10:30 - 11:00	Question and answer period

Afternoon Session:

During the afternoon, the interviewers conducted practice interviews with persons provided by the researcher. The interviewees were not used in the analysis of the data.

May 13, 1980

9:00 - 10:30	The practice interviews conducted during the previous afternoon session were discussed. A final question and answer period took place.

APPENDIX E

INTRODUCTION TO THE CLIENT INTERVIEW

Introduction to Client Interview

Interviewer: _____

Date of interview: _____

Time of interview: _____

Residence of interviewee:

_____ Lansing _____ Ann Arbor _____Detroit

Telephone Number: _____
(area code) (number)

Hello, I'm _____. Several days ago we sent you a letter asking for your participation in a research study being conducted by Burt Danovitz of Michigan State University. The purpose of this interview is to ask you some questions about your experience with the Bureau of Rehabilitation and Social Security benefits. This interview should take about 25 minutes. I want you to know that all the information you give me will be kept confidential; that is, your name will never be used.

Now, before we start, do you have any questions?

All right, let's begin:

APPENDIX F

MEMORANDUM TO COUNSELORS

MEMORANDUM
MICHIGAN DEPARTMENT OF EDUCATION

DATE: May 28, 1980

TO: Counselors Serving SSI/SSDI Beneficiaries

FROM: Harry Smith HS

SUBJECT: Work Disincentives Research Study

Burt Danovitz from the University Center for International Rehabilitation at Michigan State University is conducting a research study regarding work disincentives and the impact on the rehabilitation of Social Security beneficiaries. Part of the study involves interviewing vocational rehabilitation counselors.

Burt Danovitz has been given approval by the Bureau of Rehabilitation to contact counselors serving Social Security beneficiaries. You may be contacted in the near future to be interviewed. It should be understood that the interview is not mandatory and that counselors need only participate on a voluntary basis. I would also like to stress that the interviews will be anonymously reported. This is to encourage as frank a discussion as possible. The nature of this study is such that client specific information is not required by Mr. Danovitz; therefore, it should not be released to him.

The Bureau of Rehabilitation has agreed to cooperate in this study because it is recognized that work disincentive is a problem that affects state vocational rehabilitation agency clients nationally. We are, therefore, looking forward to the results.

If you have any questions regarding the interviews, you may either contact me or Burt Danovitz at (517) 355-1824 or (517) 394-6674.

Thank you for giving this matter your consideration.

HS/jvn

cc: Area Administrators
District Office Supervisors

APPENDIX G

INTRODUCTORY LETTER TO ADVOCATES

Introductory Letter to Advocates

Hello:

I am writing to you to ask for your participation in a research study. The study has to do with work disincentives, that is, certain rules and regulations within the Social Security Administration that require a termination of Social Security Disability (SSDI) and Supplemental Security Income (SSI) benefits to beneficiaries when they return to work. People receiving SSI and SSDI who are involved with the Michigan Bureau of Rehabilitation are one such group facing this problem. The goal of the Bureau of Rehabilitation (BR) is to assist people in getting a job; yet, if someone goes to work, they may lose their benefits. The possibility of this happening may affect a person's desire to continue in a rehabiliation program. This is what this research is all about: to what extent do vocational rehabilitation services assist people in overcoming existing work disincentives?

To do this study, I would like to talk with as many people as possible about their experiences with the rehabilitation of Social Security beneficiaries. I am trying to obtain a beneficiary, vocational rehabilitation counselor, and advocate perspective. You and/or your organization have been identified as an advocate for handicappers, and I assume that many of the people that you come into contact with may be currently or have been faced with the work disincentives problem. Therefore, I would like to conduct a 15-minute telephone interview with you to discuss your perceptions of this problem. What you say in the interview will be strictly confidential, and your name or organization will not be associated with any specific data obtained during the interview. This is to encourage as frank a discussion as possible.

I will be calling you within the week for purposes of conducting the interview. If you prefer to not participate or if you think that another person in your organization would be more informed regarding the topic area, I will proceed as you so desire. Also, if you have any questions about the study or if you would like to arrange a specific time for the interview, feel free to call me. My number is (517) 355-1824, or (517) 394-6674.

I am looking forward to speaking with you.

Sincerely,

Burt Danovitz
Researcher
Michigan State University

APPENDIX H

THE CLIENT STRUCTURED TELEPHONE INTERVIEW PROTOCOL

The Client Structured Telephone Interview Protocol

SEX M F Lansing Ann Arbor Detroit

1. A rehabilitation counselor needs information to see if a person can be accepted for vocational rehabilitation services. This is called diagnostic services. In order to provide this information, did your counselor have you do any of the following diagnostic activities (please respond yes or no)?

yes	no	1.	Go to a doctor for a general physical examination.
yes	no	2.	Go to a medical specialist, such as an eye doctor, a heart specialist, a bone doctor, or any other specialist.
yes	no	3.	Go to a psychiatrist or psychologist.
yes	no	4.	Go to a rehabilitation facility to be evaluated; for example, Peckham, Goodwill, JVS, Hillcrest, or any other facility.
yes	no	5.	Go to a hospital for diagnostic purposes.
yes	no	6.	Go anywhere else for diagnostic services. Please explain:

_____

_____

INTERVIEWER INSTRUCTIONS: If all responses to item 1 were No, go to item 8.

2. Did you understand the reasons for getting diagnostic services?

   3 yes
   2 somewhat
   1 no

3. While you were going for diagnostic services, which of the following would best describe how you felt?

   3 I felt encouraged to continue in the rehabilitation program.
   2 I felt neither encouraged nor discouraged to continue in the rehabilitation program.
   1 I felt discouraged to continue in the rehabilitation program.

4. About how long a time was it from when your rehabilitation counselor arranged diagnostic services to when you completed them?

5. Did you consider that amount of time:

   3 fast
   2 neither fast nor slow
   1 slow

6. As a result of receiving diagnostic services, did you:

   3 learn a lot about yourself
   2 learn some about yourself
   1 learn very little about yourself

7. Would you say that the diagnostic services were:

   3 an important service in eventually getting a job
   2 not very important, but did contribute some to your getting a job
   1 unimportant in eventually getting a job

8. Before seeing your rehabilitation counselor for the first time, did you have any specific ideas about the kind of work you wanted to do?

   3 yes---go to item 9
   2 cannot remember--go to item 9
   1 no---to to item 10

9. Did your job goal become part of your rehabilitation plan?

   3 yes
   2 part of it did
   1 no

*10. What was the job goal you agreed on with your rehabilitation counselor?

**11. Would you say that the job you eventually got was the same as the job goal set by you and your counselor?

   3 yes
   2 somewhat
   1 no

**12. Which of the following statements describes your feelings about the vocational counseling you received from your rehabilitation counselor?

   3 very satisfactory
   2 adequate
   1 not satisfactory

---

*denotes item taken directly from Vandergoot's "The Structured Interview"
**denotes items adapted from Vandergoot's "The Structured Interview"

**13. Which of the following statements describes the discussion about the job goal you had during vocational counseling?

3 The discussion I had with my counselor really made me think about my future.
2 The discussions with my counselor were interesting, but I don't think it made a difference in my ideas.
1 The discussion really didn't mean that much to me.

14. How did the job goal you agreed on with your rehabilitation counselor match up with your interests?

3 very well
2 somewhat
1 not at all

15. How did the job goal you agreed on with your rehabilitation counselor match up with your abilities?

3 It matched very well.
2 It matched somewhat.
1 It did not match.

16. Which of the following statements would best describe your satisfaction with the job goal you agreed on with your rehabilitation counselor?

3 very satisfied
2 somewhat satisfied
1 not at all satisfied

17. Did the job goal set for your rehabilitation program seem to be a job that would allow for:

3 a lot of advancement
2 some advancement
1 very little advancement

18. Did the process of setting a job goal affect your desire to continue in the rehabilitation program?

3 Yes, I was eager to continue with the rehabilitation program.
2 No, it did not have any real effect on me.
1 Yes, I wanted to quit the rehabilitation program.

19. Would you say that the job goal set for your rehabilitation program was:

3 your decision
2 a joint decision, arrived at by you and your counselor
1 mainly the rehabilitation counselor's decision

**denotes items adapted from Vandergoot's "The Structured Interview"

20. Which of the following statements describes your satisfaction with the number of job goals discussed between you and your rehabilitation counselor?

    3 very satisfied
    2 somewhat satisfied
    1 dissatisfied

THE FIRST PART OF THE INTERVIEW HAD TO DO WITH DIAGNOSTIC AND VOCATIONAL COUNSELING SERVICES. NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT OTHER REHABILITATION SERVICES THAT YOU MAY HAVE RECEIVED.

21. Which of the following services did your rehabilitation counselor provide or arrange for you? Answer yes or no to each one.

yes	no	1	counseling
yes	no	2	vocational training
yes	no	3	education
yes	no	4	purchase of books or other training materials
yes	no	5	maintenance money; that is, financial assistance
yes	no	6	transportation
yes	no	7	physical and/or mental restoration; that is, medical treatment, medical supplies, artificial limbs, mental health counseling
yes	no	8	interpreter services
yes	no	9	occupational licenses

INTERVIEWER INSTRUCTIONS:
ASK THE NEXT FOILS ONLY IF THERE IS NO RESPONSE TO THE FIRST NINE FOILS.

yes	no	10	Not relevant to me because I was not accepted for services.
yes	no	11	I did not receive any services.

22. What is your feeling about the number of services that were provided to you?

    3 satisfied
    2 somewhat satisfied
    1 dissatisfied

23. Are there other rehabilitation services that you would like to have received?

    1 yes, what are they?_____
    2 I am not sure
    3 no

24. How much did the services which you did receive help you in getting a job?

    3 They helped a lot.
    2 They helped somewhat.
    1 They did not help.

25. Which of the following statements best describes the effect these services had on your desire to continue in the rehabilitation program:

    3 I was encouraged to continue in the rehabilitation program.
    2 The services were neither encouraging or discouraging.
    1 I felt discouraged as a result of the services I received.

26. Which of the following statements best describes your feelings about the rehabilitation services you received?

    3 very satisfactory
    2 adequate
    1 not satisfactory

27. When you wanted to see your rehabilitation counselor, was he/she

    3 easy to reach
    2 sometimes easy and sometimes hard to reach
    1 hard to reach

28. Which of the following statements best describes your satisfaction with the amount of time you spent with your counselor?

    3 very satisfactory
    2 adequate
    1 not satisfactory

29. Would you say that the contacts you had with your rehabilitation counselor were:

    3 very useful
    2 somewhat useful
    1 not useful

30. In terms of getting a job, do you feel that your counselor was:

    3 encouraging to you
    2 neither encouraging or discouraging to you
    1 discouraging to you

31. Which of the following most describes your counselor's abilities:

    3 My counselor did the job very well.
    2 My counselor did a fair job.
    1 My counselor could have done a much better job.

32. Was the amount of time it took to receive rehabilitation services:

    3 faster than you expected
    2 about what you expected
    1 slower than you expected

33. Which of the following best describes your feelings about all the people you met who were working at the Bureau of Rehabilitation?

    3 People seemed to be really interested in me.
    2 People seemed somewhat interested in me.
    1 It seemed like most people were not very interested in me.

34. As a result of receiving rehabilitation services, did you get a job?

    2 yes---go to item 35
    1 no ---go to item 40 and then to item 45

35. What was your job title?

---

36. About how much money per week did you make when you started the job?

    1 $10 - 50 per week
    2 51 - 75 per week
    3 76 - 100 per week
    4 101 - 125 per week
    5 126 - 150 per week
    6 151 - 200 per week
    7 more than $200 per week

37. Which of the following statements best describes that job?

    3 The job matched up very well with my abilities.
    2 The job matched up adequately with my abilities.
    1 The job did not match up well with my abilities.

38. Were you satisfied, somewhat satisfied, or dissatisfied with how the job matched up with your interests?

    3 satisfied
    2 somewhat satisfied
    1 dissatisfied

39. Did the job you got as part of rehabilitation services allow for:

    3 a lot of advancement
    2 some advancement
    1 very little advancement

40. Before starting the job you got as a result of participating in a rehabilitation program, which of the following benefits were you receiving?

    1 Supplemental Security Income; that is, SSI
    2 Social Security Disability Insurance; that is, SSDI
    3 Worker's Compensation
    4 Aid to Families with Dependent Children; that is, AFDC
    5 General Assistance
    6 Other; please explain _____

    _____

41. Compared to receiving the benefits you just mentioned, did having the job to which you were rehabilitated to make you feel:

    3 more financial secure
    2 just as financially secure
    1 less financially secure

42. How satisfied were you with the amount of contact you had with your rehabilitation counselor when you first started working?

    3 very satisfied
    2 satisfied
    1 dissatisfied

43. Are you still working?

    2 yes
    1 no---go to item 45

44. Do you think that you will continue to work?

    3 yes---go to item 46
    2 uncertain
    1 no

45. Which of the following best explains why you are not working at this time?

    1 I did not make enough money.
    2 I was not satisfied with my job.
    3 I have medical problems.
    4 I was laid off.
    5 Other; please explain._____

    _____

    _____

46. Given your experience with rehabilitation services, which of the following would you recommend to a friend who is receiving financial benefits such as SSI or SSDI?

    3 Recommend that they go and see a rehabilitation counselor.
    2 Not recommend anything.
    1 Recommend that they not go and see a rehabilitation counselor.

47. While participating in the rehabilitation program, did you expect your benefits, such as SSI or SSDI, to stop when you got a job?

    3 Yes, I expected that.
    2 I was not sure.
    1 No, I did not expect that.

48. How concerned were you that your Social Security benefits would stop once you were rehabilitated and working?

    3 I was not concerned.
    2 I was somewhat concerned.
    1 I was very concerned.

49. In order to continue receiving Social Security benefits, did you ever decide not to work?

    1 yes
    2 no

50. How clearly did your rehabilitation counselor point out to you the effects of returning to work on your SSI, SSDI, or other benefits?

    3 very clearly
    2 somewhat clearly
    1 not clearly

Rate the following as to their importance to you by saying either important, somewhat important, or unimportant:

51. The money I received from Social Security:

    1 important
    2 somewhat important
    3 unimportant

52. Medicare or Medicaid:

    1 important
    2 somewhat important
    3 unimportant

53. Food Stamps:

    1 important
    2 somewhat important
    3 unimportant

54. Rent supplements

    1 important
    2 somewhat important
    3 unimportant

55. Which of the following benefits was or is the most important to you?

    1 financial payments from Social Security
    2 Medicare or Medicaid
    3 Food Stamps
    4 Rent Supplements

56. Currently, when someone returns to work they lose most of their Social Security benefits. Do you think that if benefits were not totally lost, more people would return to work?

    3 yes
    2 don't know
    1 no

57. Do you know what a "trial work period" is?

    2 yes; please explain_____

    _____

    _____

    1 no

58. Do you know what "substantial, gainful activity" is?

    2 yes; please explain _____

    _____

    _____

    1 no

59. Do you have any additional comments that you would like to share about your experiences with either vocational rehabilitation services or Social Security? _____

    _____

This is the end of the interview. I want to thank you very much for your participation. Goodbye!

APPENDIX I

THE COUNSELOR STRUCTURED TELEPHONE INTERVIEW PROTOCOL

Counselor Structured Telephone Interview Protocol (STIP)

1. Are you primarily a counselor serving SSI, SSDI, SSI/SSDI, or a general caseload in addition to SSI/SSDI?

   1 SSI
   2 SSDI
   3 SSI/SSDI
   4 General caseload and SSI/SSDI

2. Do your clients understand the reasons for participating in diagnostic services?

   3 yes
   2 somewhat
   1 no

3. Which of the following best describes how your clients feel when they are going for diagnostic services?

   3 They feel encouraged to continue in the rehabilitation program.
   2 They feel neither encouraged or discouraged to continue in the rehabilitation program.
   1 They feel discouraged to continue in the rehabilitation program.

4. About how long does it take from when you arrange for diagnostic services to when they are completed?

   _____

5. Do you consider that amount of time

   3 fast
   2 neither fast nor slow
   1 slow

6. As a result of receiving diagnostic services, do your clients:

   3 learn a lot about themselves
   2 learn some about themselves
   1 learn very little about themselves.

7. Would you say that the diagnostic services are:

   3 an important service in eventually getting a job.
   2 not very important, but do contribute some to getting a job.
   1 unimportant in eventually getting a job.

8. Before seeing you for the first time, do most of your clients have any specific ideas about the kind of work they want to do?

   3 yes
   2 somewhat
   1 no

9. Do your clients' vocational goals usually become part of their rehabilitation plan?

   3 yes
   2 part of it
   1 no

10. Which of the following would best describe the vocational goals your clients have when they first see you?

   3 realistic
   2 somewhat realistic
   1 unrealistic

11. Would you say that the final vocational placement is usually the same as the vocational goal that you initially establish with your clients?

   3 yes
   2 somewhat
   1 no

12. Which of the following statements best describes the vocational counseling that takes place with your clients?

   3 very satisfactory
   2 adequate
   1 not satisfactory

13. Which of the following statements describes the discussions about a vocational goal you have with your clients?

   3 The discussions seem to really make my clients think a lot.
   2 The discussions seem interesting, but they do not make a difference in my clients' ideas.
   1 The discussions seem not to mean much to the clients.

14. How does the vocational goal established with clients generally match up with their interests?

   3 very well
   2 somewhat
   1 not at all

15. How does the vocational goal established with your clients generally match up with their abilities?

    3 It matches very well.
    2 It matches somewhat.
    1 It does not match.

16. Which of the following statements best describes your satisfaction with the vocational goals that are established?

    3 very satisfied
    2 somewhat satisfied
    1 not at all satisfied

17. Do the vocational goals set with your clients generally allow for:

    3 a lot of advancement
    2 some advancement
    1 very little advancement

18. Does the process of setting a vocational goal affect your clients' desire to continue in a rehabilitation program?

    3 Yes, they are eager to continue.
    2 No, it does not really affect them.
    1 Yes, frequently, they want to quit.

19. Generally, is the vocational goal established for your clients:

    3 your client's decision
    2 a joint decision, arrived at by you and your clients
    1 mainly your decision

20. Which of the following statements best describes your satisfaction with the number of vocational goals discussed between you and your clients?

    3 very satisfied
    2 somewhat satisfied
    1 dissatisfied

THE FIRST PART OF THE INTERVIEW HAD TO DO WITH DIAGNOSTIC AND VOCATIONAL COUNSELING SERVICES. NOW, I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT OTHER REHABILITATION SERVICES THAT YOUR CLIENTS RECEIVE.

21. Leave blank.

22. What is your feeling about the number of rehabilitation services that are provided to your clients?

    3 satisfied
    2 somewhat satisfied
    1 dissatisfied

23. Do you think that there are other services that should be provided to your clients?

    3 no
    2 I am not sure
    1 yes

24. In your estimation, how much do the rehabilitation services provided to clients contribute to their getting a job?

    3 They contribute a lot.
    2 They contribute somewhat.
    1 They do not contribute.

25. Which of the following statements best describes the effect of rehabilitation services on your clients' desire to continue in their rehabilitation program?

    3 They are encouraged to continue.
    2 The services are neither encouraging or discouraging.
    1 They feel discouraged as a result of the services received

26. Which of the following statements best describes your feeling about the quality of the rehabilitation services provided?

    3 very satisfactory
    2 adequate
    1 not satisfactory

27. Do your clients find you:

    3 easy to reach
    2 sometimes easy and sometimes hard to reach
    1 hard to reach

28. Which of the following statements best describes your satisfaction with the amount of time you spend with your clients?

    3 very satisfactory
    2 adequate
    1 not satisfactory

29. Would you say that the contacts you have with your clients are:

    3 very useful
    2 somewhat useful
    1 not useful

30. In terms of eventually getting a job, do you think your clients find you:

    3 encouraging
    2 neither encouraging or discouraging
    1 discouraging

31. In your estimation, which of the following most describes how well you do your job as a vocational rehabilitation counselor?

    3 I do my job very well.
    2 I do a fair job.
    1 I could do a much better job.

32. Generally, do your clients feel that the amount of time it takes to receive rehabilitation services is:

    3 faster than they expect
    2 about what they expect
    1 slower than they expect

33. Which of the following best describes your perceptions about all the Bureau of Rehabilitation employees' interest in your clients?

    3 The Bureau personnel seem really interested in my clients.
    2 The Bureau personnel seem somewhat interested in my clients.
    1 The Bureau personnel seem not very interested in my clients.

34. Of the beneficiaries who are referred to you, what percentage are eventually placed into a competitive wage earning job, status 26?

    _____

35. What types of jobs are the clients you serve usually placed in?

    1 professional, technical, and managerial
    2 clerical and sales
    3 service
    4 agricultural and fishing
    5 skilled industrial
    6 semiskilled and unskilled industrial
    7 other

36. About how much money per week do your clients earn when they first start working?

    1 $ 10 - 50 per week
    2 51 - 75 per week
    3 76 - 100 per week
    4 101 - 125 per week
    5 126 - 150 per week
    6 151 - 200 per week
    7 more than $200 per week

37. Which of the following best describes the jobs that clients are rehabilitated to?

    3 The jobs match up well with their abilities.
    2 The jobs match up adequately with their abilities.
    1 The jobs do not match up well with their abilities.

38. Are you satisfied, somewhat satisfied, or dissatisfied with how your clients' jobs match up with their interests?

    3 satisfied
    2 somewhat satisfied
    1 dissatisfied

39. Do the jobs that clients are usually rehabilitated to allow for:

    3 a lot of advancement
    2 some advancement
    1 very little advancement

40. Leave blank.

41. Do you think that compared to receiving Social Security benefits, being rehabilitated to a job makes people feel:

    3 more financially secure
    2 just as financially secure
    1 less financially secure

42. How satisfied are you with the amount of contact that you have with your clients when they first start working?

    3 very satisfied
    2 satisfied
    1 dissatisfied

43. Do you think that most of the people closed in Status 26 in the last year are still working?

    3 yes
    2 not sure
    1 no

44. Of those that are working, do you think that they will continue to work on a permanent basis?

    3 yes
    2 uncertain
    1 no

45. Which of the following best explains why people stop working after they are successfully rehabilitated?

    1 They do not make enough money.
    2 They are not satisfied with the job.
    3 They have medical problems.
    4 They get laid off.
    5 Other, please explain: _____

    _____

46. Given your experience with rehabilitation services, which of the following would you recommend to a friend who is receiving financial benefits such as SSI or SSDI?

    3 Recommend that they apply for rehabilitation services.
    2 Not recommend anything.
    1 Recommend that they not apply for rehabilitation services.

47. While participating in their rehabilitation programs, do your clients usually expect their SSI or SSDI benefits to be terminated when they get a job?

    3 Yes, they expect that.
    2 I am not sure.
    1 No, they do not expect that.

48. How concerned are your clients that their Social Security benefits will stop once they are rehabilitated and working?

    3 They are not concerned.
    2 They are somewhat concerned.
    1 They are very concerned.

49. In order to continue receiving Social Security benefits, do you sometimes encourage your clients to not work?

    2 no
    1 yes

50. How clearly do you explain the effects of returning to work on your clients' Social Security benefits?

    3 very clearly
    2 somewhat clearly
    1 not clearly

Rate the following as to their importance to your clients by saying either important, somewhat important, or unimportant.

51. The financial payments received from Social Security.

    3 unimportant
    2 somewhat important
    1 important

52. Medicare or Medicaid.

    3 unimportant
    2 somewhat important
    1 important

53. Food Stamps.

    3 unimportant
    2 somewhat important
    1 important

54. Rent supplements.

    3 unimportant
    2 somewhat important
    1 important

55. Which of the following benefits do you think is the most important to your clients?

    1 financial payments from Social Security
    2 Medicare or Medicaid
    3 Food Stamps
    4 Rent Supplements

56. Currently, when someone returns to work they lose all or most of their Social Security benefits. Do you think that if benefits were not totally lost, more people would return to work?

    3 no
    2 I do not know
    1 yes

57. Do you know what a "trial work period" is?

    2 yes, please explain_____

    _____

    1 no

58. Do you know what "substantial, gainful activity" is?

    2 yes, please explain_____

    _____

    1 no

59. Do you have any additional comments that you would like to share about the rehabilitation of Social Security beneficiaries?

This is the end of the interview. I want to thank you very much for your participation. Goodbye!

APPENDIX J

THE ADVOCATE STRUCTURED TELEPHONE INTERVIEW PROTOCOL

Advocate Structured Telephone Interview Protocol (STIP)

1. Is your organization primarily managed by consumers?

   1 yes
   2 no

2. When beneficiaries are requested to get diagnostic services, are the reasons for the services made understandable to them?

   3 yes
   2 somewhat
   1 no

3. Which of the following best describes how beneficiaries feel when they are going for rehabilitation diagnostic services?

   3 They feel encouraged to continue in their rehabilitation program.
   2 They feel neither encouraged nor discouraged to continue in their rehabilitation program.
   1 They feel discouraged to continue in their rehabilitation program.

4. About how long a time do you think it takes from when a rehabilitation counselor arranges for diagnostic services to when they are completed?

   _____

5. Do you consider that amount of time:

   3 fast
   2 neither fast nor slow
   1 slow

6. As a result of receiving rehabilitation diagnostic services, do beneficiaries:

   3 learn a lot about themselves
   2 learn some about themselves
   1 learn very little about themselves

7. Would you say that the diagnostic services are:

   3 an important service in eventually getting a job
   2 not very important, but do contribute some to getting a job
   1 unimportant in eventually getting a job

8. Before seeing a rehabilitation counselor for the first time, do most beneficiaries have any specific ideas about the kind of work they want to do?

   3 yes
   2 somewhat
   1 no

9. Do you think that beneficiaries' vocational goals usually become part of their rehabilitation plan?

   3 yes
   2 part of it
   1 no

10. Which of the following would best describe the vocational goals that beneficiaries have when they first see a rehabilitation counselor?

   3 realistic
   2 somewhat realistic
   1 unrealistic

11. Would you say that the final vocational placement is usually the same as the vocational goal that is established with beneficiaries?

   3 yes
   2 somewhat
   1 no

12. Which of the following statements best describe the vocational counseling that takes place between the rehabilitation counselor and beneficiaries?

   3 very satisfactory
   2 adequate
   1 not satisfactory

13. Which of the following statements describes the discussions about a vocational goal that rehabilitation counselors have with beneficiaries?

   3 The discussions seem to really make beneficiaries think a lot.
   2 The discussions seem interesting, but they do not seem to make a difference in the beneficiary's ideas.
   1 The discussions seem not to mean much to the beneficiaries.

14. How does the vocational goal established with beneficiaries generally match up with their interests?

   3 very well
   2 somewhat
   1 not at all

15. How does the vocational goal established with beneficiaries generally match up with their abilities?

    3 It matches very well.
    2 It matches somewhat.
    1 It does not match.

16. Which of the following statements best describes your satisfaction with the vocational goals that are established for beneficiaries?

    3 very satisfied
    2 somewhat satisfied
    1 not at all satisfied

17. Do the vocational goals that are set for beneficiaries' rehabilitation programs generally allow for:

    3 a lot of advancement
    2 some advancement
    1 very little advancement

18. Do you think that the process of setting a vocational goal affects the desire of beneficiaries to continue in a rehabilitation program?

    3 Yes, they are eager to continue.
    2 No, it does not really affect them.
    1 Yes, frequently they want to quit.

19. Generally, is the vocational goal established for beneficiaries:

    3 the beneficiary's decision
    2 a joint decision,
    1 mainly the rehabilitation counselor's decision

20. Which of the following statements best describes your satisfaction with the number of vocational goals discussed between the rehabilitation counselor and the beneficiary?

    3 very satisfied
    2 somewhat satisfied
    1 dissatisfied

THE FIRST PART OF THE INTERVIEW HAD TO DO WITH DIAGNOSTIC AND VOCATIONAL COUNSELING SERVICES. NOW, I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT OTHER REHABILITATION SERVICES THAT PEOPLE RECEIVE WHILE THEY ARE INVOLVED WITH THE BUREAU OF REHABILITATION.

21. Leave blank.

22. What is your feeling about the number of rehabilitation services that are provided to beneficiaries?

    3 satisfied
    2 somewhat satisfied
    1 dissatisfied

23. Do you think that there are other services that should be provided as part of someone's rehabilitation program?

    3 no
    2 I am not sure
    1 yes

24. In your estimation, how much do the rehabilitation services provided to beneficiaries contribute to their getting a job?

    3 They contribute a lot.
    2 They contribute somewhat.
    1 They do not contribute.

25. Which of the following statements best describes the effect of rehabilitation services on beneficiaries' desires to continue in their rehabilitation programs?

    3 They are encouraged to continue.
    2 The services are neither encouraging nor discouraging.
    1 They feel discouraged as a result of the services received.

26. Which of the following statements best describes your feelings about the quality of the rehabilitation services provided?

    3 very satisfactory
    2 adequate
    1 not satisfactory

27. Do you think that rehabilitation counselors are:

    3 easy for clients to reach
    2 sometimes easy and sometimes hard for clients to reach
    1 hard for clients to reach

28. Which of the following statements best describes your satisfaction with amount of time that rehabilitation counselors spend with beneficiaries?

    3 very satisfactory
    2 adequate
    1 not satisfactory

29. Would you say that the contacts that take place between the rehabilitation counselor and beneficiaries are:

    3 very useful
    2 somewhat useful
    1 not useful

30. In terms of getting a job, do you feel that rehabilitation counselors are:

    3 encouraging to their clients
    2 neither encouraging nor discouraging to their clients
    1 discouraging to their clients

31. In your estimation, which of the following most describes how well vocational rehabilitation counselors do their job?

    3 They do their job very well.
    2 They do a fair job.
    1 They could do a much better job.

32. Is the amount of time that it takes to receive rehabilitation services:

    3 faster than you expect
    2 about what you expect
    1 slower than you expect

33. Which of the following best describes your perceptions about the Bureau of Rehabilitation employees' interest in beneficiaries?

    3 The Bureau employees seem really interested in beneficiaries.
    2 The Bureau employees seem somewhat interested in beneficiaries.
    1 The Bureau employees seem not very interested in beneficiaries.

34. Of the beneficiaries who are referred to vocational rehabilitation counselors, what percentage do you think are eventually placed into a competitive wage-earning job?

    _____

35. What types of jobs are beneficiaries usually placed in as a result of receiving rehabilitation services?

    1 professional, technical, and managerial
    2 clerical and sales
    3 service
    4 agricultural and fishing
    5 skilled industrial
    6 semiskilled and unskilled industrial
    7 other

36. About how much money per week do rehabilitated beneficiaries earn when they first start working?

1 $ 10 - 50 per week
2 51 - 75 per week
3 76 - 100 per week
4 101 - 125 per week
5 126 - 150 per week
6 151 - 200 per week
7 more than $200 per week

37. Which of the following best describes the jobs that beneficiaries are rehabilitated to?

3 The jobs match up well with their abilities.
2 The jobs match up adequately with their abilities.
1 The jobs do not match up well with their abilities.

38. Are you satisfied, somewhat satisfied, or dissatisfied with how the jobs match up with beneficiaries' interests?

3 satisfied
2 somewhat satisfied
1 dissatisfied

39. Do the jobs that beneficiaries are usually rehabilitated to allow for:

3 a lot of advancement
2 some advancement
1 very little advancement

40. Leave blank.

41. Do you think that compared to receiving Social Security benefits being rehabilitated to a job makes people feel:

3 more financially secure
2 just as financially secure
1 less financially secure

42. How satisfied are you with the amount of contact that a rehabilitation counselor has with beneficiaries when they first start working?

3 very satisfied
2 satisfied
1 dissatisfied

43. Do you think that most of the people closed rehabilitated in the last year are still working?

    3 yes
    2 not sure
    1 no

44. Of those that are working, do you think that they will continue to work on a permanent basis?

    3 yes
    2 uncertain
    1 no

45. Which of the following best explains why people stop working after they are successfully rehabilitated?

    1 They do not make enough money.
    2 They are not satisfied with the job.
    3 They have medical problems.
    4 They get laid off.
    5 Other, please explain:_____

    _____

    _____

46. Given your experience with the Bureau of Rehabilitation, which of the following do you usually recommend to an individual who receives Social Security benefits and has a disabling condition?

    3 Recommend that they apply for rehabilitation services.
    2 Not recommend anything.
    1 Recommend that they not apply for rehabilitation services.

47. While participating in a rehabilitation program, do people usually expect their SSI or SSDI benefits to be terminated when they get a job?

    3 Yes, they expect that.
    2 I am not sure.
    1 No, they do not expect that.

48. How concerned are beneficiaries that Social Security benefits will stop once they are rehabilitated and working?

    3 They are not concerned.
    2 They are somewhat concerned.
    1 They are very concerned.

49. In order to continue receiving Social Security benefits, do you sometimes encourage beneficiaries not to work?

    2 no
    1 yes

50. How clearly do you think rehabilitation counselors explain the effects of returning to work on beneficiaries' Social Security benefits?

    3 very clearly
    2 somewhat clearly
    1 not clearly

Rate the following as to their importance to Social Security beneficiaries by saying either important, somewhat important, or unimportant.

51. The financial payments received from Social Security.

    3 unimportant
    2 somewhat important
    1 important

52. Medicare or Medicaid.

    3 unimportant
    2 somewhat important
    1 important

53. Food Stamps.

    3 unimportant
    2 somewhat important
    1 important

54. Rent supplements

    3 unimportant
    2 somewhat important
    1 important

55. Which of the following benefits do you think is the most important to beneficiaries?

    1 financial payments from Social Security
    2 Medicare or Medicaid
    3 Food Stamps
    4 Rent Supplements

56. Currently, when someone returns to work they lose all or most of their Social Security benefits. Do you think that if benefits were not totally lost, more people would return to work?

    3 no
    2 I do not know
    1 yes

57. Do you know that a "trial work period" is?

    2 yes, please explain_____

    _____

    1 no

58. Do you know what "substantial, gainful activity" is?

    2 yes, please explain_____

    _____

    1 no

59. Do you have any additional comments that you would like to share about the rehabilitation of Social Security beneficiaries?

This is the end of the interview. I want to thank you very much for your participation. Goodbye!

APPENDIX K

SUBSCALES OF THE STRUCTURED TELEPHONE INTERVIEW PROTOCOL (STIP)

Subscales of the Structured Telephone Interview Protocol (STIP)

Subscale	Item
Diagnostic	2,3,4,5,6,7
Vocational Counseling	9,10,11,12,13,14,15,16,17,18,19,20
Rehabilitation Services	22,23,24,25,26,32
Client-Agency Relationship	27,28,29,30,31,33
Placement & Follow-up	34,35,36,37,38,39,41,42,43,44
Miscellaneous	46,47,48,49,50,51,52,53,54,56,57,58

APPENDIX L

RATER INSTRUCTIONS FOR CONTENT VALIDATION

Rater Instructions for Content Validation

The items that you are being asked to rate were developed for a research project designed to study the impact of vocational rehabilitation services on assisting Social Security Disability Insurance and Supplemental Security Income beneficiaries in overcoming existing work disincentives. The items to be considered by you will be the major instrument for collecting the research data.

This research project was developed because Supplemental Security Income and Social Security Disability Insurance beneficiaries face considerable obstacles and deterrents to employment. This primarily is the result of the structure of the Social Security Administration benefit system. The Social Security Administration, in addition to providing benefits, is a major referral source to the state vocational rehabilitation agency. When a beneficiary is referred to the state vocational rehabilitation agency, the goal is to successfully place the beneficiary into paid employment. The purpose of this project is to obtain clients', vocational rehabilitation counselors', and consumer advocates' perspectives of the vocational rehabilitation activities that assist people in successfully overcoming disincentives to employment.

All of the research subjects--clients, counselors, and advocates--will be interviewed over the telephone. Each interview is expected to last approximately 15 minutes.

Your help is needed in evaluating the items that comprise the interview. This will lead to the possible retaining, eliminating, or modifying of each item.

The interview items fall into six different categories. Five of the categories represent the different components of the vocational rehabilitation program, and the sixth category includes miscellaneous items. The categories are as follows:

1. Diagnostic: Items in this category include questions regarding the evaluation process that takes place at the beginning of a person's rehabilitation program. Diagnostic services are provided to determine eligibility for rehabilitation services.

2. Vocational Counseling: Items in this category include questions regarding the process of establishing a vocational goal. This process is also part of eligibility determination.

3. Rehabilitation Services: Items in this category include questions regarding the rehabilitation services provided once a person is determined to be eligible.

4. Client-Agency Relationship: Items in this category include questions regarding the characteristics of the relationship between the vocational rehabilitation agency's personnel, and the client throughout the rehabilitation process.

5. Placement and Follow-up: Items in this category include questions regarding the placement and follow-up services that are provided when a client is ready for employment and initially employed.

6. Miscellaneous: Items in this category include questions that do not fall into any of the other five categories. These items either provide descriptive information or data related specifically to work disincentives.

There are two tasks that need to be completed when you evaluate the items. First, sort the items according to the category that you think they represent, i.e., place diagnostic items in the diagnostic category, vocational counseling items in the vocational counseling category, and so on. A white envelope with category titles is provided for this task. After you determine the category for the item, turn each item card over and rate the items as follows:

3 - A Good Item: The item is a valid measure of the category.

2 - A Modifiable Item: With changes the item will be a valid measure of the category.

1 - A Redundant Item: The item addresses a problem that was reviewed in a previous item.

0 - A Bad Item: The item is not a valid measure of the category.

After each item is rated, write suggestion which you may have that would contribute to improving the item (also on the back of each item card). When you are finished sorting, rating, and commenting on all of the items, place the six white envelopes containing the appropriate items into the large envelope.

Thank you for your help and cooperation.

APPENDIX M

CODING FOR THE STRUCTURED TELEPHONE INTERVIEW PROTOCOL (STIP)

Coding for the Structured Telephone Interview Protocol (STIP)

Item

1A - 1F:	1 = yes 2 = no
2:	Score is equal to the number of foil chosen
3:	Same as item #2
4:	3 = less than one month
	2 = 1-2 months
	1 = more than 2 months
5 - 9:	Same as item #2
10:	3 = professional, technical, managerial
	2 = clerical, skilled, sales, agricultural, fishing
	1 = service, unskilled, semiskilled
11 - 20:	Same as item #2
21A - 21K:	1 = yes 2 = no
22 - 33:	Same as item #2
34:	2 = yes 1 = no
35:	3 = professional, technical, managerial
	2 = clerical, skilled, sales, agricultural, fishing
	1 = service, unskilled, semiskilled
36:	3 = more than $200/week
	2 = $126-200/week
	1 = less than $125/week
37 - 42:	same as item #2
43:	2 = yes 1 = no

44 - 48: same as item #2

49: 1 = yes 2 = no

50 - 56: same as item #2

57 - 58: 2 = yes: correct answer

1 = yes: incorrect answer

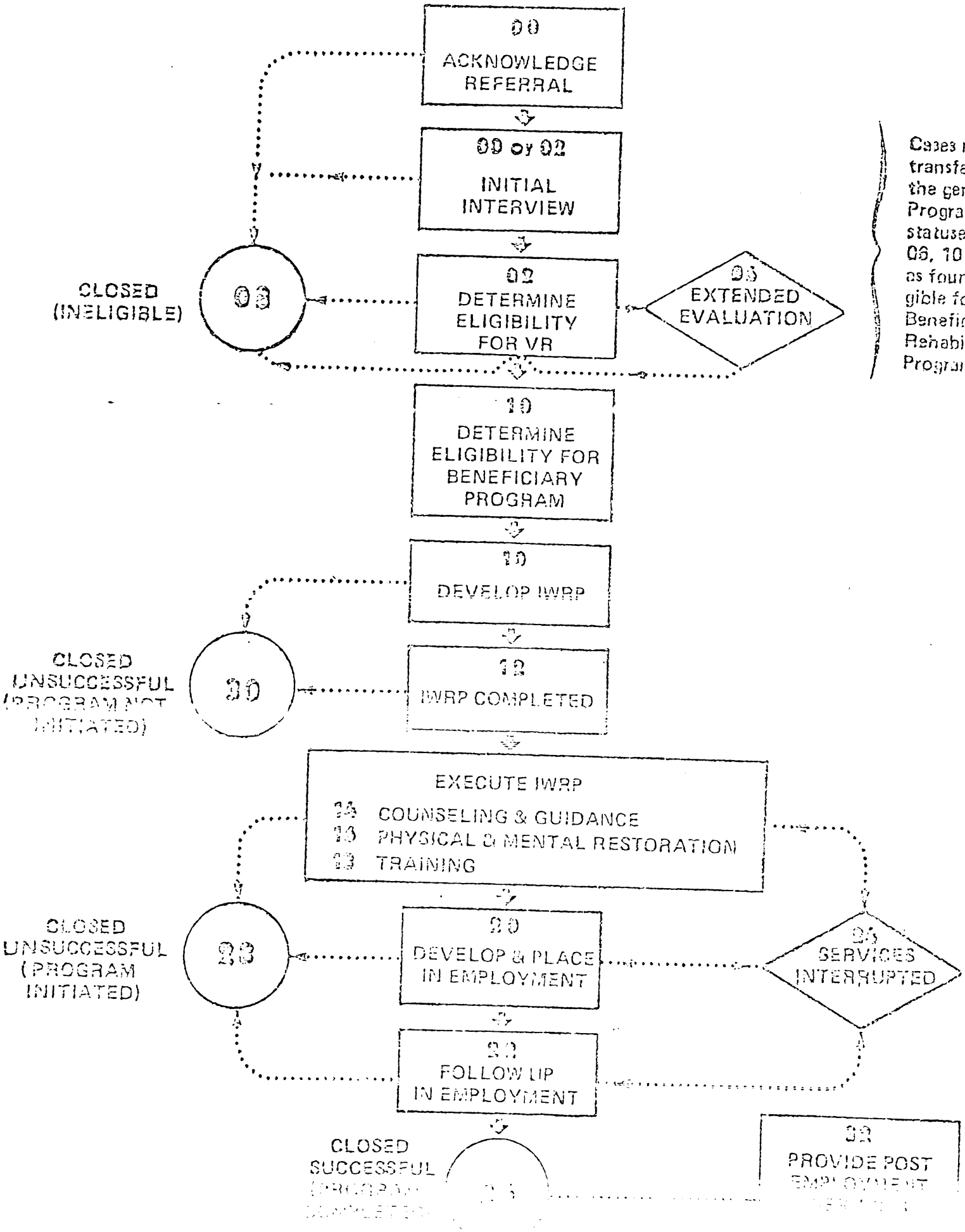
1 = no

59: 1 = yes 2 = no

APPENDIX N

VOCATIONAL REHABILITATION STATUSES

Flow Diagram--VR Process For Beneficiary Counselors



BIBLIOGRAPHY

BIBLIOGRAPHY

Adams, A. Preliminary Report: Comparison of Characteristics of Severely and Non-Severely Disabled Clients Rehabilitated during Fiscal Year 1975, (memo) Wash. D.C.: October 22, 1975.

Anastasi, Anne. Psychological Testing. Fourth Edition. New York: MacMillan Publishing Co., 1976.

Babbie, E. R. Survey Research Methods. Belmont, California: Wadsworth Publishing Co., 1973.

Berkowitz, M. Work Disincentives. Paper to be published in 1980 by the Institute for Information Studies, Fall Church, Virginia.

Berkowitz, M., Horning, M., McConnell, S., Rubin, J., Worrall, J. D. An Economic Evaluation of the Beneficiary Rehabilitation Program, in Alternatives in Rehabilitating the Handicapped: A Policy Analysis. Jeffrey Rubin (Ed.), forthcoming.

Berkowitz, M., Johnson, W., Murphy, E. H. Public Policy toward Disability. New York: Praeger Publishing, 1976.

Better, S. R., Fine, P. R., Simison, D. L., Doss, G. H. Counselor Perceptions of Proposals to Reduce Rehabilitation Disincentives. Paper presented at the annual National Rehabilitation Association National Conference, Chicago, Illinois, September, 1979.

Better, S. R., Fine, P. R., Simison, D., Doss, G. H., Walls, R. T., & McLaughlin, D. E. Rehabilitation Disincentives: An Empirical Investigation of the Relationship between Disability Benefits and Vocational Rehabilitation Outcome. Milbank Memorial Fund Quarterly/Health and Society.

Bitter, J. A. Introduction to Rehabilitation. St. Louis, The C. V. Mosby Co., 1979.

Burks, H. M., & Stefflre, B. Theories of Counseling. New York: McGraw-Hill Book Co., 1979.

Burton, L. A Service Provider's Guide to Federal Disability Law. Berkeley, California: Disability Law Resource Center of the Center for Independent Living, Inc., 1979.

Cain, G. G., & Watts, H. W. Income Maintenance and Labor Supply. New York: Academic Press, 1977.

Califano, J. A. Testimony before the House Ways & Means Sub-Committee on Public Assistance and Unemployment Compensation. Washington, D.C.: June, 1979.

Campbell, D. T. & Stanley, J. C. Experimental and Quasi-Experimental Designs for Research. Chicago: Rand McNally, 1963.

Comptroller General of the United States. Improvements Needed in Rehabilitating Social Security Disability Beneficiaries. Wash., D.C.: Report B-16403, 1976.

Cornfield, J., & Tukey, S. W. Average values of mean squares in factorials. Annals of Mathematical Statistics, 1956, 27, 907-949.

DeJong, G. The Movement for Independent Living: Origins, Ideology, and Implications for Disability Research. East Lansing, Michigan: The University Center for International Rehabilitation, 1979.

DiMichael, S. G., in The Vocational Rehabilitation of the Disabled. Malikin, D., & Rusalem, H. (Eds.), New York: New York University Press, 1969.

Dorken, H., and LaRocca, J. "Perspectives on National Health Insurance and Rehabilitation," Emerging Issues in Rehabilitation. Wash., D.C.: Washington Transportation Alliance, Institute for Research Utilization, 1977.

Dunn, D. J. What Happens after Placement? Career Enhancement Services in Vocational Rehabilitation, in Placement in Rehabilitation, Edited by D. Vandergoot and John D. Worrall, Baltimore: University Park Press, 1979.

Erikson, E. Childhood and Society. New York: Norton, 1950.

Finn, J. D. A General Model for Multivariate Analysis. New York: Holt, Rinehart and Winston, 1974.

Fowler, D. R., & Mayfield, D. G. Effect of Disability Compensation. Archives of Environmental Health, 1969, 19, 719-725.

Garrett, J., in Vocational Rehabilitation of the Disabled. Malikin, D., & Rusalem, H. (Eds.). New York: New York University Press, 1969.

Glass, G. V., & Stanley, J. C. Statistical Methods in Education and Psychology. Englewood Cliffs, New Jersey: Prentice-Hall, 1970.

Goldenson, R. M. (Editor-in-Chief), Dunham, J. R., & Dunham, C. S. (Associate Editors). Disability and Rehabilitation Handbook. New York: McGraw-Hill Book Co., 1978.

Greenblum, J. Effect of Rehabilitation on Employment and Earnings of the Disabled: Sociodemographic Factors, Social Security Bulletin, 42, August, 1979, 8-36.

Greenblum, J. The Effects of Vocational Rehabilitation on the Earnings of Disabled Persons. U.S. Department of Health, Education, and Welfare. Publication No. (SSA) 77-11852, 1977.

Greenblum, J. The Impact of Vocational Rehabilitation on the Disabled. Paper presented at the Annual Meeting of the American Public Health Association, Miami Beach, Florida, October, 1976.

Grigg, C. M., Holtman, A. G., & Martin, P. Y. Vocational Rehabilitation of Disabled Public Assistance Clients: An Evaluation of Fourteen Research and Demonstration Projects. Talahassee, Florida: Institute for Social Research, Florida State University, 1969.

Holland, J. L. Making Vocational Choices: A Theory of Careers. Englewood Cliffs, New Jersey: Prentice-Hall, 1973.

Indiana Rehabilitation Services. Economic Disincentives to the Employment of SSDI and SSI Beneficiaries: A State Vocational Rehabilitation Agency's Experience. Indianapolis, Indiana, 1976.

Information Memorandum RSA-IM-77-37. Distribution of Source of Referral of Cases Closed by State Vocational Rehabilitation Agencies during Fiscal Year 1975. Wash., D.C., Feb. 11, 1977.

Information Memorandum RSA-IM-77-71. Wash., D.C., June 8, 1977.

Jacques, M. E. Rehabilitation Counseling: Scope and Services. Boston, Mass.: Houghton Mifflin Co., 1970.

Kerlinger, F. N. Foundations of Behavioral Research. New York: Holt, Rinehart, and Winston, Inc., 1965.

Kroll, A., Dinklage, L., Lee, J., Morley, E., and Wilson, E. Career Development: Growth and Crisis. New York: John Wiley & Sons, Inc., 1970.

Krute, A., and Burdette, E. "1972 Survey of Disbled and Nondisabled Adults: Chronic Disease, Inquiry and Work Disability," Social Security Bulletin, 41:3-15, 1978.

Lasch, C. The Culture of Narcissism. New York: Warner Book, 1979.

Levinson, D., Darrow, C., Klein, E., Levinson, M., and McKee, B. The Seasons of a Man's Life. New York: Alfred A. Knopf, Inc., 1978.

Luft, H. S. Poverty and Health: An Empirical Investigation of the Economic Interactions. Doctoral dissertation, Harvard University, 1972, 5-7, 111.

Magnusson, D. Test theory. Reading, Massachusetts: Addison-Wesley, 1966.

Masters, S., & Garfinkel, I. Estimating the Labor Supply Effects of Income Maintenance Alternatives. New York: Academic Press, 1977.

Micek, L. A., & Bitter, J. A. Service Delivery Approaches for Difficult Rehabilitation Clients. Rehabilitation Literature, 1974, 33, 258-263.

Nagi, S. Z. "An Epidemiology of Disability among Adults in the U.S.," Millbank Memorial Fund Quarterly: Health and Society, 54: 439-67, 1976.

Nagi, S. Z. Disability and Rehabilitation: Legal, Clinical, and Self Concepts and Measurement. Columbus, Ohio: Ohio State University Press, 1969.

Nelson, J. R. "Summary of Recent Congressional Initiatives Relating to Social Security Act Programs," in The Social Security Disability Insurance and Supplemental Security Income Programs, by Tom Joe and Alan Bogatay. Chicago: The Center for the Study of Welfare Policy, 1980.

Noble, J. H. Rehabilitating the Severely Disabled: The Foreign Experience. Journal of Health Politics, Policy and Law, 1979, Vol. 4, No. 2.

Ollman, B. Alienation. Cambridge: Cambridge University Press, 1978.

Payne, S. L. The Art of Asking Questions. Princeton, New Jersey: University Press, 1973.

Pearl, Arthur. Landslide. Secacus, New Jersey: The Citadel Press, 1973.

Perry, S. L. Project Daybreak: An Organizational Analysis. Boston: Northeastern University, Department of Rehabilitation and Special Education, 1974.

Raj, D. The Design of Sample Surveys. New York: McGraw-Hill, 1972.

Rehabilitation Facilities of Wisconsin. A Case Study. Unpublished paper, December, 1978.

Rejda, G. E. Social Insurance and Economic Security. Englewood Cliffs: Prentice-Hall, 1976.

Robbin, L. On the Elasticity of Demand for Income in Terms of Effort. Economica, June 1930, 123-129.

Sonquist, J. A., Baker, E., & Morgan, J. N. Searching for Structure, AID III. University of Michigan: Institute for Social Research, 1971.

Townsend, M. R. Sheltered Workshops: A Handbook. Washington, D.C.: National Association of Sheltered Workshops and Homebound Programs, 1966.

Treitel, R. Recovery of Disabled Beneficiaries: A 1975 Follow-up Study of 1972 Allowances. Social Security Bulletin, 42, April, 1979.

Treitel, R. Rehabilitation of the Disabled. Social Security Bulletin, 34, March 1971, 22.

Turem, J. Adding Dependents of the Disabled to SSI: Effect of ADC. Wash., D.C.: The Urban Institute, 1974.

Urban Institute. Report of the Comprehensive Service Needs Study: Final Report. Wash., D.C., 1975.

U.S. Department of Commerce. Statistical Abstracts of the United States, 1978. 99th Annual Edition. Wash., D.C., 1978.

U.S. Department of Health, Education, and Welfare. Social Security Handbook. 6th Edition. Publication No. (SSA) 77-101 35 R, July, 1978.

U.S. Department of Health, Education, and Welfare. SSI for the Aged, Blind, and Disabled in Michigan, Publication No. (SSA) 11142, November, 1979.

U.S. Department of Health, Education, and Welfare. Monthly Benefit Statistics, No. 12. Office of Research and Statistics, Nov. 13, 1978.

U.S. Department of Health, Education, and Welfare. State Vocational Rehabilitation Agency Program Data, Fiscal Year 1977. OHDS-78-25053, 1978.

U.S. Department of Health, Education, and Welfare. State Vocational Rehabilitation Agency Fact Sheet Booklet Fiscal Year 1977. OHDS-78-25053, 1978.

U.S. Department of Health, Education, and Welfare. Annual Report to the President and the Congress, Fiscal Year 1978 on Federal Activities Related to the Administration of the Rehabilitation Act of 1973 as amended. Office of the Secretary, Wash., D.C., 1978.

U.S. Department of Health, Education, and Welfare. Work Disability in the United States. Washington, D.C.: Social Security Administration, 1977.

U.S. Department of Health, Education, and Welfare. Vocational Rehabilitation and Independent Living Rehabilitation Program, Proposed Rulemaking. Federal Register, Nov. 29, 1979.

U.S. Department of Health, Education, and Welfare. If You Become Disabled, Publication No. (SSA) 79-10029.

U.S. Department of Health, Education, and Welfare. A Guide to Supplemental Security Income. Publication No. (SSA) 77-11015, Sept., 1977.

U.S. Government Printing Office. The White House Conference on Handicapped Individuals. Volume Two: Final Report. Wash., D.C., 1977.

United States Senate and House of Representatives. Rehabilitation, Comprehensive Services and Developmental Disabilities Act. Public Law 602, 95th Congress, 1978.

United States Senate and House of Representatives. Rehabilitation Act of 1973, Public Law 112, 93rd Congress, 1973.

United States Senate and House of Representatives. Social Security Amendments of 1972, Section 301, as amended in 1972, Section 1612A, 92nd Congress, 1972.

Vandergoot, D. An Application of the Theory of Work Adjustment to Vocational Counseling in a Rehabilitation Agency. Unpublished doctoral dissertation, Michigan State University, 1975.

Walls, R. T., Masson, C., & Werner, T. J. Negative Incentives to Vocational Rehabilitation. Rehabilitation Literature, 1977, 38, 143-150.

Walls, R. T., Stuart, J. D., & Tseng, M. S. Macro- and Micro-Aspects of Program Evaluation in Rehabilitation. Resource for Evaluating Vocational Rehabilitation, Institute, West Virginia: Rehabilitation Research and Training Center, West Virginia University, 1974.

Walls, R. T., & Thvedt, J. E. Negative Incentives. In Interim Progress Report, R-34, West Virginia Research and Training Center, Feb., 1979.

Warwick, D. P., and Lininger, C. A. The Sample Survey: Theory and Practice. New York: McGraw-Hill, 1975.

Wilcox, C. Toward Social Welfare. Homewood, Ill: Richard D. Irwin, 1969, 40-47.

Wise, E. H. The Right to Work Versus Social Security Disability Benefits. Rehabilitation Literature, 1974, 35, 79-80.