HISTORY OF REHABILITATION MOVEMENT:

PATERNALISM TO EMPOWERMENT

AMOS SALES

UNIVERSITY OF ARIZONA

CHAPTER TOPICS

- Introduction
- Pre-1900s
- 1900 – 1920s
- 1930s – 1950s
- 1960s – 1970s
- 1980 – To Date
- Summary

INTRODUCTION

Rehabilitation can be defined as a philosophy, a concept, a discipline, or a service delivery system. However defined, it refers to a process of restoring an individual to the fullest levels of functioning possible. Vocational rehabilitation refers to a comprehensive sequence of services designed to maximize employment or independence of individuals with disabilities. Rehabilitation, for the purposes of this chapter, is very broadly defined as a societal response, as reflected in public and private service efforts, to individuals with a disability. The United States population of individuals with disabilities who could benefit from rehabilitation services is estimated at one in five (over fifty million) persons.

The political, social, economic, and/or vocational form of rehabilitation and its emphasis reflects society's beliefs about, and perceptions of, individuals with disability at any given time. A review of rehabilitation as a formal response to disability reflects evolving improvement in social attitudes toward disability within our society. This response has evolved from providing a right to simple survival, dependency, and custodial care to a right to independence and full inclusion. In the United States, the historical evolution of rehabilitation has been from "paternalism" to "empowerment." This evolution is a consequence of changing social movements, individual leadership, changing public attitudes and beliefs regarding individuals with disabilities, and increasing advocacy for and by consumer groups.

Rehabilitation, as it exists in the United States today, is a result of dozens of interrelated historical movements, events, organizations, academic disciplines, and professional fields. For example, advocacy groups in support of various disability groups have highlighted recognition and concern for rehabilitation services since the nineteenth century.

Medically based rehabilitation began in the early twentieth century primarily as a response to veterans who were disabled in wars. Vocational rehabilitation for citizens in the United States followed as a logical consequence of providing such services to World War I disabled veterans.

Rehabilitation reflects the value our society places on work. A core belief is that everyone should work, if possible. In our capitalist society, work is a right, and rehabilitation services have become an established right for individuals with disability in the United States. Our entire way of life is based on the assumption, as guaranteed within our Constitution, that every individual has the right to life, liberty, and the pursuit of happiness. These rights impose a corresponding obligation upon the United States government to provide the necessary services to insure equal access of its citizenry to these rights. Therein lays the rationale for the existence of the federally legislated state/federal program of vocational rehabilitation. For those individuals in our society who, because of disability, do not have equal access to employment, the federal

government has the obligation to insure this right. Other rationales have bee identified as justification for the formal federal rehabilitation response. The range from awareness of intrinsic dignity of man to cost-effectiveness of the service. None, however, provides as valid a rationale as that of the federal government's obligation to provide the services needed to insure equal acces

The rehabilitation movement in this country is much broader than the st of the development of the federal legislation establishing a state/federal partnership. It has evolved from the basic values of our society. Its roots ar the ideals, customs, and traditions of the United States citizenry. The rehabilitation service system, as it has evolved, encompasses services provic through the federally legislated state/federal program, the not-for-profit community rehabilitation programs, and the private for profit businesses. These areas of rehabilitation and rehabilitation service have grown and evol as an expression of public support of and services for individuals with disabilities.

This chapter will attempt to highlight the history of rehabilitation in the United States by identifying the cultural context, rehabilitation-related developments, and resulting federal rehabilitation legislation in the followin time frames: pre-1900s, 1900-1920s, 1930-1950s, 1960-1970s, and 1980 to date. Much of what is shared in this chapter has been written before from different perspectives. Much of it is a digest of the following works, the authors of which need to be fully credited: C. Esco Obermann's 1965 Histo of Vocational Rehabilitation in America;[9] N. Groce's 1992, The U.S. Role International Disability Activities: A History and Look Towards Future;[3] G Wright's 1980 Total Rehabilitation;[14] A. P. Sales' 1986 History of the Natio Rehabilitation Association "Journal of Rehabilitation,"[12] and the 1999 Instit on Rehabilitation Issues.[6]

The reader is encouraged to review these reference sources for further detail and information that is more specific. The history of rehabilitation in United States is, in reality, a history of the impact of its leadership. This chapter will be able to identify only a select few of that leadership.

PRE-1900s

CULTURAL CONTEXT

In order to provide a context in which to place historical events in rehabilitation, the following historical highlights are provided. The North American colonies were populated by a mass immigration of religious dissenters and poor people during the seventeenth and eighteenth centuries. Immigrants primarily from the British Isles, Germany, and the Netherlands came to farm or support farmers. Three million non-natives had arrived by 1770s and the small Native American population was greatly reduced by European diseases and by wars with the various colonies.

The colonists held a high regard for alcoholic beverages and considered them an important part of their diet. Drinking was pervasive because alcohol was regarded not as an intoxicant, but primarily as a health substance with preventive and curative powers. Alcohol played an essential role in daily rituals and in collective activity, such as barn raising. While drunkenness was condemned and punished, it was viewed only as an abuse of a God-given gift.

Cocaine and opium were legal during the nineteenth century and were favored drugs among the middle and upper classes. Opium and morphine were common ingredients in various potions. Until 1903, cocaine was an ingredient of Coca Cola. Heroin, which was isolated in 1868, was hailed as a non-addicting treatment for morphine addiction and alcoholism. By the end of the nineteenth century, concern had grown over the indiscriminate use of these drugs, especially the addicting patent medicines. Cocaine was ruled illegal after it became viewed as predominantly used by African Americans following Reconstruction. Opium was first restricted in California in 1875 when it became associated with Chinese immigrant workers.

During the 1770s, the British attempted to control colonial trade by taxing colonists to pay for British colonial administration. This clashed with colonial traditions of self-government and eventually resulted in rebellion and the successful American Revolution. The U.S. experienced increased immigration, and the exploitation of great natural resources fueled economic growth into the nineteenth century. The developing support of public education and antislavery sentiment reflected a widespread democratic ethic.

In the early 1800s, the first temperance movement began in response to dramatic increases in production and consumption of alcoholic beverages. Agitation against ardent spirits and the public disorder they spawned gradually increased during the 1820s. The belief that alcohol was addicting and capable of corrupting the mind and body took hold among the general population. The American Society of Temperance, created in 1826 by clergymen, spread the anti-drinking gospel. By 1835, out of a total population of 13 million citizens, 1.5 million had taken the pledge to refrain from distilled spirits. This wave of temperance resulted in dramatic reductions in the consumption of distilled spirits, although beer drinking increased sharply after 1850. A second wave of the temperance movement occurred in the late 1800s with the Women's Christian Temperance Movement embracing the concept of prohibition. Carey Nation, Kansas' anti-saloon crusader, began raiding saloons with a hatchet. Recruitment of women into the movement was major and the crusades to close down saloons were prevalent.

The War of 1812 with Britain had, as one result, the British burning the Capitol and the White House before a treaty was signed in 1814. The Mexican War (1846-1848) occurred in relation to annexing of Texas and, by the U.S. winning, Texas, California, and other territories were annexed. The Gadsden Purchase in April 1854, included territory now part of Arizona and Mexico. In

February 1861, seven southern states set up the Confederate States of Amer The Civil War began in April 1881 when confederates fired upon and captu Fort Sumter in Charleston, South Carolina. By May, eleven states had sece from the Union. President Lincoln issued the Emancipation Proclamation i January 1863, freeing all slaves in areas still rebelling. In April 1865, the confederates surrendered. President Lincoln was assassinated prior to the conclusion of the war. In 1867, Alaska was sold to the United States by Ru for $7.2 million.

The English industrial revolution spread to the United States in the mid nineteenth century and caused an explosion of industrial demand for raw materials and new markets. Inventors provided the means for larger-scale production. Transportation and communication enhanced this growth. Railroads were first introduced in the United States in the 1820s, with the fi continental railroad completed in 1869. Morse perfected the telegraph in 18 and the first telephone exchange went into operation in 1878. A new class c industrial workers was needed, lacked job security, and suffered from dangerously overcrowded conditions at work and at home. This need result in a population shift in the late nineteenth century. By 1890, as many indus wage earners existed as did farm laborers, tenants, and farm owners.

REHABILITATION RELATED DEVELOPMENTS

The history of rehabilitation-related developments in the United States l predates the turn of the twentieth century. American ideas and attitudes tow individuals with disabilities were brought from England, home to many of t early colonists. One colonial perception was that disability was the result o God's punishment. Colonial response to disability was custodial, with care provided by the family, church, or community. These early ideas, perceptio attitudes, and practices provided a base on which America's subsequent rehabilitation efforts would rest. One influence on these ideas and attitudes the Poor Relief Act of 1601, passed in England shortly before major immigration to America began. This Act was considered a milestone in the history of social legislation. It represented, for the first time, a national government acknowledging public responsibility for "disabled in need." On negative of the Act was that it made a clear distinction between those deeme "worthy" of assistance and those who were not. Another negative was that t Act did not encourage restoration of disadvantaged persons to productive liv

The Poor Relief Act was American law for the first 150 years of the colonies existence. After the Revolution, it would remain the model for futu legislation. The Act's distinction between "worthy" and "unworthy," and resulting rights granted by society, would influence society for centuries. T first almshouse for "worthy poor" vagrants, mentally ill, and disabled was founded in Boston in 1662. The first hospital for mentally ill patients was established in 1773 in Virginia. Fifty years would pass before the next simil

institution, the Eastern Lunatic Asylum, was established in Lexington, Kentucky. In 1742, the Quakers, with the help of Benjamin Franklin of the Pennsylvania Provincial Assembly, established the first general hospital of the colonies, the Pennsylvania Hospital near Philadelphia, which accepted all kinds of illnesses, including mental illness. A second general hospital, the New York Hospital, was founded in 1791. Hospitals proved important in the evolution of rehabilitation as human conditions other than medical began to be recognized.

The eighteenth century era of Enlightenment, with its emphasis on systematic analyses of bodies of knowledge, encouraged the scientific study of disability as a human condition. In the United States, examples of such studies were treatises on whether individuals who were profoundly deaf could reason and, if not, how could they know of the existence of God. Many of these inquiries addressed whether individuals with disabilities could be "trained." This led to the discovery that individuals with disabilities, when provided the same educational and social advantages as non-disabled, often demonstrated greater promise and potential than expected. It also resulted in a gradual change in perception among the public as it became apparent that people with disabilities could do more. Scholars, by trial and error, began to develop educational schemes and techniques, which, by the late eighteenth century, resulted in the beginnings of schools and institutions for children and adults with disabilities.

The 1880s saw an increase in public interest in disability and special programs in facilities. The first few decades of the nineteenth century saw the development of schools, benefit societies, and advocacy groups dedicated specifically to one particular type of disability, such as blindness or deafness. This development represented a positive shift from earlier eras' perceptions of all individuals with disabilities as "the infirm" or "the cripples." This emphasis on differences between various disabilities, rather than on common concerns, became a legacy for at least a century and a half. A "favored pecking order" related to the various disability groups arose among the public. Blindness, followed by deafness, was of primary concern to the public, whereas mental retardation was not.

Interest in establishing special programs for children with disabilities began to grow in the first quarter of the nineteenth century. The first United States educational institution for disabled children, a private school for deaf children, was founded in Baltimore in 1812. In 1815, Abbe Sicard, of the National Institute of Deaf Mutes in Paris, sent one of his teachers, Laurent Clerc, with Thomas Galludet, to Hartford, Connecticut, to help establish the first public school for individuals who were deaf. The school remains in operation today and is known as the American School for the Deaf. European experts in other disability areas came to the U.S. to establish schools, institutions, and associations. All of these efforts were greatly aided by the mid nineteenth century growth in organized charities. The mid to late nineteenth century saw

the United States continuing to develop services based on contributions fron Europe.

In the early 1800s, the forerunners of the federal vocational rehabilitatio program were rehabilitation facilities and the vocational services they provi In 1837, the first workshop-type program began at the Perkins Institute for t Blind near Boston. One major United States development in 1864 was the establishment of Galludet, a college for deaf education. This college is now Galludet University, and continues to be the only liberal arts institution of higher education specifically designed for persons who are deaf.

A large number of service societies were established between 1840 and 1890, but were criticized as being opposed to the concept of "rugged individualism" prevalent at that time. One example is the Red Cross, forme 1881, although it dated back to the Civil War when Clara Barton delivered volunteer services.

Interestingly, the historical development and treatment of individuals wi physical disabilities differed significantly from other disability groups. Serv for such individuals occurred several decades after other disability groups. Physical disabilities were linked directly or indirectly to medical treatment i hospitals. During the mid to late nineteenth century, numerous hospitals, schools, and institutions were established for those with physical disabilities

American surgeons who provided Civil War medical services were the f to explore what would come to be known as "rehabilitation," a term not in regular use until after World War I. These efforts to improve or restore som functioning to an individual with a physical impairment were by no means comprehensive. Once medical care or surgery and prostheses were provide most children and adults with physical disabilities were still in need of care supervision by their family or a state-run "poor farm."

Individuals with mental retardation were housed in lunatic asylums, poorhouses, almshouses, or local jails throughout most of the nineteenth century. Some attempts to meet their special needs began in the middle of t century. An experimental school, first funded by the Massachusetts legislat in 1848 to train "pauper idiots," was successful and incorporated in 1851 as Massachusetts School for Idiotic and Feeble-Minded Youths. It later was renamed the Walter E. Fernald State School. Other examples include the Pennsylvania Training Program for Feeble-Minded Children in 1853, The O State Asylum for Education of Idiotic and Imbecile Youth in 1857, the Connecticut School for Imbeciles in 1857, and the Kentucky Institute for the Education of Feeble Minded Children and Idiots in 1860.

Positive learning related to rehabilitation and special education came fro these schools. Individuals with mental retardation were found to be teachab and many could learn to function in the community. In 1863, the Hospital f the Ruptured and Crippled opened in New York, and addressed vocational needs of children with disabilities. A renewed interest in training children w

orthopedic problems resulted in legislation establishing facilities for the care, treatment, and education of crippled children. The first such facility opened, in Minnesota in 1897 followed by Wisconsin, Indiana, Iowa, New York, North Carolina, Nebraska, and Massachusetts.

The first school to train children to earn a living, The Industrial School for Crippled and Deformed Children, was opened in Boston in 1893. Classes for handicapped children in public schools began in the latter part of the nineteenth century. An example is special classes for children with mental retardation instituted in Springfield, Massachusetts in 1896. Special education as a distinct profession, however, was slow to develop.

In the late nineteenth century, Dorothea Dix's concern for a more humane treatment of people with mental illness led to a movement to build hospitals for them in the United States. The number of such hospitals rose to 123 in 1890, of which 75 were state owned. Dorothea Dix founded 32 of these 75. At the height of industrialization in the late nineteenth century, religion was dedicated to individualism and the government's doctrine of laissez faire. Henry Ward Beecher, a prominent Protestant minister, preached the theory of Social Darwinism—survival of the fittest in the economic world. Despite this, many new social programs emerged from the Protestant faith. Examples include the Salvation Army, which came to the United States by way of Britain in 1879, and the start of Goodwill Industries in 1902 by a Methodist minister, the Reverend Edgar Helms.

In the 1890s, there was tremendous growth and interest in the field of psychology. William James, the United States' first prominent psychologist, stressed the application of psychology in the classroom with an emphasis on the individual rather than the social goals of education. C. Stanley Hall, the first president of Clark University, established the American Journal of Psychology and, in 1892, helped found the American Psychological Association. Hall emphasized the uniqueness of the individual in his studies of children and adolescents. Jane Addams created the first organized secular program of social welfare, called Hull House, in Chicago in 1889. Addams also helped bring about the first 8-hour day work laws for women, the first child labor laws, and the first juvenile court. She was a strong supporter of reform in education.

FEDERAL REHABILITATION LEGISLATION

The first federal rehabilitation legislation in the 1700s in the United States was indeed paternalistic. It was based on a perceived need to take care of and to provide services to veterans as payback for becoming disabled in the Revolutionary War of 1776 and as Merchant Marines in 1789. This first national pension law, passed on August 26, 1776, provided veteran benefits and compensation for service-connected disability. Loss of limb or disabled to the degree one could not work, resulted in half of their service pay for life.

The need for additional federal legislation in this area did not surface fo eighty-six years. The large number of veterans with disabilities resulting fr the Civil War, required additional national legislation by Congress in 1862. The General Law, as it was called, applied to service members of the Civil and all subsequent wars. It remained unchanged during the war with Spain was still in effect at the start of World War I. The Law required that to rece compensation, an individual must have become ill or wounded from their military service. It added new benefits for widows, children, and dependent relatives of deceased service men. For the first time, veterans' preference w provided in federal Civil Service. Preference was also given to those applyi for homesteading, with time in service counted toward the residency requirement for asserting a claim.

1900s – 1920's

CULTURAL CONTEXT

From the 1900s to 1920, societal and demographic changes were signifi in the United States. The population doubled, from 50 million to 102 millio with the majority of this increase coming from immigration. This rapid gro coincided with a dramatic increase in the number of people living in cities, from a ratio of rural to urban population of 50-50 in 1890 to 30-70 in 1920. Increasing urbanization brought greater access to education, newspapers an magazines, and a loss of the closely-knit family unit and community suppor base.

The Industrial Revolution resulted in marked changes in the nature of w and roles of workers, who had to acquire specialized skills and function wit a supervised hierarchy. For the first time in the United States, social status affected by what one did for a living rather than bloodline or land holdings. New technology and inventions, such as Thomas Edison's practical light bul electric generating system, sound recording device, and movie projector, hel shape the future. In 1908 Henry Ford introduced the practical, low-cost Mo T, nicknamed the "Tin Lizzie," which put the common person in the driver's seat and ushered in the age of mass automobile travel. By 1927, fifteen mill Model Ts had been produced.

With major increases in city populations and industrialization, the urban boss, who dealt in public privileges and commanded public support, became very powerful and influential person. Growing out of the abuses of the urba boss, the Populist-Progressive Movement began in the 1890s, and continued until the start of World War I in April 1917. This movement pressed for ref of graft in politics and government, and was significant in that it was the firs political movement to insist that the federal government had some responsibility for the commonwealth. The Progressive Movement spanned presidencies of Theodore Roosevelt, Taft, and Wilson, and stressed the nee

assuring most Americans some fairness in a society in which power and wealth were in the hands of a few. In 1913, an amendment to the Constitution authorized the collection of a federal income tax that made possible federally supported rehabilitation programs. The Progressive Movement, generated for women's suffrage and led by Susan B. Anthony to enfranchise the women's vote, resulted in a bill that was presented to the Senate in 1886. Twenty-three years later, the bill received a majority vote, President Wilson signed the bill in 1919, and it was ratified by an adequate number of states in 1920 as Amendment XIX to the Constitution.

The passage of this amendment was the culmination of the Women's Christian Temperance Movement, a response to the heavy drinking practices of the major influx of European immigrants in the late nineteenth century, who became the new lower class. The Liquor Prohibition Amendment prohibited the manufacture, sale, and transportation of alcoholic beverages in the United States. This resulted in police destroying barrels of beer during the 1920s era of bootleggers, speakeasies, indulgence, corruption, and crime; typified by infamous Chicago gangster Al Capone.

Economic prosperity increased following World War I with an increase in women workers, women's suffrage (1920), and a drastic change in fashion (flappers, mannish bobbed haircuts for women, and clean-shaven men).

Two ineffectual presidents characterized the 1920s. Harding, inaugurated in 1921, was viewed as totally inept, more interested in playing cards than serving as president. His successor, Coolidge, believed that the less done as president the better. Hoover began his term in 1929 with Black Thursday, October 24, of that year bringing the Great Depression. Hoover's philosophy of rugged individualism did not help resolve the depression.

REHABILITATION RELATED DEVELOPMENTS

Several social concerns at the turn of the century set the stage for the federal government to become increasingly involved in disability issues. An awareness and concern was present to assist those who had work-related disabilities. Work-related disabilities were increasing because of new dangers from more complex manufacturing and processing technologies in mines, in factories, and on farms. Once an injury occurred, workers who had moved from small cities to big cities lacked family and community support networks.

The concept of employer responsibility for workers disabled on the job was in its infancy. Worker injuries were considered a personal misfortune. Injured workers, or their families, were responsible for care. Injury to the primary wage earner often brought poverty to an entire family, and a life dependent on what little charity was available. The only exception to this was the long established practice of providing small pensions to those severely injured in warfare.

In 1883, President, Benjamin Harrison, urged Congress to adopt a progr similar to that adopted in Germany. At the close of the nineteenth century, common law stated that the master or employer was responsible for the inju or death of employees when the employer was negligent. With industrial expansion, the number of accidents increased as did lawsuits citing negligen Many states, between 1900 and 1910, by judicial act, exempted employers f responsibility for disabilities resulting from work. The first Worker's Compensation legislation was passed in New York in 1910 followed by fort five states and territories by 1921. Initial laws did not include rehabilitation With this legislation, employees were compensated for occupational injuries but no longer had the right to sue their employers.

At the turn of the twentieth century, a variety of groups, both religious a secular, began establishing workshops. Goodwill Industries, St. Vincent de Paul, Volunteers of America, and the Salvation Army began salvage progra that employed individuals with a disability or alcoholism. These types of facilities spread across the United States. During the first decades of the twentieth century, a number of hospitals and institutions for "cripples" exist outside the mainstream of the general medical community. No rehabilitatio was provided. Medical care and supervision was the emphasis. Children bo with major physical disabilities might spend the first six to ten years of their lives in facilities for "crippled" children, often never returning to, or seeing their parents. Improved surgical techniques and better prosthetics and ortho permitted greater quality of life for some, but little was done to try to integra individuals with disabilities into the broader society.

A great system of free public education developed in the United States starting in the mid 1800s. By 1900, 33 states had passed compulsory attendance laws and, by 1920, all states had these laws. John Dewey, a psychologist, stands out as the education leader in the early 1900s. His research interest, and emphasis in a child-centered school system, was based freedom of the child to investigate and experiment in an individually suppor environment. Dewey was very supportive of vocational education, which w consistent with his belief in learning by doing. Only isolated vocational education programs existed in public schools in the early part of the twentie century. They were confined to industrial schools for poor and delinquent children. Through federal support, at the turn of the century, vocational education became part of most curricula in the public schools. This experie was fundamental to the development of vocational rehabilitation. During th time, there was a continuing growth and interest in psychology. Hall brough Sigmund Freud to Clark University for a series of lectures in 1909. Considerable interest also developed in the French psychologist, Alfred Bin whose objective measurement studies of children's intelligence led to the development of the first intelligence scale, the Binet-Simon IQ Test. Louis Terman, in his work at Stanford University, revised the Binet scales in 1916

resulting in the development of the well-known Stanford-Binet test for intelligence.

Medical advances during this time increased the population of individuals with disabilities. The first public health hospitals were established at the turn of the century. Medical advances and increased sanitation resulted in people living longer and living with disability after an injury or illness. World War I resulted in a large population of men with disabilities. Societal response to this was, as in the past, to implement pay back programs of vocational education and training through federal education and rehabilitation legislation in the early 1900s.

In the United States, World War I (1914 - 1918), with its massive casualties and forced refinement of surgical and post surgical care, might be considered a watershed for the field of rehabilitation. For the severely injured, survival rates were not significantly better than they had been in the nineteenth century. Of 400 American service men that became quadriplegic during World War I, half died at the battlefront and 8 of 10 who survived died within 90 days of returning home.[2] For those with less severe injuries, medical and surgical techniques had experienced some improvement, but comprehensive services were yet to be provided. Medical care, in even the best of civilian hospitals, was no better. Henry Kessler, as quoted in Groce,[5] recalls that during his orthopedic surgeon residency days in New Jersey, paraplegic patients "....were allowed to lie in a bed of sawdust, treated almost like animals. The theory was that if their bowel and bladder could not be controlled, at least the bed could be kept clean by removing the sawdust."[pp. 20-21]

An exception in this era was the work of Fred Albee in New Jersey. Albee, an orthopedic surgeon who had gained international fame for adapting techniques devised for tree grafting to grafting of human bones, believed the restoration needs of war injured veterans could be supported by "three legs of a tripod," physical restoration services, vocational guidance, and placement. This idea was revolutionary, yet supported by the United States Surgeon General through the construction, in Colonial, New Jersey, of one of three comprehensive rehabilitation hospital facilities Albee proposed. The hospital remained unique in delivering the tripod services proposed by Albee until it was closed at the end of World War II. One of Albee's students, Henry Kessler, carried forth these early ideas of rehabilitation medicine.

In the years following World War I, new volunteer groups in support of individuals with physical disabilities, began to flourish. The creation of facilities that would come to be called rehabilitation centers was one of the first national efforts to focus specifically on vocational rehabilitation for the physically disabled. The establishment, in 1889, of the Cleveland Rehabilitation Center began the expansion in the early twentieth century. In New York, in 1917, the Red Cross Institute for the Crippled and Disabled—now the International Center for the Disabled (ICD)—was established.

Supported by a philanthropic donor as an experimental school for war injure veterans, the Institute quickly expanded to include the civilian population, a served as a national clearinghouse for sharing the latest information on rehabilitation and disabilities. In 1917, the Red Cross also set up retraining programs for the disabled at Walter Reed and other Army hospitals. The Re Cross took on Braille transcription as a volunteer service in 1921. Goodwill Industries, first founded in 1902 with a welfare emphasis, began to expand vocational efforts in their facilities. A great number of other private volunta organizations, specifically devoted to physical disability issues, were soon established at local, regional, and national levels. The majority of these organizations supported disability specific populations, and concentrated on research and improved services.

These organizations added to the numerous advocacy groups and societi supporting specific disabilities such as deaf or blind. Most of these organizations grew out of a sense of civic duty. They were supported by religious denominations or were linked to hospitals or institutions. Followir World War I, these organizations filled a vacuum, and no significant, coordinated, federal government umbrella structure for providing service to adults and children with disabilities was available.

One of the unique characteristics of our American democracy is the volunteer organization. Through these organizations, people with common interests and goals may freely come together and organize to carry out their purposes. The National Rehabilitation Association (NRA) epitomizes the influence that voluntary associations have had in the development of our society and its institutions. NRA has been one of the primary leaders in the development of rehabilitation in this country as it relates to legislation, programs, and attitudes. NRA is, unquestionably, one of the oldest and strongest advocates for persons with disabilities.

Organizations usually have their beginnings in attempts by groups to me their needs or to solve their problems. If some difficulties are presented that cannot be resolved by individuals acting as individuals, group action is typically taken. The forming of the NRA was no exception to this general n In the second decade of the twentieth century, the new service of "vocationa rehabilitation" was emerging as a formal attack on one of the most pressing problems stemming from disability—unemployment. While the medical profession, the workmen's compensation movement, and voluntary organizations contributed to the beginnings of this new service, the educatio profession produced the combinations of interests and capabilities that most nearly met the vocational requirements of people with disabilities. The men and women who took up this work generally came from the field of educatic and the programs that were started in the several states were generally in sta departments of education and were a special function of divisions of vocatio education.

History of Rehabilitation Movement: Paternalism to Empowerment

The United States' reliance on voluntary organizations versus a more unified federal role continues to influence how society approaches disability issues. Some beliefs and practices continue today that negatively impact public opinion. For example "helping the disabled," continues to be defined as a good deed or a charitable act. Thus, it is one's "civic duty" or requirement, to contribute to the many non-profit, tax-deductible organizations. This results in individuals with disabilities being perceived as needing continuing support from charity rather than being perceived as competent citizens and taxpayers. Dependence on voluntary contributions of funds results in fierce competition for monies between various disability groups. This has tended to limit a free exchange of ideas and collaboration across disability groups. One result of this competition has been the need, on the part of those soliciting funds, to portray a particular disease or disability in the most pathetic terms in order to be the most deserving of contributions. National telethons and the "poster child" exemplify this. This competitive soliciting contributes to much of society's confusion regarding the roles and responsibilities of state and federal governments and the rights and responsibilities of individuals with disabilities.

Early vocational guidance programs greatly influenced the developing process of vocational rehabilitation. Frank Parsons, a social worker, established the first vocational guidance programs in the United States, in Boston, in 1908. Parsons' program emphasized understanding oneself, understanding the requirements and conditions for success, and reasoning in relation to these two. As Parsons' concepts spread, advocates in education, social work, business, and government joined together in founding, in 1913, the National Vocational Guidance Association, the forerunner of the American Counseling Association. World War I brought an increased need to choose the right man for the right job, as stressed in Parsons' theory. Selective tests were devised. The first group of intelligence tests, the Army Alpha and the Army Beta, were used respectively for literate and illiterate recruits. Following World War I, these testing techniques extended to all areas of vocational guidance, including vocational rehabilitation.

At the 1923 meeting of the National Society for Vocational Education, in Buffalo, the specialists in vocational rehabilitation held a sectional administrative meeting where these issues and the possibility of a separate organization were discussed. At a later business session on December 8, 1923, a new group was formed titled the National Civilian Rehabilitation Conference. The new National Civilian Rehabilitation Conference met in Indianapolis in 1924 in conjunction with the National Society for Vocation Education. During the meeting, a formal vote was passed to establish the conference as an independent association. At the meeting in Memphis in March 1927, the Conference changed its name to the National Rehabilitation Association.

FEDERAL REHABILITATION LEGISLATION

In 1917, the federal government passed the Smith-Hughes Act that serv as a model for future state-federal legislation and authorized grant-in-aid support to states for vocational education. The Act provided federal monies vocational education to states that matched some percentage of these funds met certain requirements as listed in their State Plans. This precedent for human service programming was administered under a new Federal Board f Vocational Education. In 1918, for the first time, the United States House a Senate unanimously approved federal legislation on disability and rehabilitation. The Act, which essentially established the field of rehabilitat was referred to as the Soldiers' Rehabilitation Act. It was designed as a program for veterans to meet what was perceived as a governmental payba obligation for military service and injury. Because of the retraining emphas of the Act, the Federal Board of Vocational Education was authorized to oversee the Act's program services provided to disabled veterans. This legislation provided an opening for similar legislation related to the civilian population, and Congress was soon debating whether such a program shoul available to civilians. Industry leaders who viewed such programs as dangerously "socialistic" raised strong opposition. In 1920, Congress passe the Smith-Fess Act, (Civilian Vocational Rehabilitation Act). Like the 191 legislation, it only provided for training to workers who had become disable on the job and was funded on a temporary basis. The Act remains significa the first federal action in the US to provide vocational rehabilitation service citizens with disabilities, and the first to reflect a social obligation to insure access to employment for individuals with disability.

The Smith-Fess Act of 1920, as a grant-in-aid program, provided federa funding as an incentive for states to develop plans and deliver rehabilitation services. Today, state programs in all fifty states, the District of Columbia, the Commonwealth of Puerto Rico, make up what is referred to as the state/federal vocational rehabilitation program. Within this program, counselors are responsible for locating consumers, determining eligibility ar rehabilitation potential, providing counseling and related services necessary attain a vocational objective, and arranging directly or indirectly for placem From the earliest days until quite recently, the delivery of vocational rehabilitation services followed the medical model. Eligibility for state-fed vocational services required a medically definable disability that presented a handicap or barrier to employment or independence, and a determination by counselor of a successful outcome that was reasonably obtainable. The Act targeted occupationally injured populations and called for cooperative agreements to be established with existing workers' compensation boards an commissions. It also established an ongoing office within the federal government dedicated to disability issues. This office provided a focal poin bring together concerned individuals to share ideas and concepts of national

importance. This federal legislation, in response to the needs of citizens with disabilities, was tenuous in that it had to be reauthorized each year. From 1920-1930, only 45,000 individuals had been rehabilitated and slightly over $12 million in federal dollars had been spent. Other federal and state efforts on behalf of individuals with disabilities were less visible in the early twentieth century. During this time, there was a tremendous growth, on a state-by-state basis, in the area of special education.

1930s -1950s

CULTURAL CONTEXT

The impact of voluntary organizations was significantly reduced as the Great Depression, resulting from the stock market crash in October 1929, grew in the early 1930s. Unemployment reached more than 12 million, many of whom became homeless and stood in long lines for free food and baths. In radio "fireside chats," President Franklin Delano Roosevelt broadcast hope for recovery under his "New Deal." Although some new legislation such as the Social Security Act evolved, the Great Depression reduced the national tax base and voluntary contributions from the public. State rehabilitation-related programs were hit hard. Special education programs funded through local taxes were cut. Hospitals and training centers also eliminated rehabilitation services.

Nevertheless, this period represents one of growth in public awareness of disability. The public debate about eugenics and, by extension, disability, had been growing since the turn of the century and increased after the rise of the Nazi party in Germany. Franklin Delano Roosevelt easily gained the presidency because of a platform of government responsibility for the state of the economy and the relief of starving and homeless individuals suffering under the depression. President Roosevelt concentrated on trying to overcome massive societal problems such as inadequate food, housing, and employment. Even though he himself was disabled, the needs of individuals with disabilities were not addressed.

When Adolph Hitler declared war on Poland in September 1939, Britain and France declared war on Germany. After two years of trying to avoid involvement, the United States entered the war after Japan bombed Pearl Harbor on December 7, 1941. World War II involved sixty-one countries and resulted in the deaths of an estimated fifty-five million soldiers and civilians. In addition, Hitler's Nazi party killed some five to six million Jews in the Holocaust. Germany surrendered to the Allied Forces in May 1945. Japan surrendered shortly after Harry Truman, who succeeded Roosevelt as President in 1945, approved the dropping of atomic bombs on Hiroshima and Nagasaki in August 1945.

The post-war baby boom increased the number of infants born with impairments and the polio epidemic of the late 1940s and early to mid 1950s

further added to this population. Demographic changes began to have a dire impact on disability and related programs. In the years following World Wa II, families began to move away from rural areas or small towns and their traditional support networks. Growing numbers of people spent the workda offices, stores, or factories. The need for new support systems was evident a people looked to the government for help.

At that time, the medical profession and the public were much more awa of "rehabilitation" as a process. Returning veterans, and the advocacy group they formed at the close of the war, were particularly effective at articulating the needs of Americans with disabilities. The 1950s reflected tremendous economic growth and technological advances and the Korean War, 1950-19 brought increased public awareness of disability and the need for rehabilitati services. The philosophical concepts underlying rehabilitation were very compatible with President Eisenhower's philosophy of dynamic conservatio

The post-war military activities of the Soviet Union in the late 1940s led United States' fear of further Soviet advances. This fear resulted in the formation in 1949 of the North Atlantic Treaty Organization, a military coalition, and the start of the "Cold War." Economic growth changed life patterns for middle and working classes, with suburban "tract" housing becoming the norm. President Dwight D. Eisenhower served two terms, fro 1953 through 1960. His philosophy of dynamic conservatism and his war experiences resulted in his strong support of federal rehabilitation programs. The administrations of Eisenhower, Kennedy, and Johnson, 1953-1969, saw federal expansion in rehabilitation services that has been referred to as the Golden Era of Rehabilitation.

REHABILITATION RELATED DEVELOPMENTS

Franklin Delano Roosevelt, who dominated most of the 1930s and 40s a the United States' President, was disabled because of polio. He downplayed this fact and, except in indirect ways, did not advocate for disability organizations. Eleanor Roosevelt, on the other hand, exhibited great interes disability issues from the 1920s until after World War II.

In the late 1940s and early 1950s, major rehabilitation centers were developed as models of medical care and professional and vocational trainin These included the Institute for the Crippled and Disabled in New York, the Cleveland Clinic (later the Cleveland Rehabilitation Center), the Sister Kenn Institute in Minneapolis emphasizing care for children and adults with polio Rusk's Institute of Physical Medicine and Rehabilitation in New York, the Kessler Institute for Rehabilitation in New York, and Henri Viscardi's Abili Inc., in Long Island. By 1946, state rehabilitation agencies were involved ir funding the development of comprehensive rehabilitation centers. In 1954, Hill Burton Act provided some support for their development. In 1965, fed

rehabilitation legislation provided considerable funding for rehabilitation centers and staff.

These non-profit rehabilitation centers and community workshops provided, in addition to the federal rehabilitation programs and private for profit rehabilitation programs, the third major emphasis in rehabilitation service. In the late forties and the fifties, the efforts of these centers led to the American mass media—movies, newspapers, magazine, and radio—addressing disability issues with growing frequency and candor. Numerous movies depicting the return to civilian life of veterans had powerful impressions on audiences. Helen Keller gained media notoriety and the Readers' Digest regularly carried "true life" stories about individuals "facing" and, almost invariably, "overcoming" a disability. Although inspirational, these stories presented detailed facts about people and families coping with disabilities. Media attention began to focus on "gifted" individuals with disabilities.

Inspirational stories became the vogue. It would be decades before descriptions of an individual with a disability would no longer contain words such as "noble," "inspirational," and "courageous." Not all disabling conditions received this attention. It was only after World War II that public discussions of mental retardation began and not until the 1970s that similar discussions occurred related to mental illness.

In the early years of World War II, service members who were permanently disabled remained in the Army hospitals, such as the Walter Reed Hospital, until medicine could do no more for them. They were then discharged to civilian life with services to be provided by the Veterans Administration that had no comprehensive programs. This lack of services became more pronounced as new antibiotics controlled infections and resulted in more service members surviving serious injuries. As the enormity and complexity of the needs of newly disabled service members became clear, the United States military responded with innovative programs.

Rehabilitation, as a part of physical medicine and war-related injuries, was an idea whose time had come. Two physicians who played key roles in its development, during and after the war, were Henry Kessler and Howard Rusk. Kessler, a member of the Naval Reserves was called to service as a Lieutenant Commander and had been involved in physical medicine and rehabilitation for two decades. He performed front line surgery in the South Pacific. In 1943, he was transferred back to the United States to build a new amputation center, the Mare Island Naval Hospital in California, which became a leading military rehabilitation facility. Kessler was known for ensuring comprehensive state-of-the-art services that encouraged patients to become informed consumers. He touched the lives of not only thousands of individuals with disabilities, but also hundreds of medical professionals who studied with him.

Howard Rusk, an Internist from St. Louis, enlisted in the Army Air Force in 1942 and served as Head of Medical Services at the Jefferson Barracks in

Missouri. With no training in rehabilitation or disability, he noted the simpl fact that his patients made better progress when they were intellectually and physically challenged. He developed programs to accomplish this, and gradually formulated the idea that rehabilitation should be a specialty withir general Internal Medicine and not exclusively the domain of surgeons. Rusl emphasized the "rehabilitation of the individual," not the injury. Soon he w in charge of initiating rehabilitation programs, titled Convalescent Training Programs, in Army Air Force hospitals, and developed twelve such progran where hundreds of medical personnel were introduced to his rehabilitation concepts.

World War II was a stimulus for improved medicines and medical technologies that permitted longer and healthier lives for individuals with disabilities. Of equal importance were advances in prostheses and orthotics began during the war and progressed rapidly in the next few decades. Dr. George Deaver, one of Rusk's assistants, was the first to prove that individu with paraplegia could walk if properly braced.

Henri Viscardi, an advocate with a disability, spent the World War II ye as an American Red Cross volunteer at the Walter Reed Hospital. He and t other individuals with amputations confronted Rusk in his office over the practice of providing veterans with shoddy wooden prostheses. Within wee and with the support of the hospital's commanding officer, the army institut an ongoing research project funded by Congress that developed improved a innovative prostheses over the next decade. By 1945, U.S. researchers had pioneered the use of new, lightweight materials such as plastics to replace heavier and more cumbersome steel and wood.[9]

The close of World War II marked a new era for rehabilitation in the Ur States. Federal and private non-profit rehabilitation programs had to be reb and expansion of rehabilitation facilities was a natural consequence. Progra were comprehensive, but maintained a strong physical restoration compone Special education programs had all but disappeared, and there continued to l few alliances across the various disability specific groups. At the close of t war, government and civilian agencies initiated studies to determine how be to serve returning disabled veterans. It was soon evident that veterans were being fairly well served, but the needs of the disabled civilian population w great and largely unmet. One study estimated that 23 million were disabled some way and the numbers were growing because of advancements in medicine, surgery, and antibiotics. Only 10% of paraplegic veterans in Wo War I survived the first year, whereas, 80% of World War II paraplegic veterans were alive and active a decade later. Survival rates in this time fra were equally dramatic in the civilian population.[9]

In some ways, the mid 1950s through the 1960s were the heyday of Uni States based rehabilitation and expertise. Medical and technological advanc improved professional training, research, and comprehensive legislation on

disability made the United States preeminent. One example is Rusk establishing in 1950 what is now titled the Howard A. Rusk Institute of Rehabilitation Medicine at the New York University Medical Center. Training programs flourished in fields such as physical therapy, occupational therapy, rehabilitation counseling, social work, special education, speech pathology, and rehabilitation medicine. Students of these different disciplines shared ideas and literature. However, communication between these fields frequently lagged behind communication within them. The division among academics reflected the past divisions found within private organizations and specific groups of individuals with disabilities. Scarce funding and minimal public attention often drove professional groups to compete rather than collaborate. While there were a few exceptions, the emphasis for most in rehabilitation was on how the individual with a disability could adapt to society, and the sociological concept of "stigma" associated with a disability dominated the era.

The early 1950s through the late 1960s saw the development of two social action movements of great significance; the Parents' Movement and the Disability Rights Movement of Persons with Disabilities. These two movements would eventually overlap and begin to unite with rehabilitation. The Parents' Movement was on behalf of children with mental retardation and in support of special education. While individuals who were severely retarded had been institutionalized, special programs and classes for mildly and moderately retarded children had evolved since the mid nineteenth century, but were the exception in most American school districts. Most educators in the early 1900s felt that little could be done for "retarded children" and that the public school system was not necessarily responsible for their education. It is not surprising that the first academic programs to be eliminated under the impact of the Great Depression were special education programs. "Higher functioning" retarded children were abandoned to the back of the regular classroom and the more severely impaired were simply sent home or institutionalized. The impact is seen in New Jersey where there were more children in public school special education classes in 1918 than in 1950.

Within the general public, retardation was still considered to be a shameful condition, a reflection of "weak" or "poor" genes, and a punishment or "cross to bear" by God. Parents often sent such children to a private institution for the mentally retarded. The late 1940s and early 1950s saw the beginning of a consumer driven parents' movement that sought to obtain services for developmentally disabled children and adolescents. From modest beginnings evolved the National Association for Retarded Children (NARC), which served as a catalyst for parent advocates nationally. In 1950, this association held its first nationwide convention. By 1956, it had well over 50,000 members with branches in every state, dealing with legislation and parent education. Dr. Salvatore De Michael was the first Executive Director of NARC. He came to the organization with expertise in legislation from Switzer's Office of

Vocational Rehabilitation in Washington. De Michael's successor, in 1957, was Gunnar Dybwad, whose background as a lawyer helped frame consume entitlement issues in legal terms. Parents involved with NARC became awa that medical and educational professionals often knew little about mental retardation beyond their ability to identify and name certain conditions. As result, the parents supported education and research programs. In 1957, the Office of Education and Switzer's Office of Vocational Rehabilitation (OVR began to support teacher training programs and research in special educatior While early advocates of mainstreaming argued that special education shoul be part of the public school curriculum, most of the energy was in trying to convince public educators that they had a responsibility to these children.

The parents' movement not only addressed educational issues but, as the children grew older, the focus broadened to issues of preparing the mentally retarded child and young adults for a "normal" life. The concept of normalization, as discussed by Bengt Nirje of Sweden and Wolf Wolfensberger, was essentially mainstreaming and was related to providing age-appropriate activities for individuals with mental retardation in an environment approximating that of nondisabled peers.[13]

The Disability Rights Movement had its beginnings in the early origins Independent Living, a byproduct of the polio epidemic of the 1950s. By returning post-polio persons to their home, significant savings occurred. As result, individuals with disabilities and their families gained experience in various aspects of independence. Because they represented large numbers, special summer camps, youth groups, and education programs were made available to them. This provided opportunities to meet and learn from other with similar experiences. Other influences included deinstitutionalization, normalization, and mainstreaming. As early as 1956, the National Rehabilitation Association passed a resolution in support of legislation in thi area. In 1957, and later in 1961, legislation failed.

Beginning with its inception, the National Rehabilitation Association assumed a leadership role in national legislation. In 1930, the Association t major responsibility for the renewal legislation for the State-Federal Vocatic Rehabilitation program. It drafted its own bill and succeeded in getting it introduced in Congress. When it became apparent that close watch would h to be kept on this legislation, the Association made a special appeal to its members for funds to finance sending representatives to Washington as nee to lobby for passage of the bill. A fund of $3,449.00 was raised by this spec appeal. This was a phenomenal amount, since the normal budget of the Association was less than $200.00 a year.

With legislative activities taking so much time of the Association, in 19 it was decided to establish a headquarters in Washington, DC. With the depression, plans to hire an Executive Director had to be abandoned. Instea the Association placed major energies behind successfully implementing the

1936 and 1940 rehabilitation legislation. Growth within the Association saw the development of sub-units and regions. E. B. Whitten was employed as Executive Director in 1948.

State chapters were authorized in 1950 and professional divisions in 1957 with the start of the National Rehabilitation Counselor Association. The Association's national political support was very strong and the Rehabilitation Act of 1954 resulted in expansion of services and programs and in construction of facilities through the 1965 Amendments.

FEDERAL REHABILITATION LEGISLATION

The 1933 Amendments to the Rehabilitation Act reflected the government's effort under President Roosevelt's "New Deal" to combat the Depression. Vocational Rehabilitation was still considered charitable work. The professional rehabilitation worker was titled "agent." The continuing emphasis in service delivery was on what needed to be done to the individual with disability rather than involving them in their own rehabilitation. In 1935, the Rehabilitation Act, virtually unchanged, was made a permanent program. This resulted from lobbying for an amendment to the Social Security Act of 1935 by representatives of the National Rehabilitation Association. The Randolph Sheppard Act (1936) allocated funds for the development and expansion of facilities for people who are blind and gave them exclusive rights for vending machines in federal buildings. The Wagner-O'Day Act (1938) made it mandatory for the federal government to purchase products from blind individuals. In 1939, Amendments to the Social Security Act increased annual grants and appropriations for rehabilitation.

Between 1920 and 1943, the Rehabilitation Act provided services only to the physically disabled. The growth of disability advocacy groups and organizations was slowed by the Depression and the start of World War II, as disability issues became a lower priority. In contrast, federal involvement with disability groups and programs increased for two reasons—the need to utilize all available workers on the home front, and the need to rehabilitate injured veterans. Immediately after the U.S. involvement in World War II, President Roosevelt asked the Federal Security Administration to study what would constitute an adequate vocational rehabilitation program during and after the war. Recommendations resulted in great expansion of the Rehabilitation Act and generated interest, still discussed today, in the state-federal vocational rehabilitation program being a part of the Department of Labor. World War II directly influenced the first major expansion of the Rehabilitation Act and of eligibility for services within it. The goals of the 1943 Disabled Veterans Rehabilitation Act, Public Law 78-16, signed by President Roosevelt, were clear. They were to direct "disabled manpower" into war production and provide comprehensive services necessary for employment of disabled veterans in peacetime pursuits. For the first time, the Act received strong support from

government and business. It provided more liberal funding, extended servic to the mentally handicapped and the mentally ill, provided for the option of separate state/federal vocational rehabilitation program for persons who are blind, and established the Office of Vocational Rehabilitation (OVR) within Federal Security Agency. More importantly, the Act expanded the provisio services from job training to medical, surgical, mental health, and physical rehabilitation services. Surveys funded under this law found that the civilia population of people with disabilities was much larger and received fewer services than previously believed.

Enormously high unemployment rates and poverty subsistence levels w universal among all disability groups at the end of the War. Large numbers newly disabled veterans who wanted to return to the work force became increasingly vocal about these problems. From the mid 1940s, employment became the prominent issue for disabled individuals and groups. In 1944, t Serviceman's Readjustment Act, called the "GI Bill of Rights," was passed. provided extensive support for readjustment and rehabilitation. In 1945, Congress enacted Public Law 79-176 to establish the National Employ the Physically Handicapped Week and paved the way for President Truman's organizing The President's Committee on Employment of the Physically Handicapped. As a non-government agency, the Committee served in a national advocacy role on behalf of employment for disabled individuals. T Committee's work resulted in an increase in numbers employed and a growi public awareness of the problems confronted by people with disabilities. Th Committee's employment activities led to questions regarding transportation accessibility, workers' compensation, legal protection, independent living, social equality, and ultimately, civil rights.

In 1957, President Eisenhower established the Department of Health, Education, and Welfare (HEW), the new home of the Office of Vocational Rehabilitation (OVR). Mary Switzer was appointed the first Director. Her long-standing interest in rehabilitation and her personal and professional contacts with rehabilitation leaders, such as Howard Rusk, provided entree t the OVR position. She was noted for her innovative ideas, her genius for bringing individuals and programs together to reach a workable consensus, her respect for and ability to lobby Congress. These activities inspired increased expansion and funding of the federal rehabilitation program durin the 17 years of her administration. In her tenure, funding for the program increased forty-fold. By using the example of restoring individuals with disabilities to "taxpayers," with a return of $10 for every dollar expended on their rehabilitation, Switzer argued that the program was an example of a productive public program that could justify its expenditures.

Switzer lobbied Congress to pass the 1954 Rehabilitation Act Amendments. This legislation launched what has been referred to as the Golden Era of Rehabilitation. The Amendments were based on the

government's search for ways to address mounting welfare and dependency needs. They broadened state federal programs and provided for the establishment of public and non-profit rehabilitation facilities. Evaluation and work adjustment services for state agency consumers were approved and the utilization of rehabilitation facilities was increased. In addition to service, research, and demonstration areas, funds for training grants were approved. Switzer was now empowered to fund whatever she chose in the field of rehabilitation. Her emphasis on training was at the graduate level.

Rehabilitation counseling had the unique distinction of being the only profession established by an Act of Congress. Those employed in the field were labeled rehabilitation workers, agents, or advisors. The establishment of graduate level training programs in 1954 identified the competencies necessary to serve as a rehabilitation counselor. However, the requirement that all "counselors" in the state/federal program have the Masters degree in rehabilitation was not mandated for another 44 years, in 1998. Research on a wide range of psychological, social, educational, and behavioral aspects of disabling conditions was funded. For the first time, information on disability was to be systematically studied and integrated into training, policy, and service programs.

The effective funding of a wide range of rehabilitation programs from the 1950s through the 1970s is directly attributable to Mary Switzer's vision. She funded some of the first movements toward independent living and disability rights. Other funding interests included Playwrights, the National Theatre for the Deaf, and film captioning. Her Office of Vocational Rehabilitation (OVR) provided a central focus for rehabilitation issues throughout the government.

1960s -1970s

CULTURAL CONTEXT

Political and social strife and reform movements characterized the 1960s. Non-violent demonstrations of Afro-Americans resulted in the Civil Rights Act of 1964, but violent riots occurred within urban ghettos, Watts and Detroit, in the mid 1960s. New concern for the poor led to President Johnson's Great Society Programs, the Medicare Act, the Higher Education Act, and the Water Quality Act. Feminism became a national cultural and political movement, and the National Organization for Women was founded in 1966. Nineteen Sixty-Four saw the beginning of the Vietnam War. In 1965, United States' troops were deployed, and their numbers reached a high of 543,900 in 1969. Opposition to the United States' involvement in Vietnam became increasingly more violent, particularly by college students in 1969, the same year that astronauts Neil Armstrong and Buzz Aldrin became the first humans to set foot on the moon. A cease-fire agreement was signed in Vietnam in 1973.

Increases in alcohol consumption as well as illegal drugs during the 196 raised public concern. LSD, legal in the 1950s, became illegal in 1965 whe became associated with the counter-culture. The use of cocaine reappeared about 1970. At first, its use was viewed as a harmless tonic, but as the stree price fell, the acute and long-term effects began to alarm the public. In 197(Jerry Rubins claimed that marijuana makes each man God. Timothy O'Lear recommendations to turn on, tune in, and drop out characterized the promin drug use of the time. Alcohol and drug use was synonymous with the large counter-culture, symbolized by Woodstock, a music festival held in Bethol, New York that drew almost one-half million people.

In late 1963, a stunned nation came to a standstill as it reacted to the assassination of President Kennedy. Ten years later, the American constitutional system faced its worst challenge since the Civil War. From A 1973 through August 1974, the nation tensely watched the resignation of the Vice President and the unfolding developments of Watergate that eventually under threat of impeachment, led to the resignation of the President of the United States, Richard Nixon, on August 8, 1974. The Watergate revelatior and scandal not only led to a loss of faith in government, but also galvanizec Congress. It led to a new emphasis on congressional oversight, of not only implementing laws but also evaluating their effects.

The economic boom of the 1960s began to falter in the 1970s and result in a severe recession in 1974—1975. Protectionist trade practices, the decli of the dollar, and monetary instability resulted in inflation. The impact of th energy crisis was devastating in terms of general inflation and unemployme Attempts to curb inflation drove the prime interest rate to over 20% by 1980 thus greatly reducing automobile and housing sales. High inflation destroye retirement programs and individuals spent rather than saved because commodities would cost more the next year. The energy crisis caused a re-evaluation of government priorities. Many programs such as vocational rehabilitation were told, "...to do more with less," and there was increased accountability on the part of federal programs. Within this sluggish econom developed a growing distrust of big government and a weakening support fo new social policies, i.e. school busing and racial quotas were opposed in co

REHABILITATION RELATED DEVELOPMENTS

The parents' movement had progressed so quickly that when the initial c rights legislation began redefining rules for African-American children, it became apparent to several people in the parents' movement that these rules were also pertinent to retarded children. By the early 1960s, increasing numbers of retarded children were being served with the more severely retar beginning to receive attention, but progress was very slow. In 1960, no mor than 1 in 4 eligible mentally retarded children had been enrolled in special public school classes. Interest in mental retardation was helped enormously

when President Kennedy initiated the President's Panel on Mental Retardation in 1961. It was furthered by the public admission by Eunice Kennedy Shriver, President Kennedy's sister, of their sister Rosemary's mental impairment. Suddenly, politicians were willing to take issues of mental retardation seriously.

The 1960s and 1970s were turbulent years of great social strife and change in the United States with many minority groups, through protest, civil disobedience, and consumer voter power, demanding changes in the status quo. Social unrest sparked action in the disabled community as well. During the civil rights movement of the 1960s, culminating in the Civil rights Act of 1964, many of the activists were individuals with disabilities. Under a civil rights commitment, individuals with disabilities began to argue that their shared problems and concerns outweighed their differences. Many Americans with disabilities began to realize they were dealing with issues similar to those of other minority groups. They began to see that their disability was not an issue of specific medical diagnosis, but a minority status, and that they deserved the same rights and protections granted other minority groups. With this came a new activism. By the mid-1970s, numerous organizations administered for and by people who were disabled, were founded to address political, economic, and social concerns. These organizations worked closely with one another, and their actions represented a social movement that came to be known as the Disability Rights Movement or the Independent Living Movement

Independent living rehabilitation represents an expansion of support into life areas other than work. The Independent Living movement is based upon other social movements in the 1960s and early 1970s, including civil rights, consumerism, decentralization, self-help, and deinstitutionalization. In 1972, the first Center for Independent Living was incorporated in Berkeley, California. Individuals with disabilities staffed it as peer counselors and advocates. Other centers developed at the Universities of Texas, Ohio, and Michigan. By 1985, a directory listed 298 independent living programs in the United States with at least one program in each state. Centers for Independent Living (CIL) were created to be community-based, non-residential, private not-for-profit, consumer-controlled organizations. Consumer controlled meant that the majority of employees and the Boards of Directors were to be people with disabilities. CILs now exist under federal rehabilitation funding in all states. Their primary goals are to serve as advocates for eliminating environmental, economic, human rights, and communication barriers that are detrimental to people with disabilities; provide public awareness and education to dispel myths about disability and people with disabilities; and offer direct services to individuals with disabilities.

While CIL operations will vary from location to location, all have a core of four direct services:

- Information and referral wherein information is provided to help consumers self-assess their problems and situation;

- Peer counseling composed of one-on-one or group supportive and non-therapeutic interactions with other people with disabilities are used for self-exploration and help with self-advocacy;
- Skill training in which acquisition of specific skills or competencies is attained in such areas as health maintenance, application and management of financial benefits, job development skills, household management, personal/interpersonal communication skills, and self-care in activities of daily living (e.g., bathing, dressing, transportation); and,
- Advocacy and information services designed to help consumers act on their own behalf to maintain or improve independent living skills.

The Golden Era of rehabilitation began to wane in the late 1960s. Switz retired in 1970, and the rehabilitation orientation in the social and rehabilitat services reverted to a social welfare persuasion. A struggle for priority and attention in the federal program increased between individuals with severe disabilities and individuals who were disadvantaged and had been brought i the system by President Johnson's War on Poverty. The 1970s also saw stat rights issues having a major impact on rehabilitation. Large state umbrella service agencies began absorbing state rehabilitation programs, which were traditionally independent and unique human services systems. In the early 1970s, an active militancy on the part of individuals with severe disabilities resulted in scrutiny of the program by Congress. The Rehabilitation Act experienced its first veto by President Nixon in 1973. Nixon did not suppor the Act's funding of public offenders and opposed proposed independent liv provisions. Congress deleted Independent Living provisions and Nixon sig the Act that year. Ford similarly opposed rehabilitation appropriation. President Reagan's targeted destruction of the Act in the early 1980s throug Block Grant approach and reduction-in-funding proposals highlighted just h fragile and at risk were rehabilitation legislative gains. NRA, through its Legislative Network, is credited with insuring the survival of the Rehabilitat Act, as well as insuring increases over presidential budget proposals for fun the State/Federal Vocational Rehabilitation Program.

As the Rehabilitation Act and its amendments from the 1920s to the 197 targeted specific disability populations, the occupationally disabled populati no longer was the sole focus of the state/federal rehabilitation program. Private-for-profit rehabilitation had its greatest growth after the 1975 Califo legislation that mandated the addition of vocational rehabilitation services t the medical services provided through state Workers' Compensation Law. T private for profit emphasis is on case management necessary to return an injured worker to gainful employment versus the public sectors' emphasis o

maximizing potential. Many states followed with "mandatory" vocational rehabilitation legislation causing a tremendous growth in employment in the private sector that exceeded the growth in other federal programs. Recent studies show that almost forty percent of qualified rehabilitation counselors are employed in private-for-profit rehabilitation firms, about thirty percent in the state federal rehabilitation program, about ten percent in private nonprofit rehabilitation facilities, and almost ten percent work in private practice.

The National Rehabilitation Association began to see a loss in its national legislative leadership role in the mid-to-late 1970s when it began to experience a significant loss in membership. This loss resulted, in part, from a major change in the organizational administrative structures within state agencies providing vocational rehabilitation services. From 1973 to 1978, the number of state agencies administratively housed in "umbrella" state social service agencies had increased from only a few to over thirty. Within these states, NRA membership dropped dramatically as state vocational rehabilitation administrators lost their autonomy and their ability to provide administrative support for state agency employees' participation in NRA chapter programming and activities. In addition, within these states, many new state directors were appointed with no background in rehabilitation and without an appreciation for the benefits accrued to the agency by supporting employees in a strong and active state NRA chapter.

Directors of State/Federal Vocational Rehabilitation agencies had provided the primary leadership within NRA since 1923. In 1974, the Council of State Administrators for Vocational Rehabilitation, an affiliate within NRA, severed their administrative linkage with NRA to become a separate and independent association. Their exit resulted in loss of support for employee membership. In 1975, NRA successfully intervened through the court system in the well-known "Florida test case" over compliance issues related to service delivery within that state. In some states, membership was discouraged because of NRA's position, and significant losses in NRA membership were experienced that year. NRA's reduction in national political impact has been proportional to its loss in chapter membership.

During the early 1970's, the following developmental milestones in relation to rehabilitation counselor education occurred:

- The Council on Rehabilitation Education (CORE) was formed in June of 1971 in order to accredit Rehabilitation Counselor Education (RCE) programs through the continuing review and improvement of master's degree level RCE Programs. CORE described the Rehabilitation Counselor as "a counselor who possesses the specialized knowledge, skills, and attitudes needed to collaborate in a professional relationship with people who have disabilities to achieve their personal, social, psychological, and vocational goals" (CORE, 1996).[4] The purpose of accreditation is to both promote

excellence in education and to protect the customers receiving services (CORPA, 1995).

- In 1974, the Commission on Rehabilitation Counselor Certification (CRCC) was incorporated as an independent, not-for-profit organization to certify Rehabilitation counselors. Since then, more than 35,000 counselors have fulfilled the certification requirements. As this document is written, the Certified Rehabilitation Counselor (CRC) designation is generally recognized as the standard for determining that VR counselors have achieved a certain level of competence. Application for the CRC certification requires that the individual is of good moral character; holds a minimum of a master's degree in rehabilitation counseling or a counseling discipline; completes a supervised work experience; and passes a certification exam (CRCC, 2005).[3]

FEDERAL REHABILITATION LEGISLATION

President Lyndon Johnson's War on Poverty resulted in the Rehabilitati Act Amendments (1965) literally doubling the federal government's financi support and increased the federal financial share contributed to states from 6 to 75%. Congress broadened the definition of disability to include those wh had "behavior disorders," as diagnosed by a psychologist or psychiatrist. Th expanded definition meant that services were provided through the state/fed program to people with alcoholism and drug addiction and those with antiso personality and sociopathic diagnoses. The amendments also strengthened t growth of rehabilitation facilities by authorizing new construction of vocatic rehabilitation facilities and sheltered workshops. The 1965 Amendments an the preceding 1954 legislation stimulated phenomenal growth in the numbe new facilities.

The Amendments of 1968 increased the federal funding share to 80% ar provided a further response to social need; the "socially disadvantaged," we identified as eligible for service. The amendments also broadened consume eligibility to include deaf, blind, and migratory worker populations. During time, reorganization in Health, Education, and Welfare resulted in the development of Social and Rehabilitation Services with OVR becoming the Rehabilitation Services Administration under this unit.

The legislation that has had the broadest impact on the field of rehabilitation was the Rehabilitation Act of 1973. Its sweeping impact was in large measure, to consumer advocacy that influenced its civil rights orientation. These amendments reflect a philosophical shift in legislation wherein the traditional "medical model" of public vocational rehabilitation v diminished by championing a partnership between the counselor and consu

The Act consisted of four sections.

- The civil rights portion of Section 501 mandated nondiscrimination

the federal government in its own hiring practices in the hope that the federal government would prove to be a role model for private sector employers.

- Section 502 addressed concerns about accessibility, especially architectural barriers and their handicapping effect on people with disabilities, and established the Architectural and Transportation Compliance Board to enforce accessibility standards.
- Section 503 prohibited discrimination in employment on the basis of physical or mental disability and required affirmative action on the part of all federal contract recipients and their subcontractors who received more than $2500 in federal funds.
- Section 504 prohibited exclusion based on disability of an otherwise qualified person with a disability from participation in any federal or federally sponsored program or activity, such as attending school (elementary, secondary, and post secondary), or day-care centers, and access to hospitals and public welfare offices. This section emphasized accessibility of buildings and programs. A person with a disability could not be found unqualified without considering whether a reasonable accommodation would render the individual qualified.

In addition to Sections 501-504, the Rehabilitation Act of 1973 provided for rehabilitation research by establishing the National Institute of Handicapped Research (NIHR), now the National Institute on Disability and Rehabilitation Research (NIDRR). NIDRR is responsible for disseminating information on ways to increase the quality of life for people with disabilities, educating the public about ways of providing rehabilitation to people with disabilities, conducting conferences on rehabilitation research and engineering, and producing and disseminating statistics on employment, health, and income of people with disabilities.

The Rehabilitation Act of 1973 also regulated the daily practice of rehabilitation counseling in the state/federal system. It gave rehabilitation service priority to those people with the most severe disabilities and emphasized "consumer involvement." Consumer involvement meant that people with disabilities (i.e., the consumers of rehabilitation services) shared an equal role with the rehabilitation counselor in the development of rehabilitation plans. The Act mandated the use of an Individualized Written Rehabilitation Program (IWRP) that must specify vocational objectives and services provided, as well as how progress toward the objectives is to be evaluated. Mandates for consumers to serve on state agency policy development boards were provided.

The Rehabilitation Act of 1973 also broadened the definition of disability. Disability could now be documented by the existence of a physical or mental impairment that substantially limits one or more of the major life activities. These include having a record of such an impairment (such as recovering

alcoholics or drug addicts, people with a history of mental illness, people wi epilepsy who have been seizure free), or being regarded as having such an impairment, (such as having a disfigurement), or obesity. The 1973 Rehabilitation Act also authorized a study of the needs of severely handicap people.

The Rehabilitation Act of 1973 was amended in 1974 to provide transfe the Rehabilitation Services Administration to the Department of Health, Education, and Welfare, to convene the first White House Conference on Handicapped Individuals (now called the National Council on Disability), a to establish Regional Rehabilitation Continuing Education Programs (RRCEP's) to provide in-service training to staff on a regional basis. The Rehabilitation Extension Act of 1976 continued the act for two years with n changes. While not specifically rehabilitation legislation, the landmark spec education legislation of 1975, Individuals with Disabilities Education Act (IDEA), should be noted because of its impact on rehabilitation because of transition needs of students. This legislation increased the numbers of stude with disabilities served and graduating from the public schools. One indirec outcome of this legislation was increased parental awareness of the resource limitations of the state/federal vocational rehabilitation program in meeting their offspring's needs.

Another act having a major impact was the Developmental Disabilities Assistance and Bill of Rights Act of 1976. Its purpose was to ensure that persons with developmental disabilities received the services necessary to achieve their maximum potential. The Act required that each state have a network of protection and advocacy organizations independent of the agenc that provide service. These networks provided support for the developing Parents Movement.

The 1978 rehabilitation legislation, signed by President Carter, was title the Rehabilitation Comprehensive Services and Developmental Disabilities Amendments. These amendments provided significant funding for a whole new dimension of rehabilitation services for independent living. The amendments authorized funds for Centers for Independent Living and agenc independent living services to people with severe disabilities who may not h any vocational objectives. The intent of independent living services was to assist people with disabilities to gain maximum control over their lives and minimize reliance on others for self-maintenance. Services include preventi of dependency, early intervention activities designed to reduce or postpone dependency (e.g. teaching people with spinal cord injuries to prevent pressu sores or decubitus ulcers), rehabilitation for independence, special training f daily living skills (e.g. bathing, grooming, dressing, cooking, cleaning), and maintenance of independence services designed to avoid relapses, some of which, like attendant care, may be needed for a lifetime.

The 1978 amendments also expanded the program by establishing the

American Indian Vocational Rehabilitation Program Tribal 130 project(s) (now known as Section 121 Programs), and authorizing the National Institute of Handicapped Research, later renamed the National Institute on Disability and Rehabilitation Research (NIDRR) as a funding agency for individual research grants and Rehabilitation Research and Training Centers. Another funded program established was the Helen Keller Center for the Deaf/Blind.

The 1979 Rehabilitation Act Amendments provided that individuals with disabilities be guaranteed substantial involvement in policies governing their rehabilitation. The Office of Special Education and Rehabilitation Services (OSERS), with the Rehabilitation Services Administration as one unit, was created within the newly established cabinet-level Department of Education in 1979. This was seen as an important move for two reasons. It established the position of Commissioner for Rehabilitation Services Administration (RSA) as a presidential appointment approved by the Senate. It also reduced the levels of government between the Commissioner of Rehabilitation and his/her supervisor by having the Commissioner answer directly to the Assistant Secretary of Education.

1980 TO DATE

CULTURAL CONTEXT

The last two decades of the twentieth century and the first decade of the 21st century saw the computer and wireless internet access transform society and industry. The personal computer, with software and Internet connection, became a fundamental tool in offices, homes, and schools. The Reagan Years, 1981-1988, brought one of the largest eras of economic prosperity to the United States economy. This was the result of increased defense spending, budget and tax cuts, and deregulation that led to the largest federal budget and trade deficits in United States history. These, in turn, led to a stock market crash in 1987.

The 1980s began with Ronald Reagan becoming President. His political philosophy identified a limited role for government in meeting the needs of disadvantaged persons or persons with disability. He cut state medical benefits to disability groups when he was governor of California. When President Reagan took office, disability benefits under Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs for needy aged, blind, and disabled persons were being paid to about seven million disabled citizens. The Social Security Administration began a review two months after Reagan took office of 30,000 SSDI and SSI cases a month. Approximately forty percent of the cases reviewed (75,000 people receiving benefits) were cut off in what was considered a purge of the disability roles. During the Reagan years, a forceful anti-communist foreign policy ran parallel with major social change and eventual reform of the Soviet Union. These two factors contributed to the end of the "Cold War" near the end of the decade.

The 1980s brought increased demands for zero tolerance of drug use an punishment for casual users. Crack cocaine use in the lower socioeconomic levels of society was one influencing factor. The Omnibus Drug Bill of 198 provided for punishment and prison. The failed War on Drugs has been ongoing since the middle 1980s.

In 1988, George Bush was elected President. In August 1990, Iraq's Sac Hussein invaded and conquered Kuwait. George Bush organized a United Nations approved international force that began bombing Iraq in January 19 and a ground attack in February 1991 to stop the invasion. A cease-fire was accepted in April 1991 with sanctions imposed on Iraq.

In the 1992 presidential election, Democrat Bill Clinton defeated Presid Bush. In 1994, Republicans gained control of both houses of Congress. President Clinton won reelection in 1996, but a Republican controlled Cong who pursued President Clinton for perceived and real scandals plagued his administration. Major Congressional investigating energies resulted in limit activity on legislation. Congress did pass legislation in which federal protection for welfare recipients ended, and programming funds were turnec over to the states. Clinton was impeached but served the rest of his term wit George W. Bush elected in a close and controversial election as President in 2001.

President G. W. Bush inherited from the Clinton administration a boom economy, and the highest federal budget surpluses ever. However, tax cuts, recession, and the "War on Terror", targeting Osama Bin-Laden, the "mastermind" behind the September 11, 2001 terrorist "kamikaze type" commercial airplane attacks destroying the World Trade Center Towers and damaging the Pentagon, soon eliminated this federal surplus in the first year the Bush term. During the first few months of the War on Terror, military expenditures were estimated at over one billion dollars monthly when Bush ordered the invasion of Pakistan in search of Osama Bin-Laden with U.S. a "international" coalition of military troops. This monthly military expenditu was projected to have doubled when President Bush, in 2003, led an invasio Iraq with the resulting military occupation of that country.

President Bush was reelected in 2004 and his domestic policies and his "staying the course" commitment to the Afghanistan and Iraq wars resulted the largest U.S. budget deficit ever. For example, as opposed to the conservative yearly estimate in 2002 of $12 billion a year being spent in Afghanistan and Iraq, recent yearly expenditures related to the wars are now over 140 billion yearly. By comparison, the state federal vocational rehabilitation program, under the Rehabilitation Act, is funded at two billior dollars yearly. From 2002-2006, a Republican dominated Congress did littl oppose war expenditures or address a variety of pressing social issues. Bec of the public's growing concern regarding this and escalating violence in the war in Iraq, Democrats were elected in control of both House and Senate in

2006.

The U. S. economy entered its longest post World War II recession in December 2007, resulting in the Bush administration taking more control of the economy by proposing and enacting multiple economic programs intended to preserve the economy's financial system.

Barack Obama, the first African American to hold the office, was elected in 2008 and inaugurated as president on January 20, 2009. He inherited an economic depression that included a major drop in housing prices caused by bankers, unsecured house mortgages, and "bundled" debt from mortgages sold on the stock exchange. Banks, major corporations, and the automobile industry were all at risk with unemployment rising steadily. President Obama signed the $787 billion economic stimulus legislation—already proposed by Bush—into law in the form of the American Recovery and Reinvestment Act in February 2009. The following month, he intervened in the troubled automotive industry by providing loans and setting terms for bankruptcy and reorganization of General Motors Corporation, which gave the U.S. government a temporary 60% equity stake in the company.

In 2010, he signed into the law the Tax Relief, Unemployment Insurance Reauthorization and Job Creation act of 2010. This legislation kept the U. S. economy from collapsing but did not greatly improve it. In 2011, national unemployment rates are at 9.6% with the housing market reflecting continuing foreclosures in housing and drops in the value of homes.

One of Obama's campaign pledges was to end the war and bring troops home from Iraq. He indicated that he would withdraw troops from Iraq in 18 months but, to the dismay of his supporters, he increased troop levels in Afghanistan. In 2011, troop levels in Afghanistan were at 100,000 and in Iraq 50,000 with an estimated similar level of "contract" forces equaling these levels in each country. On May 11, 2011, Obama announced that a small team of American Navy Seal forces, acting on his direct order had killed All-Qaeda leader Osama Bin-Laden in Pakistan. Additional war costs were incurred when Obama led and contributed to the United Nation's military intervention of Libya in 2011. As a result of the recession and efforts to resolve it, the War on Terror, and continuing costs on three war fronts, the U. S. national debt as of 2011 was at a record high $12.9 trillion dollars and obviously in need of reduction. With a Congress split politically on how to resolve this, little hope for early resolution of this problem existed.

REHABILITATION RELATED DEVELOPMENTS

Under the continuing Disability Rights Movement, individuals with disabilities began to oppose the role of passive recipient of care. They advocated for independent roles in society and for input into the established organizations that made decisions on their behalf. They began to challenge society's paternalistic attitude toward them, and many rehabilitation

professionals and organizations changed their advocacy emphasis. Individu with disabilities believe they are fully equipped to direct and control their ov lives and asked service providers to shift from roles of decision makers to technical advisors. Many organizations and agencies changed along with consumers while others paid only lip service. Some even ignored the new activism and carried on as usual. This new activism among individuals with disabilities in the United States is reflected in changes in national legislation restructuring of some organizations to enable increased input from consume and in a better-educated public on disabilities issues.

The progress of the disability movement is a reflection of broader social and demographic considerations. The majority of consumer leaders, as well individuals with disabilities, were born during or influenced by, the post-wa baby boom generation. In the 1950s and 1960s, these leaders saw special education and rehabilitation as avenues of early support. In the 1970s and 1980s, they began to be concerned with employment issues for people with disabilities. Social and economic equality assumed a more prominent role, a they demanded the right to equal treatment and economic self-sufficiency. I the period from the 1980s to-date, issues for individuals with disabilities expanded to retirement and geriatric services. Their political advocacy has reflected their interests over this time.

A backdrop of the disability rights and the independent living movemen has been an increase in public understanding of disability issues. The public also increasingly aware of the cost of individuals with disabilities if they rer outside mainstream employment. This understanding, and the support of advocacy and consumer groups, has resulted in federal legislation through th 1980s intended to improve participation and quality of life for individuals w disabilities. It also resulted in several national initiatives to increase the employment of individuals with disabilities. Likewise, it provided the conte for the 1992 Amendments to implement ADA concepts and the 1998 Amendments to the Rehabilitation Act to re-emphasize employment. The 1 Amendments were incorporated into a broad Workforce Investment Act tha transferred administration for workforce training and development to local communities.

As opposed to rehabilitation programs designed in the 1970s to insure e access because of perceived handicap and to address needs of what society perceived as a vulnerable citizenry, the 1990s legislation began to question t relevance of this perspective. Given improvements in economic opportuniti greater public and consumer understanding of disability, significant advance medical, social, and rehabilitation technology, and the disability rights movement, special programs or protections for people with disabilities are viewed with skepticism by individuals with disability and by legislators. Pr legislation deemed specialized services, entitlements, cash payments, and sc subsidies as appropriate. Current legislative pressures relate to consolidatio

and integration of services, and to utilizing technology. Political discussions have begun to focus on what should comprise publicly appropriate resources to meet a person's needs.

The interrelatedness of consumer advocacy and increased awareness of disability issues by the public resulted in a consensus that consumers have the right to determine to what end their rehabilitation should be directed. The solutions proposed in legislation throughout the 1990s reflect this consensus as can be seen in requirements of "informed choice" and "empowerment" in the 1992 Rehabilitation Act Amendments. This right is also institutionalized in the 1998 amendments to the Rehabilitation Act that gave a consumer-controlled entity–the State Rehabilitation Council (SRC)–the authority and responsibility to participate in the development, review, and implementation of state plans within the state federal rehabilitation program. SRCs have continued the legislative shift toward more consumer control and empowerment.[1]

As public policy supporting their access to employment broadened, individuals with disabilities were confronted with an ever-changing work environment. The Protestant work ethic at the turn of the century has become a minority position in our society. Additionally, work itself has changed dramatically. With global competition and downsizing, employers view workers as expendable. The commitment by a company to an employee is linked specifically to the company's need for employees' skills and their ability to produce. Careers within organizations are no longer the mode. Now organizations provide avenues through which individuals pursue personal goals. In this new economy, key worker requirements are autonomy, self-direction, flexibility, and continuous learning. This new economy presents a far more challenging labor market for individuals with disabilities.

To ensure its leadership in advocacy position, the National Rehabilitation Association finalized reorganization efforts at the turn of the 21st Century. From its beginnings in the early 1920s, the National Rehabilitation Association has proven to be the driving force behind every major rehabilitation initiative since the implementation of national rehabilitation legislative efforts at the turn of the twentieth century. The history of the Association's successes is a distinguished history of effective leadership and impact. Its failures are similarly linked to leadership. The Association must benefit not only from its successes, but also from its failures as its membership works together for a better future. NRA's newly developed professional identity proposes a commitment to proactive initiatives and broader issues. To maintain a leadership role, the Association must pursue its purpose collaboratively with related associations, consumer advocacy groups, and consumer groups. What future federal rehabilitation legislation may bring depends on the Association's and related professional and consumer partners' impact and leadership.

FEDERAL REHABILITATION LEGISLATION

Throughout the 1980s, federal rehabilitation legislation continued with emphasis on trying to ensure adequate funding levels necessary to provide individuals with disabilities the possibility of inclusion. During this time, legislation was greatly influenced by public endorsement of the Disability Rights Movement. In 1980, a continuing resolution reauthorized the Act. Again, in 1982 and 1984, it was reauthorized with no major changes. In 19 because of consumer advocacy, the word "qualified" was inserted before the word personnel. In 1986, reauthorization endorsed the concept of supported employment, offering support strategies to provide needed assistance to individuals who are severely disabled to work in competitive environments. Services to help consumers transition from high school to work were also emphasized, but minimal funding was provided in supported employment a transition. The legislation also added support for individual consumer right and revised the IWRP format to include consumer statements of their own rehabilitation goals.

The Technology-Related Assistance for Individuals with Disabilities Ac 1988 established a national information and program referral network and developed a state-level consumer-responsive program of technology-related assistance. It also developed training and funded demonstration and innova projects designed to increase public awareness.

Perhaps the most widely recognized rehabilitation related legislation is t Americans with Disabilities Act (ADA) of 1990. Like the Rehabilitation A 1973, the ADA is a very significant piece of civil rights legislation. This legislation is regarded as landmark civil rights legislation that prohibits discrimination against people with disabilities in virtually every aspect of society. It provides enforceable standards against disability-based discrimination and a role for the federal government in enforcing those standards.

The ADA defined disability using Section 504 of the 1973 Rehabilitatio Act, and added a category of disability for those with contagious diseases. substantial number of people with Acquired Immune Deficiency Syndrome (AIDS) was nonexistent in 1973 when Section 504 was written, and this population was given protection against discrimination. The ADA also explicitly excludes certain groups who might otherwise be considered disab including individuals who use illegal drugs, transvestitism, exhibitionism, homosexuality, compulsive gambling, kleptomania, and pyromania.

The ADA is organized into five sections or Titles. Title I, the Employm Provision, prohibits discrimination because of disability in hiring, job traini promotion, and firing. Essentially, it requires employers with 15 or more workers to make reasonable accommodations for qualified job applicants wi disabilities, if accommodation is not an undue hardship. Reasonable accommodations relate to a variety of changes such as physical modificatio

the workplace, part-time or modified work schedules, provision of amplification devices or computer equipment, modifying the job application process such as giving a job application exam orally, and providing readers or interpreters. The two disability categories of alcoholism and drug addiction were specifically excluded from Title I.

Title II, the Public Service Provision, is an extension of Section 504 of the 1973 Rehabilitation Act. It prohibits discrimination against individuals with disabilities in state and local government programs and activities, such as public housing or use of a library, and requires that individuals with disabilities have equal access to the services and benefits of public entities, including access to buildings, telephones, and bathrooms where services are provided. This Title also requires access to public transportation. All newly built buses used for public transportation, on fixed routes, must have wheel chair lifts. If accessible buses are not available, the city/state must offer an alternative. In addition, rail systems/subways must have at least one car per train that is accessible.

Title III, the Public Accommodation Provision, prohibits discrimination on the basis of disability in public establishments such as hotels, restaurants, theaters, lawyers' offices, auditoriums, laundromats, insurance offices, museums, parks, zoos, private schools, gymnasiums, day-care centers, banks, and health care centers. All structural barriers must be removed, and reasonable accommodations must be made. Examples of Title III accommodations are adding grab bars to bath tubs, lowering telephone booths and drinking fountains, adding raised letter and Braille markings on elevator controls, having Braille bank loan application forms, and using flashing alarm lights.

Title IV, the Telecommunications Provision, requires that access to telephone and radio communications must be provided at a reasonable cost to those with hearing or speech impairments. One option, a Telecommunication Device for the Deaf (TDD), is a device that uses a keyboard to transmit written messages over the telephone. Dual Party Telephone Relay Services that provide operator assistance must be available for use in relaying communications to third parties who use a conventional telephone. Telecommunication services must be comparable to the services that everyone else receives. For example, it should be available 24 hours a day with no limits on length or location of calls. ADA's Title V addresses procedural guidelines, litigation, and technical assistance for people with disabilities who wish to use the ADA to combat discrimination.

Because of numerous court cases seeking clarification of wording, the American Disability Act was amended in 2008. The amendments revised the definition of "disability" to more broadly encompass impairments that substantially limit a major life activity, specified that assistive devices, auxiliary aids, accommodations, medical therapies and supplies have no

bearing in determining whether a disability qualifies under the law.

The 1992 Amendments to the Rehabilitation Act (PL 103-73) incorpora the values and philosophy of ADA. The amendments were perceived as an instrument to further the goals of ADA. The Amendments were crafted aro the principles of consumer empowerment and involvement in the rehabilitat process. They stress respect for individual disability, personal responsibility self-determination, and pursuit of meaningful careers, all within the context informed choice. They reflect consumer concerns about the potential for power, disparity between counselor and consumer, and provide for demonstration projects that will increase consumer choice, including the possibility of consumers selecting their own providers of vocational rehabilitation service. The Act emphasizes the need for counselors to be partners with individuals with disabilities in encouraging their self-determination and full participation.

The 1992 Amendments increased consumer control and participation in determining policies and procedures of the delivery system. They establish Rehabilitation and Independent Living Advisory Councils, consisting of a majority of people with disabilities who may address topics such as eligibili determination, prioritizing the consumers who are served first, and program evaluation. In response to Disability Movement concerns, the 1992 Amendments also modified the eligibility criteria for services by eliminatin "feasibility." Feasibility had been the third requirement of the eligibility tri For many years, eligibility was based upon the presence of the disability, a handicap to employment, and a reasonable expectation of being able to bene from services, i.e., feasibility. It is obvious that the removal of the feasibilit requirement was a significant change.

The 1992 Amendments also changed the term "handicapped" to the mo acceptable term "disabled" throughout the Rehabilitation Act, and determine that all IPE plans were to be reviewed annually with involvement by consun and/or their guardians. The 1992 Amendments also expanded support for th programs of transition from school to work services, on-the-job training, supported employment services, and continued support of research and development for rural areas, severe disability, personal care assistance, and underserved/minority groups.

The late 1990s exhibited somewhat conflicting concerns regarding the growing costs of disability and the need to enhance independence and employment outcomes for individuals with disabilities. These conflicting concerns, along with political pressures regarding high disability costs, provided the backdrop for the reauthorization of the Rehabilitation Act in 19 In an effort to contain cost, or at least contain growth in public costs, federal legislators reauthorized the Act, not as separate legislation, but as a part of a larger piece of workforce reform legislation to consolidate and devolve mul workforce and training programs to the states. Since its inception in 1920, t

vocational rehabilitation legislation had been a separate and distinct law dedicated to service for people with disabilities.

For the first time in its history, the authorization of the Rehabilitation Act linked rehabilitation services with other "labor" programs in the Workforce Investment Act in the 1998 Amendments. The preamble to the 1998 Rehabilitation Act Amendments states that one purpose of the Act is "to empower individuals with disabilities to maximize employment, economic self-sufficiency, independence, and inclusion and integration into society." While rehabilitation maintained its employment intent, this language made a clear statement that the purpose of the state federal program is not just to assist with employment but also to have broader goals related to consumer self-sufficiency. The Amendments required state vocational rehabilitation agencies to collaboratively develop employment programs in "one-stop centers," in cooperation with the Department of Labor. The Amendments also changed the Individual Written Rehabilitation Plan (IWRP) to the Individual Plan of Employment (IPE). They also allow the counselor to expand informed choice by permitting the consumer to write his/her own plan, and self-employment and small business opportunities were added as vocational goals for consumers. A major reauthorization of the Rehabilitation Act has been deferred by Congress since 1998.

From 1998 to-date, the state federal vocational rehabilitation program has been addressing two major challenges. One of these is internal and related to the federal mandate to implement a Comprehensive System of Personnel Development (CSPD) and the other is external, the need to obtain employment opportunities for individuals with disabilities during one of the worst recessions of this last century.

In an effort to improve rehabilitation outcomes, the 1992 Rehabilitation Amendments provide an outline and the 1998 Amendments require the implementation of a Comprehensive System of Personnel Development (CSPD). CSPD requires that all staff be hired at or trained to the highest level of professional certification at the state or national level. It was written into the legislation as a consumer protection to insure that qualified rehabilitation specialists provide services to individuals with disabilities. In its implementation, CSPD first targeted rehabilitation counselors employed and hired within the state/federal vocational rehabilitation agency, with the standard for counselors predominantly being national certification as a Certified Rehabilitation Counselor (CRC). In 1998, 43% of the rehabilitation counselors employed within the state/federal vocational rehabilitation program did not meet this standard. Following major efforts initiated to provide rehabilitation counseling master's degree options to counselors, in 2002, 37% did not meet this CSPD standard.[10] Over the past nine years, some increases in the numbers of practicing master's level counselors within the state-federal vocational program have been reflected nationally; however, some state rehabilitation

agencies opt out of using the CRC as a standard, and others use it but do not hire at this level of experience. The national challenge of CSPD provides ho for ensuring quality service to consumers and improved consumer outcomes attained. The success of CSPD, however, will be measured in the future.

In April 2009, as part of the American Reinvestment and Recovery Act, Congress appropriated $540 million of new funding to the state federal vocational rehabilitation program. This one-time over twenty-five percent increase in funding was viewed as an unprecedented opportunity to improve employment outcomes to consumers. Utilizing these funds, states were able activate numerous individuals off of the "wait" lists and initiate services. M of these consumers are still in early stages of the vocational rehabilitation process with actual results of this increase in funding not determined.[8]

SUMMARY

As the debate continues over what constitutes appropriate public policy terms of fiscal and social responsibility, rehabilitation legislation and progra will increasingly be pressured to demonstrate impact in terms of increases ir the number of persons gainfully employed and decreases in the number rely on public subsidies due to disability. This pressure on the state/federal vocational rehabilitation program would appear to indicate that the program would not be supported with significant additional resources. Since its inception in 1920, the state federal vocational rehabilitation program has be funded at a level where only a small fraction, 1/20th or fewer, of those needi the service could access it. The state federal vocational rehabilitation progra currently serves just over a million individuals a year in a partnership with American Indian vocational rehabilitation programs. Employment outcome are obtained for approximately half of these. This program now includes 80 agencies with vocational service programs in every state, the trust territories and the District of Columbia.

The review of the history of rehabilitation in this chapter has described i evolution in our society from paternalism to empowerment. The field of disability and rehabilitation, as it exists in the United States today, has its ro in dozens of historical movements, events, organizations, academic disciplir and professional fields. For example, advocacy groups in support of various disability groups existed from the nineteenth century. Rehabilitation, a term rarely used prior to World War I, evolved as a medically-based discipline in early twentieth century primarily as a response to veterans who were disable in wars. Federal vocational rehabilitation legislation for citizens in the Unit States followed as a logical consequence of providing such services to disab World War I veterans. This early legislation was indeed paternalistic but ha changed in recent decades to legislation supporting empowerment of individuals with disability.

The United States vocational rehabilitation effort represents a countrywide, consistent industry of service delivery. Collaborating with it are facilities within the private not-for-profit area. These facilities have developed a unique partnership with the state/federal program that has brought strength and stability to both facilities' and state agencies' efforts. The public, the private not-for-profit, and private rehabilitation programs have evolved and is reflected in the changing attitudes toward individuals with disabilities in our society. One obvious change in society's perception of individuals with disability can be documented in the language used to identify them. The late twentieth century references were to the "crippled," "idiotic," and "feebleminded." References in the early twentieth century continued to be specific to the disability, the "blind," the "deaf," the "mentally retarded," et cetera. Just after the mid twentieth century, references emphasized first the individual and then the disability, such as individuals with visual impairments. Late twentieth century popular references by society to the "physically challenged" underscore a greater public awareness and understanding of disability. Disability advocates will continue to influence how people describe and refer to people with disabilities. The recent disability movement's value of, and identity with, disability, will influence and determine new preferred references for individuals with disabilities.

Advocacy by people with disabilities began in the early nineteenth century, but its effectiveness was sporadic. Because of social, economic, and conceptual issues, self-advocacy groups of individuals with disabilities rarely worked cooperatively with one another. They often found themselves in open competition for scarce funding sources and public attention. What unity individuals with disabilities had was being defined socially and legally as "objects of charity" and, in a later period, as potential beneficiaries of medical and rehabilitation initiatives. Recent awareness and advocacy efforts among individuals with disabilities relate to a developing recognition that they have a right to participate openly and fairly in society. Advocates of the Disability Rights and the Independent Living Movements have fostered collaborative efforts in demanding civil rights as citizens rather than as recipients of charity, or patients, or consumers within medical or vocational treatment programs.

Significant legislative advantages such as the 1990 Americans with Disabilities Act, and the 1992 and 1998 Rehabilitation Act Amendments are evidence of these efforts. With emphasis on respect for individual dignity, personal responsibility, self-determination, informed choice, and inclusion, this legislation is truly empowering. The preamble to the Rehabilitation Act Amendments of 1998 states the one purpose of the Act is "to empower individuals with disabilities to maximize employment, economic self sufficiency, independence, and inclusion and integration into society."[4] This purpose, unfortunately, is not guaranteed in practice. Many older, disability related, national societies and professions have had to alter their perceptions to

be in tune with this new thinking. Many of the thoughts behind empowerme are not new. What is new is the unity with which individuals with disabiliti now expect equal treatment under the law, fair employment practices, equal access, and the right to accessible housing and transportation. This unity ha resulted in individuals with disability having an impact on how rehabilitatio services designed for them, must now be designed with them.

Service providers and consumers recognize the needs of the individual v a disability that must guide rehabilitation services in the state/federal progra and in the private sector. What the future brings in relation to rehabilitation rehabilitation counseling will be dependent, as was noted in the first paragra of this chapter, on society's evolving perception and response to individuals with disabilities.

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