THE PURPOSE OF UNDERGRADUATE REHABILITATION EDUCATION:

IMPLICATIONS FOR CURRICULUM DEVELOPMENT

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THE PURPOSE OF UNDERGRADUATE REHABILITATION EDUCATION: IMPLICATIONS FOR CURRICULUM DEVELOPMENT

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THE PURPOSE OF UNDERGRADUATE REHABILITATION EDUCATION:

IMPLICATIONS FOR CURRICULUM DEVELOPMENT

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VITA

J. Chad Duncan, son of John and Laurie Duncan, was born February 11, 1972, in Montgomery, Alabama. Chad attended school in Auburn, Alabama graduating from Auburn High School. In 1990, he entered Wofford College, where he first learned that he missed the plains of Auburn. He transferred to Auburn University in 1992, where he received a Bachelor of Science degree in Rehabilitation Services in March of 1995. Following graduation he attended Northwestern University where he received postgraduate certification in Prosthetics and Orthotics. He worked in the field of Prosthetics and Orthotics for ten years practicing patient centered services. In 2006, he received a Master of Science in Rehabilitation Counseling from Auburn University. For the past two years he served as clinical coordinator for Rehabilitation at the undergraduate and graduate level. During his doctoral studies he received the graduate student of the year award from the Department of Rehabilitation and Special education. Upon completion of his Doctor of Philosophy in Rehabilitation, he and his family will be moving to Maine where he plans to start his career in higher education as a "UMF Beaver".

He is married to Catherine E. Lewis and they have two children: Madeline Kate and John Finnegan, three dogs: Maggie, Zoe, and Winnie, and a stray cat named Black Kitty.

DISSERTATION ABSTRACT

THE PURPOSE OF UNDERGRADUATE REHABILITATION EDUCATION:

IMPLICATIONS FOR CURRICULUM DEVELOPMENT

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The goal of this study was to determine the commonalities and differences of registered and non-registered undergraduate rehabilitation education programs existent in the United States and to identify curriculum commonalities and differences among baccalaureate rehabilitation and disability studies programs, and to identify the driving purpose of baccalaureate rehabilitation and disability studies programs education within the United States. Fourteen of the sixteen programs (87.5%) responded were on the registry of The Council on Undergraduate Rehabilitation Education (CORE).

These programs responded to a questionnaire that investigated the demographics of, the curriculum structure, and driving purpose of undergraduate rehabilitation education. The major finding of the survey questionnaire revealed that a broad-based

educational experience (*Systems Change or Allied Health Professions Models*) accomplishes (a) an infusion of disability culture into the broader aspects of rehabilitation related occupations and society, and (b) students who experience these models have a greater diversity of career path options to pursue, rather than a more narrow interpretation of rehabilitation—that is, a curriculum focused only on vocational rehabilitation. Based on the findings, the following recommendations are presented for review and consideration: (a) The adoption of a *Systems Change, Leadership, and Advocacy Model* or an *Allied Health Occupations Model* or a blend of both. This type of model change meets the needs and direction, while having the capability to modify and introduce the notion of a disability friendly culture within American society, and (b) Full-time dedicated faculty positions should form the basic infrastructure of all baccalaureate rehabilitation education programs, while being supplemented with adjunct and specialized faculty to add additional layers of specialty expertise. Consistency in faculty resources creates a better opportunity for the development of a core curriculum as well as a sense of identity among undergraduate rehabilitation education programs.

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I. INTRODUCTION

"History cannot give us a program for the future, but it can give us a fuller understanding of ourselves, and of our common humanity, so that we can better face the future."

Robert Penn Warren

Undergraduate rehabilitation education has been described as an education that provides a common background with a sound foundation in western tradition that instills a holistic perspective of society and people (Gandy & Martin, 1985). The history of undergraduate rehabilitation education is in its infancy when compared to the study of religion or philosophy. The first known and documented baccalaureate rehabilitation program in the United States was developed at Pennsylvania State University in 1957 (Evenson & Holloway, 2006; Gandy & Martin, 1985; Hylbert, 1963). The evolution of the Bachelor of Rehabilitation degree was in response to staff needs in Vocational Rehabilitation agencies (and the Office for the Blind) in Pennsylvania and to recruit graduates that had a balanced educational background and who were experienced in the facilitation of professional development (Hylbert). From the beginning of this first program in 1957 in the United States, there have been estimates of 40 to 56 programs. In 2006, 40 known programs existed and a range of 19 to 24 registered programs were listed

in 2007 by the Council on Rehabilitation Education (CORE) (CORE, 2007; Herbert, 2006; Perry, 2000). The initiative by CORE, an accreditation organization, to register undergraduate rehabilitation programs resulted in the founding of the Committee on Undergraduate Education (CUE), which established specific guidelines for undergraduate educational programs to meet minimal standards of excellence. The paucity of registered programs continuing to the present, however, does not define the programmatic direction of such programs in the United States. There are approximately 45 programs in addition to those registered that could achieve registered status, but have chosen for one reason or another not to do so (Dunn, Grubbs & Mulkey, 2007).

Statement of the Problem

There are several issues involving undergraduate rehabilitation education that need to be addressed. The first issue relates to identity (or defined programmatic purpose) for undergraduate rehabilitation (Evenson & Holloway, 2006). The issue of identity is never-the-less, revealed in the variety of undergraduate rehabilitation education program names or departmental locations (Evenson & Holloway, 2006; Herbert, 2006; Perry, 2000). For instance, program names and departments vary from *Rehabilitation Services* at the University of Maine at Farmington, which is located in a Department of Health and Human Services, to *Rehabilitation Science* at Arkansas Tech University, which is located in the Department of Behavioral Sciences, to *Human Services Counseling–Rehabilitation Concentration* in the Department of Human Resources at East Central University, to *Rehabilitation Services* in the Department of Counselor Education and Rehabilitation Programs at Emporia State University, to *Rehabilitation Major* in the Department of

Human Services and Rehabilitation at Troy University, to *Rehabilitation and Disability Studies* at Auburn University (Alabama), which is located in a Department of Rehabilitation and Special Education (see Table 1).

Table 1

Undergraduate Rehabilitation Education Program Names or Departmental Locations

University	Department	Program
Auburn University (Alabama)	Department of Rehabilitation and Special Education	*Rehabilitation and Disability Studies*
University of Maine at Farmington	Department of Health and Human Services	*Rehabilitation Services*
Arkansas Tech University	Department of Health and Human Services	*Rehabilitation Science*
Troy University (Alabama)	Department of Human Services and Rehabilitation	*Rehabilitation Major*
Emporia State University (Oklahoma)	Department of Counselor Education and Rehabilitation Programs	*Rehabilitation Services*
East Central University (Oklahoma)	Department of Human Resources	*Rehabilitation Studies*

A second issue is related to congruence within the curriculum. This lack curriculum congruence has the capacity to create a lack of preciseness or unity among existing undergraduate rehabilitation education programs. Difference is not bad, but the lack of similarity in programs has the capacity to prolong the development of identity as

well as to prolong precision in curricular correspondence. CUE, through the auspices of CORE, has established minimal standards of curricular excellence, even though considerable variation within registered programs remains. These differences are exemplified vis-à-vis program names and curricular differences. In sum, a lack of identity and correspondence creates confusion regarding the mission of undergraduate rehabilitation education.

A third issue relates to discrepancy and confusion over the actual number of programs that report as undergraduate rehabilitation degree granting programs in the United States. Within CORE and/or CUE, at any given time, discrepancies exist. For example, Herbert (2006) reported on March 17, 2006 that there were a total of 19 registered programs. By October 2006 there was an increase of 5 programs to 24 registered programs reported by CUE (see Appendix A). Evenson and Holloway (2006) reported in their recent study that there were 46 undergraduate programs identified by CUE. Dunn, Grubbs, and Mulkey (2007) most recently identified 45 registered and non-registered undergraduate rehabilitation programs through the same CORE website. Herbert, reported a total 37 registered and non-registered undergraduate programs. Further complicating this issue, CORE's website (http://www.core-rehab.org/) only reports 30 registered undergraduate programs. One potential explanation for this discrepancy may be the inability to maintain currency of information related to undergraduate programs and/or timeliness of information submitted to CORE's website.

Undergraduate rehabilitation programs reported by CORE must be associated with graduate CORE accredited programs or stand-alone registered undergraduate programs that meet minimal standards established by CUE. There also exists a

discrepancy in the number of CORE programs that have associated undergraduate rehabilitation programs that have chosen not to be a part of the registry. Depending on the source consulted there may be a difference of 6 to 22 programs that have elected not to seek registry status.

A fourth issue concerning undergraduate rehabilitation education is the possible merger of CORE and the Council for Accreditation of Counseling and Related Educational Programs (CACREP). If this merger occurs, the question of current registry or potential accreditation of undergraduate rehabilitation programs will remain. Herbert (2006) offers some possible options such as (a) creating an independent accreditation organization, (b) developing of a new accreditation body within CORE, (c) affiliation with an existing accreditation body, or (d) making no effort to pursue accreditation. Certainly, these are possible solutions (although there may be other options) that may have the capacity to unite, rather than continue to fragment undergraduate rehabilitation education programs in the United States.

Purpose of the Study

This study sought to examine the commonalities and differences of registered (see Appendix A) and non-registered undergraduate rehabilitation education programs (see Appendix B) existent in the United States. This section will describe the methodology to be employed, which consists of three phases. Because of the paucity of literature regarding baccalaureate rehabilitation and disability studies programs, an expert panel was to verify the content validity of the survey developed for the study. The first phase will focus on the development of an initial pool of items constituted through a

comprehensive literature review and professional input (personal communication). A four-point Likert scale will be used to determine the significance of pooled items derived from the literature. The second phase of this study was the dissemination of a web-based questionnaire to the identified expert panel. The third phase of the study was to define the population to be surveyed. The purpose of the third phase was to examine baccalaureate rehabilitation and disability studies programs in the United States by sending notification through mail and electronically mailed questionnaires to the program coordinators of the 45 identified baccalaureate rehabilitation and disability studies programs (see Appendix B).

The goal of this study was to identify curriculum commonalities and differences among baccalaureate rehabilitation and disability studies programs, and to identify the driving purpose of baccalaureate rehabilitation and disability studies programs education within the United States.

Research Questions

The procedures detailed in this chapter are designed to address and answer the following questions:

1. Do CUE/registry programs differ from non-registry member programs in undergraduate rehabilitation education programmatic perspective pertaining to areas of preparation, and education?

2. Does the purpose of undergraduate rehabilitation education programs differ between CUE/registry and non-registry member programs?

3. Do CUE/registry and non- registry programs differ in *primary focus* or programmatic direction relative to undergraduate rehabilitation internships?

4. Do CUE/registry programs differ from non- registry member programs in curriculum presented?

Definition of Terms

Curriculum: A defined area of academic and clinical courses that lead to a baccalaureate within the occupational area of rehabilitation and disability (Arsenian, 1968; Emener & Rasch, 1984; Evenson & Holloway, 2007; Hylbert, 1963; Hylbert & Kelz; 1972).

Core Curriculum: Uniform course of study and body of knowledge, considered central and made mandatory to the program for all students of undergraduate rehabilitation education, usually consists of the junior and senior year of their education (Perry, 2000; Steger, 1974).

Expert Panelist: A professional rehabilitation educator who is cooperative, possesses relevant knowledge, experience, and opinions, and who is respected by his or her peers as reflected in publications and service to the rehabilitation field (Clayton, 1997; DeVilliers, et al., 2005; Fink, et al., 1984; Gordon, 1994; Goodman, 1987; Murray, & Hammons, 1995).

Primary Focus: Specific concentration of courses, didactic and clinical, that provides the student with knowledge and skills, which allows employment, and graduate training (Rehabilitation Counseling, Psychology, Occupational Therapy, Physical

Therapy, and Social Work) (Gandy & Martin, 1985; Hylbert, 1963; Hylbert & Kelz; 1972).

Pooled Intelligence: The collective opinion of recognized experts (DeVilliers, DeVilliers, & Kent, 2005).

Programmatic Perspective:

Registry: A list of programs that have met the guidelines established by the Council on Rehabilitation Education's (CORE) Committee on Undergraduate Education (CUE) (CORE, 2007).

II. REVIEW OF LITERATURE

The primary focus of this study was to examine and determine the curricular similarities and differences among undergraduate rehabilitation education programs through a comprehensive review of extant literature. Due to the lack of precision in past and current literature regarding the number of programs, and purposes, as well as a paucity of data relative to undergraduate rehabilitation curriculum, a comprehensive review and ultimately a national survey of existing programs is required.

Historical Perspective

To define and illustrate the evolution and importance of undergraduate rehabilitation education, it was necessary to examine differing social movements from a historical perspective to gain insight into the process of social change and its effect on the development of curriculum. An analysis of existing literature may yield a perspective regarding the dimensions of existing curricular models for undergraduate rehabilitation education programs that incorporate social change as a beneficial factor in the continuing growth and development of humanity.

Social Change

Social movement is a broad term that encapsulates the idea that groups of people with similar goals and missions seek change for the betterment of their group and society. Giddens (1993) describes social movement as a process of seeking or blocking social change brought about by a grouping of people with common goals. Blumer (1951) viewed social movements as "collective enterprises to establish a new order of life" (p. 60). Oberschall (1993) describes social movement as a collective action that requires an effort and solution of many persons to address public issues of resistance, or change that has a large-scale impact on people's lives. Historically, social movements have come about in times of dissatisfaction and resulting changes have occurred for the betterment of society. Social movements address many issues within a society such as war, taxation, civil rights, and environmental concerns. Blumer (1995) characterized these changes as cultural drifts. The idea of change creates new ideas and conceptions of others, and how ideas are to be viewed both socially and politically.

Ideas and people alone do not create social movements. Social movements are complicated, take time and have defined developmental stages (Blumer, 1995; Henslin, 1999; Oberschall, 1993; Renzitti & Curran, 2000; Stroman, 2003; Tilly, 1977). Stroman (2003) and Blumer (1995) have similar perspectives of these developmental stages in social movements. Blumer defines these stages as (a) agitation, (b) development of *esprit de corps*, (c) development of morale, (d) formation of ideology, and (e) development of operating tactics. Stroman had a more direct perspective of these stages: (a) initial unrest and agitation, (b) resource mobilization, (c) organization, (d) institutionalization, and (e) organizational decline and/or resurgence. Both Stroman and Blumer believe stage two (of

both models) is the most critical and important stage during the process of a social movement. R*esource mobilization* and/or *Development of esprit de corps* occurs during the mobilization and organization of the foundation with the concomitant feeling of belongingness for constituents, recruitment, lobbying, leadership, loyalty, media relations, and education (Blumer, 1995; Stroman, 2003). The remaining four stages are important but the second stage is considered to be pivotal for any social movement's success and continued livelihood. Without a sound foundation a movement would quickly disintegrate and become obsolete.

Educational Change

The most influential court case relative to the development and existence of public and private institutions of higher education in the United States was *Dartmouth College v. Woodward* (1819) (Current, 1964; Jeynes, 2007). This case related to and ensured freedom of religion among colleges and universities. It also supported the existence of both public and private institutions of higher education. The decision prevented the *Democratic-Republicans* of James Madison and Thomas Jefferson to allow states to control private institutions such as Dartmouth. Fortunately, for the *Federalists* and for the United States as a whole, the Democratic-Republicans did prevail. The decision gave the individual states responsibility for the creation of institutions of higher education for the express purpose to educate citizens for leadership within this young republic.

To understand how the *Dartmouth* (1819) decision relates to American higher education, one must understand the origins of higher education. During the 18th and 19th centuries, education was considered a high priority among certain religious leaders and

groups (Jeynes, 2007). These priorities led to the development of the first three institutions of higher education in America: Harvard University, Yale University, and Princeton University. Each school was privately funded and each had a religious foundation. These institutions became known as the "Big Three." At this time, existing institutions of higher education were funded by religious organizations, not with state or public funds.

After the Revolutionary War, citizens and states recognized the value and importance of higher education, as well as the economic benefits of an educated citizenry for the individual states. The University of Georgia (1785) was the first publicly funded state institution of higher education, followed by the founding of the University of North Carolina (1789). State institutions of higher education were not as highly revered or recognized because of the influence and dominance of private, religious organizations. To this day, the "Big Three" continue to be the most sought after and regarded as the best colleges to attend. Most state schools were considered inferior. In fact, several failed due to a lack of state support. Perhaps, the most successful state school was the University of Alabama (Jeynes, 2007). The University of Alabama incorporated a religious orientation and welcomed all who were interested. This openness allowed the University of Alabama to prosper while other state schools maintained strict separation of religion and state.

Change and the Civil Rights Movement

"We conclude that in the field of public education the doctrine of 'separate but equal' has no place. Separate educational facilities are inherently unequal" (***Brown v. Board of Education***, 347 U.S. 483. 495). One may argue that civil rights in America began when the Pilgrims landed at Plymouth Rock, establishing the *Mayflower Compact*

for those seeking religious freedom. This simple act of declaring religious freedom and the recognition of injustices is a consistent theme throughout American history and clearly, minority groups have challenged injustices with a typically American tradition of *doing the right thing*. The first Civil Rights Act was established in 1866 followed by subsequent Acts in 1870, 1871, and 1875. Almost one hundred years later, in 1964, what might be arguably considered the most comprehensive Civil Rights Act, was championed by, President Lyndon B. Johnson. The Civil Rights Act of 1964 prohibited discrimination on the basis of color, race, religion, or national origin for public accommodations covered by interstate commerce. Title VII of the Civil Rights Act also dealt with discrimination in the areas employment and gender bias.

The most significant and prominent case of the Civil Rights era was *Brown v. Board of Education* (1954). Thurgood Marshall argued that "separate but equal is inherently unequal." Long before the *Brown* decision a little known case, *Plessy v. Ferguson* (1896), was considered the most influential and paramount case in the civil rights movement for individuals seeking higher education (Greenberg, 1994; Jeynes 2007; Pollack, 2005). *Plessy v. Ferguson* centered on the right of segregation of whites and blacks in railroad cars in the state of Louisiana. The Supreme Court ruled that if the railroad cars were equivalent that segregation was allowed. As unpopular and ridiculous as this decision may have seemed, it had great implications for African Americans seeking or accessing a higher education. The National Association for the Advancement of Colored People (NAACP) used the *Plessy* decision as basis for several cases that dealt with discrimination. The first successful case heard by the Supreme Court was *Missouri ex rel. Gaines v. Canada* (1938) where the United States Supreme Court held that states

must provide equal in-state higher education to both whites and blacks. If the higher education was determined not to be equal, then states had the right to satisfy the requirement by establishing a second school that offered the desired education for African Americans. The alternative was to allow African Americans and Caucasians to attend the same school (Jeynes, 2007). Prior to this Supreme Court ruling, Thurgood Marshall and Charles Houston successfully represented *Pearson v. Murray* (Md. 1936) in a similar lawsuit. The Maryland Court of Appeals ruled that African Americans must be granted admission to the University of Maryland Law School based on the precedent established by *Plessy*. Subsequent cases such as *Sipuel v. Board of Regents of Oklahoma* (1948), *McLaurin v. Oklahoma Board of Regents* (1950), and *Sweatt v. Painter* (1950) set similar precedents that challenged segregation, resulting in the most influential and successful civil rights lawsuit to date, *Brown v. Board of Education* (1954) (Jeynes, 2007; Pollak, 2005,). As a result of the *Brown* decision, the Supreme Court overturned the *Plessy* ruling. Even though *Brown* was highly praised for the advancement of civil rights for African Americans, the value of this decision would ultimately extend to a seemingly forgotten segment of people who had been routinely segregated because of an attribute, disability.

Change and Women's Suffrage

In 1805, in the case of *Martin vs. Commonwealth,* the Supreme Court of Massachusetts declared that Martin, a woman, had no property rights because of her gender and interpreted her right to own property as having "no political relation to the state any more than an alien" (Frost-Knappman & Cullen-DuPont, 2005). Forty-three years after the *Martin* decision, women finally gained the right to own real and personal

property as a result of the passage of Married Women's Property legislation. Later that same year (1848), the first Women's Rights Convention was held in Seneca Falls, New York. Throughout the 1800s, women such as Harriet Beecher Stowe, Dorothea Dix, Susan B. Anthony, Sojourner Truth, Elizabeth Cady Stanton, Carrie Chapman Catt, and other strong and visionary women played significant roles and brought women's rights to the forefront of American consciousness. Their collective efforts laid the groundwork for future generations of women to unite and to continue the development of these the same issues. During the 1800s, women fought hard to acquire rights and to enter public life; however, women were denied the right to vote and were not considered actual citizens under provisions of the Fourteenth Amendment. It would not be until the 1920s that women began to be acknowledged as a political force, gaining the right to vote by the ratification of the Nineteenth Amendment to the Constitution of the Untied States.

With the enfranchisement of women in 1920, the second part of the women's movement began. It was not until early the 1960s that the women's movement re-emerged, becoming an apparent force once again (Oberschall, 1993). Women who had become a major part of the workforce during this time were expected to fulfill the roles of mother, wife, and now employee (Oberschall). Issues such as birth control, hiring practices, equal pay, sexual, and workplace discrimination became major issues confronting women. Even though women had the right to vote, they were still not considered as equals by the larger society.

In 1961, Eleanor Roosevelt was appointed as Chair of the Commission on the Status of Women, by, then President, John F. Kennedy. Roosevelt's Commission in 1963 documented considerable acts of discrimination against women in the workplace.

Oberschall (1993) reported that state commissions were established to address the Roosevelt Commission's recommendations, but most were given a low priority or ignored. The Civil Rights Act of 1964 created the Equal Employment Opportunity Commission (EEOC). Within the mandate of Title VII of the Civil Rights Act, the EEOC's sex discrimination provisions were set forth to be followed. Because of the lack of enforcement and the growing influence of the National Organization of Women (NOW), at the time the largest organized independent civil rights organization for women, NOW aggressively advocated for the rights of women, seeking rights and protections established by the Civil Rights Act and the EEOC.

Through organizations such as NOW, women had groups to join and a collective voice to promote respect, health, and equality in society. As a result of the constant advocacy by women's groups, women's rights increased considerably in the 1960s and 1970s. Women, however, continue to struggle with issues such as comparable pay in the workplace. Stark (2007) recently reported that the American Association of University Women found that women earn, on the average, 80 cents on the dollar compared to men.

The advancement of the civil rights of women brought attention to and increased the awareness of discrimination to all people. The acquisition of essential and basic rights is still a focus of attention for women and others, even in modern society's seeming enlightenment. Even with these advancements, people with disabilities continued to be denied basic rights. Those with the most significant disabilities were segregated and institutionalized as America's solution its growing social problems.

Change, Consumerism and Persons with Disabilities

During the 1960s the business/marketing consumer movement began which was led by Ralph Nader. The business/marketing consumer movement's primary objective was to establish protection, rights, and to give a voice to consumers. The business consumer movement helped create a consumer bill of rights that President Kennedy supported and proposed (Browning, Rhoades, & Crosson, 1980). These rights protected all citizens of the United States by specifically citing that each American had the right to safety, the right to be informed, the right to choose, and the right to be heard (as cited by Browning et al., 1980; Gwinner, et al. 1977). These rights coincidently read like our civil rights, yet it took a social movement to bring about change for the betterment and protection of all society. The consumer movement benefited from all preceding civil rights movements and through legislation that mandated equality for those being oppressed or segregated.

The disability rights (consumer) movement began in the 1950s when the National Association of Retarded Citizens (NARC) (sic) was created by parents of children with developmental disabilities. These parents wanted opportunity and fair treatment for their children, yet these same parents advocated for social and political change for the betterment of all children (Browning, Rhoades, & Crosson, 1980). Browning, Rhoades, and Crosson noted that what is called a consumer movement for persons with developmental disabilities was not actually a consumer movement because consumers of services were not the principal persons advocating for change—parents were the advocates.

Unlike the civil rights and the women's movements, the consumer rights and disability rights movement affected all society, not just elements based on some common attribute. Disability can occur for anyone, regardless of gender, age, or race. Disability can transform what is considered typical for an individual within society and, in an instant, create minority status for that same individuals. Unfortunately, the business/marketing consumer movement did not address the needs of all in society; individuals with disabilities were not given the same consideration to choose or right to be heard. NARC, at the time, was gaining momentum but was being propelled by what Browning et al., (1980) called secondary consumers (parents).

Disability in America

Individuals with disabilities make up one-fifth of America's population of an estimated 54 million persons (National Organization on Disability, 2007). According to the 2000 Census, there were over 49 million people with disabilities ages 5 and older living in non-institutionalized settings. In 2002, the Census Bureau reported 51.2 million people with some level of disability. In 2006, the U.S. Census Bureau indicated that more than 50 million Americans have some level of disability, with 12 percent reporting a severe disability. The World Health Organization (WHO) (2007) reports that there are 600 million persons living with some type of disability throughout the world. From U.S. Census Bureau data, disability rates for women overall (43 percent) were higher than for men (40 percent). The Rehabilitation Research and Training Center on Disability Demographics and Statistics (2005) reported the employment rate among persons with disabilities of working age (16–24) as 38.1 percent, while those without disabilities was 78.3 percent. Table 2 shows employment rate by disability status.

Table 2

2005 Employment of Working-Age People (ages 21-64) by Disability Status

Disability Status	Employment Rate Percentage
No Disability	78.3
Disability	31.1
Sensory Disability	47.8
Physical Disability	32
Mental Disability	29

Note: From Rehabilitation Research and Training Center on Disability Demographics and Statistics. (2005). *2005 Disability Status Reports*. Ithaca, NY: Cornell University. Adapted

She and Stapleton (2006) reported that data collected by the U.S. Census Bureau (2000) indicated there were over four million individuals with disabilities of working-age in institutions in the United States. The 2004 National Organization on Disability (NOD)/Harris Survey of Americans with Disabilities found that 35 percent of all persons with disabilities reported working full or part-time. Compared to those without a disability who work, a gap of 43 percent is revealed, since 78 percent of all Americans who consider themselves without disabilities are engaged in full or part-time work. This finding, when compared to the 1998 Harris Poll of 29 percent employment, reveals an actual increase of six percent. This may look promising but, when compared to the 1986

Harris Poll, 34 percent of persons with disabilities were engaged in full or part-time work. In actuality, in almost 20 years there has been only a one percent positive gain in employment in full or part-time work for persons with disabilities. Disability Statistics (2004) reported there was an estimated 7.9 percent or 14 million non-institutionalized men and women between the ages 18-64 that reported some type of work limitation. From Census Data and NOD/Harris data, we know that rates of disability have gradually increased every year, while employment rates remained stagnant. Further, the NOD/ Harris Survey reports that 26 percent, or three times as many persons with disabilities than without, have annual household incomes below $15,000.

The Harris Poll acknowledges, depending on the source and how the term of disability is presented to respondents, that disability may mean one thing to one person and something totally different to another. "Disability Statistics" (1993, p. 1) as cited in Gandy and Martin (1999) noted "… the definition of the term, and therefore the statistics on the size of the population of individuals with disability, depend on various program statistics serving selected eligible people, information collected in surveys addressing broad social purpose on interpretation of data designed to achieve particular programmatic purposes" (p. 20).

The disability movement is unlike any other movement that has occurred in the United States. Unlike the homogeneity of past movements, the disability movement is complex and diverse, particularly given the nature of disability and its effects on the individual. Past movements dealt with individual attributes that do not change, such as gender and race. Disability is an ever-changing dimension. One can be born with a disability, one can acquire a disability at any age, and one can be perceived as having a

disability. In addition to the array of possibilities, disability affects each person differently. The nature of disability is complex and its non-homogenous contexts, (including psychosocial functions impeded, physiological, severity, time and type of onset) all depend on the emotional and technological support a person may receive. Martin (1999) notes the effects of a particular disability may be totally devastating to one individual, while for another individual the same disability may have minimal effects. Vash (2004) reports that individuals will ascribe different meanings to their disability.

Martin (1999) uses the example of two persons having the same disability—a right lower arm amputation or transradial amputation. This type of amputation may create two completely different reactions in the individuals concerned, depending on the array of variables that occur. One amputation may have affected the dominant side of one individual, while the other individual's non-dominant side may have been affected. From a vocational perspective, the individual with the non-dominant side amputation may not feel like they have a disability, while the individual with the dominant side amputation may be completely disabled both vocationally and psychologically. Another aspect of disability depends on the individual's psychological perspective and their ability to cope with the amputation. Some can recover quickly and proceed with everyday life situations, while others cannot get past the amputation and become stagnant. Other factors, such as phantom limb pain, level of amputation, physiological damage, and differing rehabilitation therapies, can either support or compromise an individual in both their physical and psychological healing process.

There is no universally accepted definition of disability. Disability is a broad term that can have several different meanings based upon the audience and the usage of the

term. From a sociological view, disability is a "contested concept" because of the many ways it can be defined (Stroman, 2003) and the use of the value-laden term "normal" (Jones, 2001). The sociopolitical perspective derives from the injustices, prejudices and discrimination that individuals with disabilities have incurred based on perceptions or differences other than the 'norm' (Hahn, 1985, 1993). Hahn (1985) suggests the sociopolitical definition of disability to be whatever public policy may determine it through laws and regulations. This cynical but accurate statement is reflected in Table 2, which displays various approaches to collecting data relative to disability.

The federal government's approach to disability as defined in Section 504 of the Rehabilitation Act of 1973, and is defined by any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment. The Social Security Administration defines disability "as the inability to engage in any Substantial Gainful Activity (SGA) because of any medically determinable physical or mental impairment(s): that can result in death, or has lasted or that we can expect to last for a continuous period of not less than twelve months" (Social Security Administration, 2003, p. 12).

WHO (1996) defined disability as "any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being" (p. 413). Livneh (1997) explains WHO's definition as disability "…reflects disturbances at the person level or self-system … relates to those deficiencies in normally anticipated function, behavior, or performance" (p. 5).

Table 3

Four Major Approaches and Definitions of Disability Provided by U.S. Federal Government

Title of Survey	National Health Interview Survey (NHIS) by DHHS	Survey of Income & Program Participation (SIPP) by Census Bureau	Decennial Census	Current Population Survey (CPS) by Census Bureau
Definition of Disability	Focuses on chronic (lasting 3mos or +) health conditions and disabilities that give rise to activity limitations. Has 3 measures of disability: > Activity Limitation in major activity > Need for personal assistance in IADLs > Work Limitation	Most complex: asks about: (1) Functional limitations (2) ADLs / IADLs (3) Use of assistive tech. (4) Work disability (5) Mental functioning (6) Disabling conditions among 0-17 age (7) Receipt of SSDI, SSI, TANF, WIC.	Every 10 years gathers limited data about disability in relation to work, mobility, self-care. Defines disability as a long-lasting physical, mental, or emotional condition that limit activities in ADL, IADL, or work.	Each month asks questions: who has health conditions or disabilities that keeps them from working, forced into retirement, new work whether they receive Medicare, SSI (if under 65), or veteran's disability compensation.

Note: From: Stroman, D. F.(2003). *The disability rights movement* (pp. 30-31). New York: University Press of America. Adapted

Disability can be viewed from several paradigms. The sociological paradigm approaches disability from four models. These models are generally considered as (a) Moral, (b) Rehabilitation, (c) Medical, and (d) Disability. In the Moral model, disability is regarded as the result of sin; the Rehabilitation Model considers disability as a deficiency that must be fixed by rehabilitation professionals or other helping professionals; the Medical model considers disability as a biologically based impairment that functionally limits the individual and the impairment can be prevented, cured and or fixed (Williams, 2001); and the Disability model best interpreted by Pfieffer (2000) as "a dominating attitude by professionals and others, inadequate support services when compared with society generally, as well as attitudinal, architectural, sensory, cognitive, and economic barriers, and the strong tendency for people to generalize about all persons with disabilities overlooking the large variations within the disability community" (p. 98). Beatrice Wright more accurately describes this view as the "spread effect." Spread is when someone has a preset notion of disability which then is generalized to everyone with a disability regardless of the type. A classic example is when a group of people (one happens to use a wheelchair) goes to a restaurant and a server comes to the table to take their order. The server takes everyone's order but when it's the turn of the person who uses the wheelchair, the server asks the person next to him or her, what they would like to order. The server assumed and generalized since this individual is "in a wheelchair" they cannot order for themselves. This describes the preset notion that disability equates to inability, no matter what the disability might be.

The rehabilitation perspective of disability is more pragmatic than abstract with regard to sociological perspective. Beatrice Wright (1983), speaking from a vocational

and life context perspective, distinguishes disability as "… a limitation of function that results directly from an impairment at the level of specific organ or body system" (p. 11). From a programmatic perception of the effects of disability, Vash and Crewe (2004) regard the psychology of disability as "…normative responses from (psychologically) normal organisms to abnormal stimuli" (p. xi). It is not the individual who is disabled [sic] it's the environment's '*abnormal stimuli'* that creates the disability. Vash and Crewe (2004) report the '*abnormal stimuli'* perceptions can be biological, environmental, economic, and social in nature. Each perception can be either interpreted as a positive or negative experience.

Arokiasamy, Rubin and Roessler (2001) discuss four societal responses toward the perception of persons with disabilities, as noted in Table 4. Hershenson (1992) simplified these four perceptions by Arokiasamy et al. (2001) from a westernized perspective by theorizing that people explain disability by following three principles; faith, logic, and power. While each of these principles is considered equal, only one principle can be dominant. If the principle chosen does not help to explain the occurrence, then another principle will be chosen to explain the event. Faith is where the individual must accept the event as the will of a supernatural. Logic states that the event can be empirically determined and is caused naturally. Power gives the individual the ability to create change and control over the events (Hershenson, 1992).

Issues affecting persons with disabilities range from institutionalization, eugenics, education, employment, and rehabilitation services, recreation and have created barriers to working, living and recreating in the community. The following sections detail these issues.

Table 4

Sociological Aspect/Perceived Causes of Disability

Perceived Causes	Perceptions
Supernatural	Religious in nature: Mental illness explained by demon or witch possession, divine punishment
Medical	Psychic & Somatic Causes: incurability assumption, Internal organ based, onanism, worry, debauchery
Natural	Environmentally influenced: Humane response, moral treatment
Society	External Environment: social victimization, capitalism, institutions

Note: From Arokiasamy, C. V., Rubin, S. E., & Roessler, R. T. (2001). Sociological aspects of disability. In S.E. Rubin & R.T. Roessler (Eds.), *Foundations in the vocational rehabilitation process* (pp. 151–183). Austin, TX: Pro-Ed.

Issues Affecting Persons with Disabilities

Institutionalization

Institutionalization is not a word or action of the past. Currently there are over four million individuals with disabilities of working-age living in institutions in America (Census Bureau, 2000). The origins of institutionalization can be traced to the fourth and sixth centuries when hospices were monastically inspired refuges for the blind and for persons with disabilities (Braddock & Parish, 2001). During the sixth century some persons, primarily those with Hansen's disease were segregated. It was not until the 1600s that the first almshouses were developed in America. During the 1600s and 1700s

very few institutions existed. The first almshouse was in Boston in 1662 and the first mental asylum was located in Virginia in 1773 (Braddock & Parish, 2001). There were three forces that helped to contribute to the rise of institutions in America. These forces were urbanization, industrialization, and immigration. Each of these three forces helped evolve and energize the other. Unlike Europe with a vast history and healthy population, America was considered as a young and growing nation that had just won its independence from England in 1776.

Prior to institutionalization's purpose as a dumping ground, people who were considered to have some type of disability were cared for by their families (and others) within their own communities. In the 1700s, America was an agrarian society and sparsely populated. All persons living in an agrarian society had some type of responsibility or role to play in their family.

In the 1800s America began to experience the tolls of growth. The social forces of urbanization, industrialization and immigration were changing America's landscape rapidly from an agrarian society to an industrialized urban society. This rapid growth and move to urbanization changed the family structure and the nature in which family issues would be addressed, to include disability and poverty. People who blended into rural economies now stood out in cities where the ability to work at paid jobs was a measure of success (Berkowitz, 1987). During the 1800s institutions were becoming more prevalent as a method and means to establish control over individuals of various backgrounds, ailments, and attributes. Institutions were viewed as one solution to America's social problems. Institutions were used as a dumping ground for individuals who were homeless, destitute, poor, or had disabilities (Taylor & Seal, 2001).

The first institutions were state run facilities in Virginia, Maryland, and Kentucky (Grob, 1973, Braddock & Parish, 2001). These institutions were specifically opened to deal with people who had or were considered to have mental illness. The initial thought behind the growth of institutions and asylums was to protect and heal those who were labeled with a mental illness. During this time America addressed issues such as mental illness with a medical model approach. The physicians-superintendents who were running the asylums and institutes considered mental illness as a curable/fixable disease (Braddock & Parish, 2001; Grub, 1966; Kirkbride, [1880] 1973).

Dorothea Dix brought attention and advocated for an end to the many atrocities occurring within public almshouses, asylums and prisons. The first of her many memorial solicitations, Dorothea Dix (1843) addressed the legislature of Massachusetts about the atrocities occurring in the asylums. Dix (1843) stated:

> I come as the advocate of helpless, forgotten, insane and idiotic men and women: of beings shrunk to a condition from which the most unconcerned would start with real horror: of beings wretched in our prison, and even more wretched almshouses…. I proceed, gentlemen, briefly to call your attention to the present state of insane persons confined within this Commonwealth, in cages, closets, cellars, stalls, pens, chained, naked, beaten with rods, and lashed into obedience… Irritation of the body produced by utter filth and exposure, incited [one woman] to the horrid process of tearing off her skin by inches, her face, neck, and person, were thus disfigured to hideousness. (p. 7)

In another address five years later to the State of North Carolina General Assembly about the conditions and atrocities within their State Hospital Systems,

Dorothea Dix (1848) noted:

> I come not to urge personal claims, nor to seek individual benefits; I appear as the advocate of those who cannot plead their own cause… I am the voice of the maniac whose piercing cries from the dreary dungeons of your jails penetrate not your Halls of Legislation. I am the Hope of the poor crazed beings who pine in the cells, and stalls, and cages, and waste rooms of your poor-houses. I am the Revelation of hundreds of wailing, suffering creatures, hidden in your private dwellings, and in pens and cabins—shut out, cut off from all healing influences, from all mind-restoring cares. Could the sighs and moans, and shrieks of the insane throughout your wide-extending land reach you here and now, how would your sensibilities to the miseries of these unfortunates be quickened: how eager would you be to devise schemes for their relief—plans for their restoration to the blessing of a right exercise of the reasoning faculties. Could their melancholy histories be spread before you as revealed to my grieved spirit during the last three months … compared with the certain benefits and vast good to be secured for the suffering insane, and for their afflicted kindred, by the consecration and application of a sufficient fund to the construction of a suitable hospital in which the restoring cares of skillfully applied physical and moral treatment should be received and in which humane and healing influences should take the place of abuse and neglect and of galling chains and loathsome dungeons. (pp. 4-5)

Dorothea Dix was a pioneer in exposing the horrid conditions of almshouses, asylums and prisons where people with mental illness were confined. Dix advocated and fought fervently for better conditions and humane principles for those labeled as insane

and idiotic (Taylor & Searl, 2001) by addressing many state legislatures for the construction of institutions for people with mental illness. Between 1840 and 1870 Dix was responsible for the construction of over 30 facilities for those labeled as being mentally ill (Brown, 1998; Braddock & Parish, 2001).

In 1845, Woodward and Brigham, both superintendents of facilities in their respective states of Massachusetts and New York, recommended the first institutions for intellectual disabilities. Both men suggested a public educational provision for children with intellectual disabilities (Braddock & Parish, 2001; Brigham, 1845; Woodward, 1845). Other proponents for educationally oriented asylums were Samuel Gridley Howe, a leader of the education of blind students, Hervey Wilbur, an instructor who set up a private school in his home for children with mental retardation, and Edouard Seguin, a physician from France who was devoted to the training of persons labeled as idiots (Braddock & Parish, 2001, Taylor & Searl, 2001). Howe, Woodward, Brigham, Seguin, and Wilbur all had a vision that these schools would be training facilities for individuals with intellectual disabilities.

After the first institution for persons with intellectual disabilities opened in 1855 there was a rapid growth of institutions in America. The visions of Howe, Sequin, Woodward, Brigham, and Wilbur initially answered through an educational model, and institutions were successful in returning individuals with intellectual disabilities to communities as productive workers (Braddock & Parish, 2001; Stewert, 1882; Trent, 1995). With the advent of the Civil War, economic hardship and lack of employment opportunities prevented residents of institutions from being discharged. The exploitation of residents was apparent. They used residents to offset labor costs incurred by the

institutions (Braddock & Parish, 2001; Fenton, 1932; Knight, 1891). By 1880, the educational vision of Woodward, Howe, Sequin, and Brigham for individuals with intellectual disabilities who were institutionalized, had transformed into custodial care based on the medical model (Taylor & Searl, 2001; Wolfensberger, 1976,). Taylor and Searl noted that Howe, Seguin and Wilbur (Braddock & Parish, 2001) distrusted large segregated institutions, but by 1888 Wilbur had changed his position and called for lifelong institutionalization of individuals with intellectual disabilities.

The twentieth century brought new highs in the development of institutions across America because of the increased social forces of urbanization, industrialization and immigration. Lakin (n.d.) as cited in Martin (2001) reported individuals in institutions for the feebleminded (sic) grew considerably from 2,429 in 1880 to over 55,000 in 1926, outpacing the growth of the general public. Urbanization was increasingly significant, and the urban population of 6.1 percent in 1800 grew to an astounding 45.1 percent by 1920 (Stockwell, 1968, Taylor & Searl, 2001). This large growth resulted from the shift of the majority of the American population from rural to urban settings.

The second social force was industrialization. Industrialization was becoming increasingly significant. Unlike the agrarian society where an individual had some useful abilities and a defined social role, the industrial society depended on output and quotas. If workers were not able to keep up, then they were of no use or worth. An industrialized society is competitive, while an agrarian society is characterized more by teamwork and helpfulness.

A third social force was immigration. Immigrants were coming to America in increasing numbers. Taylor and Searl (2001) noted in a time span of 100 years from 1820

to 1920 immigrants coming to America grew from 151,000 to over 38 million. Immigration was a very complex issue. People coming to America did not share the same values or cultural nuances. These differences brought about skepticism and were used to deport, imprison, or institutionalize immigrants who were deemed feebleminded (sic) or more accurately, unfit for society.

The rapid growth of America resulted from the combined effects of urbanization, industrialization, and immigration and played a pivotal role in the rise of unemployment, homelessness, crime, cultural clashes, unemployment, and the growing presence of slums (Taylor & Searl, 2001). The solution to these social problems, at the time, was to institutionalize those who were thought responsible for the social ills of society. This thought process drastically increased the number of persons labeled as feebleminded in asylums, and institutions grew in size from 7,811 in 1890 to 16,551 in 1904 to its peak of 194,650 in 1967 (Lakin, n.d. as cited in Martin, 2001; Lakin, Bruininsks, and Sigford, 1981).

Eugenics

The eugenics movement at its peak from 1860–1920 utilized several procedures and strategies to control the population of persons with disabilities or those who were labeled as such. Members of this movement promoted segregation, sterilization, prevention of marriage and sexual relations, restrictive immigration and elimination to address the social ills of society (Martin, 2001). Darwin, Galton, and Mendel's documentation of intellectual disabilities, mongolism, cretinism, and other genetic anomalies gave rise to the science of eugenics (Parmenter, 2001). One example of Mendel's work suggested that intellectual disabilities occurred not from a variety of

genetics but from a single inheritable condition (Parmenter, 2001). These findings helped to support the justification of sterilization of individuals deemed unfit for procreation.

Concurrent with the forces of urbanization, industrialization, and immigration was the belief that America's growing social ills could be addressed with the application of eugenics as the solution. This was widely accepted among researchers and intellectuals. The medical model was the dominant view. It maintained that certain disabilities such as feeblemindedness and other social ills were hereditary (Braddock & Parish, 2001; Neilsen, 2001; Parmenter, 2001; Taylor & Searl, 2001). This perspective supported the shift from the educational model, that Howe and Seguin asserted, to the medical model. The medical model considered feeblemindedness (sic), pauperism, physical, and mental disabilities to be of biological origin, thus inheritable. Brockett, as cited in Switzer (2003) articulated there was a pathological basis to feeblemindedness. Another prominent and influential individual of the time, Henry H. Goddard, theorized that feeblemindedness (sic), morons, and other disabilities were the result of inferior genetics passed from generation to generation (Parmenter, 2001; Switzer, 2003; Taylor & Searl, 2001). Goddard is most famous for *The Kallikak Family* study in 1912. Goddard's study had a considerable impact on future policies in the continued support of institutionalization. Goddard's study stigmatized immigrants as feebleminded (sic) which prompted Congress in 1917 to consider a ban on immigration to stop the spread of mental inferiority (Parmenter, 2001; Switzer, 2003; Taylor & Searl, 2001).

Deinstitutionalization

Deinstitutionalization began in the 1950s concurrent with the civil rights movement. The *Brown* decision had a resounding effect on deinstitutionalization with the

summary "We conclude that in the field of public education the doctrine of 'separate but equal' has no place. Separate educational facilities are inherently unequal" (*Brown v. Board of Education*, 347 U.S. 483. 495). "Separate but equal is inherently unequal" has moved the deinstitutionalization movement in regards to the atrocities of segregation, abuse, and discrimination of individuals living in institutions.

The case that can be considered as the paramount case for deinstitutionalization is *Wyatt v. Stickney* (1971). The *Wyatt* case addressed the atrocities of institutional living and was one of many cases at the time but was the first case to receive widespread attention from the press and professional community (Martin, 2001). Judge Johnson ruled in the *Wyatt* case, "that all people committed to Alabama's institution had the right to treatment and habilitation under the *least restrictive circumstances"* (Martin, 2001, p. 49). The *Wyatt* case was just one of the many significant cases in the deinstitutionalization movement which conyinues today.

Most recently the *Olmstead v. L.C.* (1999) decision focused on the issue of two women who petitioned the court to live in the community rather than living in a mental hospital. The Supreme Court ruled that under the American Disabilities Act, individuals with disabilities had the right to be served in the "most integrated setting appropriate." To further demonstrate the evolution of this issue on the right to live in the community, legislation has been proposed—Community Choice Act 2007—which gives individuals who reside in nursing homes and institutions the choice to live in the community and still receive federal funds and services, often at a reduced level than institutionalization costs.

Unfortunately, deinstitutionalization is still prevalent in today's society. It was not until 1979 (reissued 2000) when the Center on Human Policy at Syracuse University

documented the plight of persons with significant disabilities in *The Community Imperative*:

> In Human Rights Domain:
>
> All people have the fundamental moral and constitutional rights. These rights must not be abrogated merely because a person has a mental or physical disability. Among these fundamental rights is the right to community living.
>
> In the domain of Educational Programming and Human Service:
>
> All people, as human beings, are inherently valuable.
>
> All people can grow and develop.
>
> All people are entitled to conditions which foster their development.
>
> Such conditions are optimally provided by the community.
>
> Therefore:
>
> In fulfillment of fundamental human rights and
>
> In securing optimum developmental opportunities,
>
> All people, regardless of severity of their disabilities, are entitled to community living. (Martin, 2001. p. 83)

This is a very powerful statement that affects all aspects of one's life.

Independent Living Paradigm

The philosophy of Independent Living (IL) is the empowerment and autonomy of people with disabilities to have freedom, choice, and control over their everyday life situations. Like the previously mentioned movements, the IL movement was in response to the dehumanizing process inherent in society's treatment of persons with disabilities, particularly those with significant disabilities. Specifically, IL was influenced by

deinstitutionalization, the civil rights movement, the "self-help' movement, demedicalization, and consumerism (McDonald & Oxford, 2005). DeJong (1979) developed a model for IL that moved from the medical model, where people were viewed as sick or broken, to the belief that problems were in the attitudes of people and society.

Ed Roberts (Father of Independent Living) in 1962 was the first student with a severe disability to enter the University of California at Berkeley. His actions and advocacy led to the first Independent Living Center located in Berkeley, California (1972). The IL movement gained momentum and support after passage of the Rehabilitation Act of 1973 Title VII authorized the first independent living centers and programs. Another significant aspect of the 1973 Rehabilitation Act was Section 504. Section 504 stated: "No otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." Title VII of the 1973 Rehabilitation Act (sec.725) helped established four core practices of the independent living philosophy:

(a) consumer control of the center regarding decision making, service delivery, management, and establishment of the policy and direction of the center;
(b) self-help and self-advocacy;
(c) development of peer relationships and peer role models; and
(d) equal access of individuals with significant disabilities to society and to all services, programs, activities, resources, and facilities, whether public or private and regardless of the funding source.

These practices helped to establish the independent living movement's approach to breaking down barriers within the community by providing each consumer the basic needs of information, peer support, housing, equipment, personal assistance, transport, and access to the environment.

Influence of Change

Martin (2001), in Lessons Learned: Implications for System Changes, *Significant Disability* emphasized that "when people are institutionalized because it is felt to be the best choice for the person or that person's family in terms of care and habilitation/rehabilitation it would seem that we have not heeded the lessons of the past century regarding the evils of institutions… or even that we are really aware of the abuses that are currently tolerated" (p. 197). This quote may not seem relevant to the development of a model undergraduate rehabilitation education curriculum, however upon closer inspection it has everything to do with undergraduate rehabilitation education. As Warren noted "history cannot give us a program for the future, but it can give us a fuller understanding of ourselves, and of our common humanity, so that we can better face the future." What we choose to teach our students is extremely significant. It is more important to have a common identity than the apparent fragmentation among undergraduate rehabilitation programs in the United States. The development of a common identity will have the capacity to enhance a stable foundation for all students entering rehabilitation programs. We are educating future leaders, educators, parents, employees, advocates, and citizens. The idea of a multidisciplinary approach (Arsenian, 1968; Gandy and Martin, 1985; Hylbert, 1963; Jaques, 1972; Redkey, 1971; Steger, 1974) is an essential element of an undergraduate rehabilitation education. More

importantly, if this multidisciplinary approach is to work there must be a unified core curriculum that programs can establish, further developing its foundation and identity for the future.

There continues to be leaders who are ignorant of the issues affecting not just people with disabilities, but all people, regardless of attribute. For example, in 2004, Rob Johnson of the Associated Press reported that the State of Alabama refused federal money to allow individuals to leave nursing homes/institutions to be cared for at home or in a community-based setting while continuing to receive Medicaid funding. The Medicaid Commissioner justified her decision for refusing federal funds, claiming she was not sure if services provided by this grant would be available after the expiration of the grant in two to five years. Perhaps more telling was the Commissioner's comment, "none of us would like to live in a nursing home, but sometimes it is the safest way to live" (p. A1).

Similarly in a New York Times (2007) article regarding amputees competing against able-bodied (sic) athletes entitled "Is He Disabled or Too-Abled?" the International Association of Athletics Federation (IAAF) officials "expressed concerns that Pitsorius [an individual who wears prosthetic legs] could topple over, obstructing others or injuring himself and fellow competitors" (p. A21). These are excuses with no real basis of fact. What is the safest way to live? Can't anyone topple over while running? These views continue to exist within individuals, our communities, organizations, and society.

Development of a clear understanding of the history of social change and legislation that counter these biases is fundamental. What seem to be disjointed

movements of blacks, women, and persons with disabilities are actually interrelated. All these movements brought rights to individuals who were being mistreated, oppressed, segregated, or discriminated against.

History of Undergraduate Rehabilitation Education

"Rehabilitation Education is an infant curriculum but, withal, a lusty infant. It no doubt will continue to be subject to careful examination, re-examination, and development for some time" (Hylbert, 1963, p. 24). This statement made some twenty-four years ago rings just as true in 2007. Currently CUE is undertaking a role and function study to further define the nature of undergraduate rehabilitation education. The primary focus of this section of the qualifying paper will be to examine the curricular similarities and differences among undergraduate rehabilitation education programs through a comprehensive review of the extant literature. This review will provide a historical roadmap of the development of undergraduate rehabilitation education programs in the United States and will provide some insights regarding the development of a model curriculum for undergraduate rehabilitation education. As a consequence of this first step, we will be able to answer the questions proposed by Herbert (2006)—questions related to the creation an independent accreditation organization, or the development of a new accreditation body within CORE, or affiliation with an existing accreditation body, last by, not to pursue accreditation. Certainly these are possible alternatives in the development of a model curriculum; however, there may be other options that have the capacity to unite, rather than to continue, the fragmentation of undergraduate rehabilitation education programs in the United States.

Pennsylvania State University

Undergraduate rehabilitation education began in 1957 in response to staff recruitment efforts by state vocational rehabilitation agencies (general and blind) to meet personnel vacancies. Thus the creation of this experimental undergraduate program was introduced at Pennsylvania State University. Hylbert (1963) noted the original curriculum was established as a preparatory employment program to meet the increasing need for personnel in the field of rehabilitation, but through its evolution and modification it has become more of a pre-professional exploration for students entering a broad variety of helping fields in either the public or private sectors. The advantage of this type of curriculum is that it allows students the opportunity to have a specialization in a particular area of study such as:

- Rehabilitation counseling
- Social work
- Psychology
- Occupational therapy
- Recreation therapy
- Optometry
- Nursing
- Prosthetics
- Physical therapy
- Speech therapy
- Audiology
- Penology
- Medical library work
- Medical technology
- Medical secretarial work
- Dentistry
- Welfare
- Public administration
- Medicine
- Placement

For this particular educational program, a Bachelor of Science or Arts required the student to complete 136 credit hours which consisted of 28 hours of general requirements, 36 hours of general electives, 21 hours in three of the four core areas, and 9 hours of credit in the fourth core area. Table 5 is a schematic representation of this curriculum.

Table 5

The Pennsylvania State University Rehabilitation Education Curriculum Program Highlights

Course	Hours
Man as a Physical Being	
Biological science**	6
Physical growth and development	3
Human genetics	3
Mammalian anatomy	3
Human physiology	3
Medical information for counselors	3
	21 hours
Man as a Social Being	
Introductory sociology**	3
Principles of economics	3

Social problems	3

(table continues)

Table 5 (continued)

Course	Hours
Sociology and social work	3
Community organization*	3
Introduction to public welfare	3
Principles of casework	3
	21 hours
Man as a Psychological Being	
Introductory psychology**	3
Educational psychology	3
Psychology of home and marital adjustment*	3
Theory of personality	3
Psychology of adjustment	3
Statistics	3
Measurement of abilities	3
	21 hours
Professional Orientation and Practical Applications	
Educational American society	3
Guidance principles and practices	3
Introduction to rehabilitation	3
	9 hours

Total	136 hours

General requirements: ROTC (6), physical education (4), English and speech (12), mathematics (3), philosophy (3) — 28 hours minimum

General electives: arts, science and mathematics, humanities, philosophy, political science, economics, etc. — 36 hours minimum

*Strongly recommended electives; total possible electives 45 hours.

**Required in common freshman years

The rehabilitation education program at Penn State consisted of a tri-dimensional understanding of the physical, social, and psychological aspects of humanity. The first consideration was to allow students time to determine their professional direction by offering flexible course selection. The second part of the curriculum was philosophical in nature: offering four pre-professional core areas of study. The first three were considered fundamental to the multi-disciplinary preparation of students:

(a) Man (sic) as a Physical being

(b) Man (sic) as a Social Being

(c) Man (sic) as a Psychological being

(d) Professional Orientation and Practical Applications

Hylbert (1963) proposed that these fundamental areas should be a common preparatory goal for any pre-professional program encompassing the field of rehabilitation and other health related fields.

Hylbert considered effective teamwork and communication skills to be essential to the program objectives. Hylbert (1963) noted:

> We must not suppose that any pre-professional curriculum will provide background resulting in 100 percent effective communication among all members of the rehabilitation team … reasonable to believe that a common pre-professional curriculum for the various disciplines involved in rehabilitation will go far toward the attainment of mutual interdisciplinary respect and effective teamwork.… (p. 24)

Hylbert (1963) also asserted that the broad holistic approach to rehabilitation curriculum allowed considerations for students to:

(a) have time to determine their direction and choice in professional direction

(b) be allowed to create teacher and student rapport

(c) have guidance in career decisions

(d) attract interested students from various other departments

(e) find a natural home for those who may have a special interest in disability (e.g., individuals with disabilities)

(f) help create a broader professional identity that other programs do not offer.

Hylbert and Skelz (1972) reported on a 12 year follow-up of Pennsylvania State's baccalaureate degree in Rehabilitation. Since the inception of Pennsylvania State's rehabilitation education program, the Rehabilitation Services Administration of the U.S. Department of Education has endorsed undergraduate education (Hylbert & Kelz, 1972). Hylbert and Kelz (1972) reported that the first tentative program in 1958–1959 with five students has grown to a more confident program of 270 students that annually awards 75 degrees. A key element of the program's success is the curriculum's flexibility and the student centered environment provided by the department (Hylbert & Kelz, 1972).

Stout University (University of Wisconsin-Stout)

In 1971 Henry Redkey described the undergraduate rehabilitation program at Stout University. He referred to students who obtained an undergraduate degree in rehabilitation studies as a *rehabilitation generalist*. A rehabilitation generalist as described by Redkey (1971) was "a person with a good basic grounding in rehabilitation and simple skills of counseling, evaluation, and the highly important attitudes towards disabled people (sic)" (p. 26). Achieving a generalist's degree indicated that graduates would have a broad base of information and skills that would match the needs of rehabilitation facilities and other health related occupations.

Redkey (1971) asserted that this experimental curriculum was an integrated program in rehabilitation. It was not just a compilation of various courses, but consisted of specific courses related to rehabilitation. The curriculum consisted of 40-44 semester credit hours in general studies. Of these 40 hours, 12 to 16 were restricted electives, and 28 hours were required credits. Table 6 is a schematic representation of the curriculum**.** Students were required to have a concentration of 28 to 32 credit hours in industrial arts, home economics, or business administration. Redkey (1971) noted that having concentrations such as these would allow the student to be more effective in whatever rehabilitation setting they might enter. To further extend the experiential experience students were required, through independent study/ internship, to work for at least a summer in a rehabilitation setting.

Table 6

Undergraduate Rehabilitation Program

General Studies — 40 Semester Credits	
English courses, general psychology, general sociology, physiology and anatomy, history, government, economics, etc. How many rehabilitation workers today, particularly in smaller facilities, have that foundation?	
Course	Credit Hours
Differential Psychology or Attitudes of Achievement Appraisal	
Restricted Electives — 12-16 Credits	
Field Experiences	2–4
Independent Studies	2–6
Principles of Rehabilitation Counseling	3
Communications with the Deaf	3
Human Factors Engineering	3
Culturally Disadvantaged Child and Family	3
Digital Computer Programming	2
Introduction to Social Work	3
Sociology of Minority Groups	3
Psychology Methods I **OR**	3
Measurements **OR**	3
Computational Statistics	3

(table continues)

Table 6 (continued)

Course	Credit Hours
Personal and Mental Health	3
Differential Psychology **OR**	
Aptitudes and Achievement Appraisal	2–3
Psychology of Learning **OR**	
Educational Psychology	2–3
Industrial Psychology	2
Psychology of Exceptional Child	2
Mental Retardation	
Required — 28 Credits	
Introduction to Rehabilitation	3
Community Resources	3
Rehabilitation Practicum	2
Juvenile Delinquency	3
Abnormal Psychology	3
Field Experience **OR**	2
Independent Studies	1–2
Rehabilitation Methods I: Evaluation	3
Physical Disabilities & Work	3
Rehabilitation Methods II: Adjustment	3
Rehabilitation Seminar	1
Mental Retardation	2

Virginia Commonwealth University

In 1974 Virginia Commonwealth University established a Baccalaureate Program in Rehabilitation Services. Gandy and Martin (1985) describe Virginia Commonwealth's rehabilitation services program as having a humanistic approach that incorporated a liberal arts perspective and professional educational foundation while providing a holistic view in working with individuals with various disabilities.

The structure of Virginia Commonwealth's program consist of 33 semester hours of coursework in liberal arts and sciences, 15 hours of community and public affairs, a 12 hour cognate in upper level social and behavioral sciences, and 33 semester hours of electives (Martin & Gandy, 1985). Gandy and Martin (1985) noted that students had the opportunity to obtain a specialization in alcoholism and drug rehabilitation. Table 7 is a schematic representation of this curriculum, with an option in Alcoholism and Drug Client Services.

Table 7

Baccalaureate Program in Rehabilitation Services

Course	Semester Hours
33 Semester Hours — Liberal Arts and Sciences	
English — Composition and Rhetoric	6
Mathematics Electives	3
Additional Communication Skills and Abilities Electives	3
Social Science Electives	9
Natural Science Electives	6
Humanities and/or History Electives	6
15 Semester Hours — Community and Public Affairs	
Methods of Community Analysis — CSE 241-242	6
American Urban Experience — CSE 315-316	6
Community Services Cognate Electives	3
30 Semester Hours — Rehabilitation Services Core Courses	
REH 201 — Introduction to Rehabilitation Methods	3
REH 202 — General Alcohol and Drug Studies	3
REH 312 — Contemporary Rehabilitation Services	3
Option in General Client Services	
REH 350 — Applied Rehabilitation Methods	3
REH 360 — Work Evaluation and Adjustment in Rehabilitation	3
REH 370 — Job Development and Placement	3

(table continues)

Table 7 (continued)

Course	Semester Hours
REH 356 — Interpretive Processes in Rehabilitation	3
REH 495 — Practicum in Rehabilitation	6
REH 539 — Current Problems in Rehabilitation	3
Option in Alcoholism and Drug Client Services	
REH 321 — Introduction to Alcoholism and Drug Abuse	3
REH 322 — The Growth Process of the Alcoholic and Drug Addict	3
REH 452 — Crisis Intervention with the Alcoholic	3
REH 494 — Practicum in the Rehabilitation of the Alcoholic	6
REH 423 — Principles, Methods, and Techniques in Treatment of the Alcoholic	3
REH 551 — Treatment of the Alcoholic with Significant Others	3
12 Semester Hours — Upper Level Social and Behavioral Sciences	
33 Semester Hours — Electives	

Syracuse University Institute on Undergraduate Rehabilitation Education

In 1973 Syracuse University held an institute on the development of rehabilitation education curriculum guidelines. The institute involved many individuals from various human service related fields, creating a multidisciplinary approach to the conference. Feinberg, Sundblad and Glick (1974) reported that it was a curriculum for undergraduate rehabilitation education and was to be focused and delivered as "the generation of a series

of educational experiences designed to provide the unique as well as the generic skills necessary for the effective functioning of the professional rehabilitation services advocate" (p. 11).

Through the task groups, data were collected on core knowledge, attitude, and skills that established two curriculum guidelines. These guidelines were:

- Core knowledge areas
- Core skill areas

Within the two curriculum guideline areas, each task group identified and suggested typical coursework to be illustrative of potential course offerings for four-year undergraduate rehabilitation service programs (Feinberg, et al., 1974). These potential but not inclusive course suggestions are provided in Table 8**.**

Table 8

Potential undergraduate rehabilitation service course offerings

Course
Academic Course in Core Knowledge Areas
Courses in Human Behavior, Growth and Development
Foundations of Human Behavior
Psychology of Childhood
Personality
Abnormal Psychology
Biology and Human Values
Culture and Personality
Psychology of Individual Differences
Courses in Social, Cultural, and Environmental Systems
Introduction to Sociology
Urban Government and Administration
Social Problems and Social Services
Public Welfare
Introduction to Political Systems
Courses in Special Populations and Their Needs
Psychology of Exceptional Children and Adults
Medical Aspects of Disability
Psychology of Disability
Drugs in Perspective

Table 8 (continued)

Course
Special Populations (continued)
Poverty in America
Nature and Needs of the Retarded
Introduction to Speech and Hearing Disorders
Maturity and Old Age
Courses on Strategies for Interventions
An Introduction to Rehabilitation
Social Service to Individuals
Social Service to Groups
Culture Change
Counseling, Case Management, and Advocacy
Institutions and Their Alternatives
Courses on Vocational, Social, and Psychological Evaluation Systems
Psychological Tests: Aptitude Testing
Psychological Tests: Personality
Statistical Methods
Participant Observation Strategies
Vocational Development and Evaluation

(table continues)

Table 8 (continued)

Course
Academic Courses in Core Professional Skill Areas
Courses in Communication Skills
Interpersonal Skill Training
Public Address
Basic English
Courses in Interviewing Skills
Interviewing Techniques in the Rehabilitation Process
General Counseling Methods
Course in Advocacy Skills
The Advocacy Process and Skills
Citizen Advocacy
Courses in Case Management Skills
Strategies for Team Management and Administration
Courses in Placement and Follow-up Skills
Vocational Placement of the Handicapped

Discussion

Since the inception of the first undergraduate rehabilitation education program at Pennsylvania State University, the curriculum's focus and philosophy on 'Man's (sic) Nature and Needs' has not changed although courses have been added to develop areas such as case management. Hylbert and Kelz (1972) further defined the rehabilitation

curriculum as broad based. The curriculum however, grew to 130 credit hours. The program is located within a College of Education with the primary course load taken in several other colleges, such as College of Liberal Arts, College of Art and Architecture, and College of Science (Hylbert & Kelz, 1972). Students have a choice of obtaining either a Bachelor of Science or Arts degree. A unique aspect of Pennsylvania State's curriculum is the required 33 elective credit hours. Hylbert and Kelz (1972) considered the substantial use of electives to be four-fold:

- extend the student's general or liberal education
- provide opportunity for wide exploration as basis for career choice
- meet entrance requirements to advance study or specialization
- increase and broaden professional competency.

Hylbert and Kelz surveyed 125 graduates from their undergraduate rehabilitation education program and found that 45 percent obtained a post-bachelor's degree while 55 percent maintained this degree as a terminal education degree. Of those obtaining a Post-bachelor's degree, 24 of the 56 (42 percent) obtained a graduate degree and reported working as rehabilitation counselors. Hylbert and Kelz (1972) noted of the 125 graduates surveyed there was a range of twenty-three occupations. These occupations are identified in Table 8**.** The majority of the twenty-three occupations reported were in human service related fields. These occupations ranged from rehabilitation counseling to youth counseling. Those occupations not considered as human service related fields ranged from military service to industrial advertising.

Interestingly Hylbert (1963) suggested that students seeking a rehabilitation education degree would be prepared for other specialized areas after receiving that

degree. Hylbert and Kelz noted of the twenty suggested occupational areas, eight were reported in the survey. More promising were the additional 16 occupational areas that graduates reported, reinforcing the viability of their earlier assertions of the program's flexible curriculum that allowed for career exploration. This broad array of occupations further supports Hylbert and Kelz's claim that students with an academic background in rehabilitation may be beneficial to the overall rehabilitation movement. Hylbert and Kelz also noted that undergraduate students tend to change their professional and education goals several times in college, and the flexibility of the rehabilitation education curriculum allows students to change within an occupational family without changing majors. Hylbert and Kelz firmly believed students who entered the undergraduate rehabilitation program did so because it was not seen as "dead-ending."

Table 9

Occupational Area Reported

1.Rehabilitation Counseling	13.Employment Interviewing
2.Rehabilitation Counseling -trainee	14.Rehabilitation Research
3.Social Casework	15.Physical Therapy
4.Rehabilitation Counseling worker non-specified	16.Industrial Advertising
5.Special teacher (sic)	17.Vocational Evaluation
6.Rehabilitation Administrator	18.Occupational Therapy

Table 9 (continued)

7.Therapeutic Activities	19.College Personnel
8.Speech Pathology	20.Library Work
9.Psychology	21.Housewife
10.Youth Counseling	22.Military Service
11.Counseling Psychology	23.Personnel Work
12.Medicine	

Note: Hylbert, K. W., & Kelz, J. W. (1972). A bachelor's in rehabilitation. *The Journal of Applied Rehabilitation Counseling, 3*(2), p.48.

Human Services Rehabilitation Education Curricular Options

Arsenian (1968) defined the helping process not in a medical model context but more from a humanistic approach to helping. Similar to Hylbert's proposed curriculum, Arsenian suggested a more generic human services curriculum. Arsenian (1968) proposed that the undergraduate curriculum's core requirements consist of five areas:

(1) Man (sic) in Nature

(2) Man (sic) in Society

(3) Man's (sic) Communicative and Expressive Arts

(4) Man's (sic) use of Movement, Recreation, and Leisure

(5) Man's (sic) Search for meaning

Both Hylbert (1963) and Arsenian's (1968) curricular content focused on the holistic perspective of the individual. Unlike Hylbert's curriculum, Arsenian proposed a curriculum that required supervised fieldwork experience. Arsenian (1968) viewed

undergraduate education as a broad experience in human services. This broad experience would provide six elements for the extension, enrichment, and preparation of the undergraduate student to enter the helping professions. These elements were:

- Human-centered
- Knowledge of Man (sic)
- Integration
- Emphasis on Assets and Becoming
- Concern for Freedom
- Service Motivation.

This broad experience allowed students to explore themselves and, to be exposed to and understand such issues as hostility, prejudices and fear of self and others, prior to entering a helping profession. This proposed curriculum was designed to allow the student to be more self-aware and to confirm or refute this understanding prior to entering a helping profession. In addition to these five core areas, Arsenian (1968) suggested there were eight tentative courses the curriculum should include. These courses consisted of:

- Human Development
- Human Personality
- World of Work
- Community Organization and Planning
- Great Social Issues of Today
- Helping Process
- Scientific Method applied to Human Affairs
- Group Dynamic

Similar to Arsenian's (1968) curriculum, Redkey (1971) proposed a rehabilitation practicum that required students to experience a variety of work situations that would put them in direct contact with consumers. Unlike Arsenian's proposed philosophical and holistic curriculum, Redkey's experimental curriculum was similar to the Pennsylvania State University program to prepare graduates to fill vacancies for the rehabilitation agency.

During the 1960s and early 1970s the field of rehabilitation was experiencing personnel shortages, thus promoting the concept of support personnel. Jaques (1972) contended that to properly serve all clients within the field of counseling it would be necessary to train support personnel from various backgrounds. To maintain proper levels of personnel in the field of rehabilitation it was necessary to give attention to the career ladder and the preparation of personnel at a variety of levels. Because of the multi-dimensional nature of rehabilitation counseling, Jaques felt the individual counselor could not perform his or her job properly without assistance from support personnel.

Proposed Broad Rehabilitation Core Curriculum

With the onset of the 1970s, rehabilitation education was gaining momentum and popularity through the development of new programs at a number of universities designed as a holistic degree path for students. These graduates were a resource for state and federal rehabilitation programs, a recruiting source, and a source for graduate programs (Culberson, 1979; Feinberg, Sundblad, & Glick, 1974; Geist & McMahon, 1981; Hylbert, 1963; Hylbert & Kelz, 1972; Jaques, 1972; Redkey, 1971; Witten, 1981). Concurrent with the development of these pioneering undergraduate rehabilitation

programs, other researchers were exploring and proposing different curricular models for undergraduate rehabilitation education.

Steger (1974) advocated for evidence based measures to justify the viability of new programs, especially at a time when resources were scarce and limited. Steger (1974) proposed that undergraduate rehabilitation programs were feeder programs for graduate education and for employment in the rehabilitation agencies. The education and training provided in undergraduate programs would yield an increased competency base in rehabilitation prior to entering graduate education programs, thus decreasing the time needed to obtain a graduate degree in Rehabilitation Counseling (Feinerg, Sundblad, & Glick, 1974; Hylbert, 1963; Steger, 1974).

Hylbert (1963, 1972) initially asserted that part of graduate training would occur at the undergraduate level. To do this, programs must have a model that is reflective of the knowledge, skills, and objectives of the rehabilitation system (Steger, 1974). Issues in developing a reflective rehabilitation program model were of concern. Steger (1974) suggested a multidisciplinary team focus approach for undergraduate rehabilitation education (Hylbert, 1963), with the ability to focus on target groups, create specialized skills, and prepare students to be trained for rehabilitation work settings. Steger (1974) further examined the rehabilitation client service subsystem, as reflected in Figure 1, and developed and proposed a common core of eight categories of skills and knowledge for undergraduate rehabilitation education:

a) *Multidisciplinary Collaboration*. Basic group skills and constructive experience in working with people from other disciplines are important for team functioning. Additional skills include the ability to assume or relinquish

leadership when knowledge, skills, or function make it appropriate and to develop common goals and language.

b) *Communication Skills.* The ability to communicate with clients clearly and with minimum levels of the facilitative conditions and to manifest similar qualities when appropriate in dealing with colleagues is important. It may also be necessary to note significant data and report observations in behaviorally referenced language, to understand the substance of other reports, and to interpret and use forms and regulations constructively.

c) *Problem Solving.* In a sense, problem solving is the essence of rehabilitation. Certainly the ability to obtain information necessary to identify specific goals and possible alternatives and to implement those options in the most appropriate manner for a client is desirable.

d) *Use of Resources.* The skill required to identify resources and see that the client is put in touch with these resources is desirable throughout the rehabilitation system.

e) *Knowledge of the Individual.* The basic physical, psychological, and social aspects of human development are typically a part of human service training programs. Rehabilitation workers need to be particularly aware of the complications and functional limitations associated with trauma and pathology, the process of vocational adjustment, learning and behavioral change, and the development and maintenance of a sense of identity.

f) *Knowledge of Social Variables.* Along with general implications of social variables, rehabilitation workers need to understand the social aspects of

stigma, deviance, and disability, the characteristics of various rehabilitation client groups, community resources in human services, and a variety of job and occupational related information.

g) *Knowledge of the Effects of Disability.* One of the characteristics of rehabilitation is its orientation to the individual who has a disability rather than to the disability itself. It is important for workers to understand the complexity of the consequences of disability, which might have physical, psychological, interpersonal, social, economic, legal, and political repercussions.

h) *Knowledge of Rehabilitation.* The history, philosophy, legal basis, and organizational structure of rehabilitation have made certain objectives, facilities, resources, and functions important. In fact, an individual's effectiveness may be limited to the extent of his or her understanding of the rehabilitation system and how it works for individual clients. (pp. 15-16)

These eight core categories would be taught in a two-course sequence design based on an assumption that students from various academic programs would be interested. The sequence supported the program orientation in which students from multiple disciplines would come together in joint study, creating a team supportive environment (Steger, 1974). Steger's (1974) educational plan was derived from the goal-oriented model of rehabilitation noted in Figure 1. Steger implied that with the use of the goal-oriented model of rehabilitation as a blue print, this model would lead to the success of rehabilitation education programs.

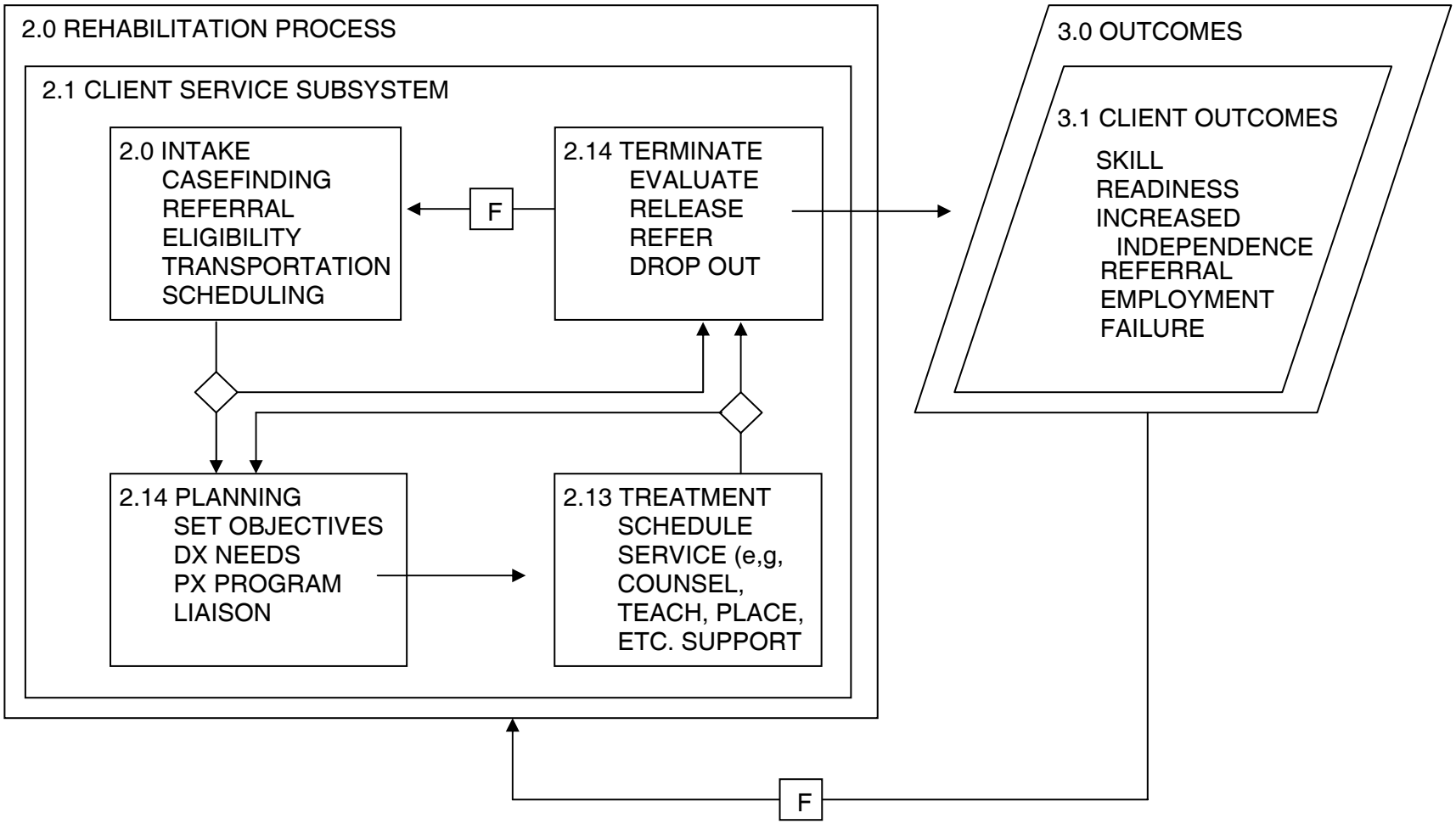

Figure 1. Major Components of the Client Service Subsystem

Steger (1974) explained the rationale and basis of the eight core categories, although he did not clearly detail the proposed curriculum. He vaguely described the two semester sequence but did not mention specific courses. The first semester, Steger (1974) suggested that students from various programs be provided core knowledge of rehabilitation: information on history, philosophy, client facilities, and organization of rehabilitation. Moreover, students would be required to demonstrate competency through group projects, papers and discussion groups. The second semester would focus on skill development in the areas of communication, problem solving, use of resources, and team functioning. An essential part of the second semester would require that students to be placed in supervised work settings. Overall courses and fieldwork experiences would provide the student with:

(a) a multidisciplinary focus

(b) the ability to create networks

(c) communication skills

(d) problem-solving skills.

Steger's (1974) proposed model for undergraduate rehabilitation education program was developed with the sole intent on moving undergraduates to the graduate level, unlike Hylbert (1963), Redkey (1971), Gandy and Martin (1985) where preparing undergraduates for the graduate level was only one aspect of their programs.

Schatz (1974) suggested in a reflection on the Syracuse Institute on Curriculum Development that within the actual design of instruction there were four categories of learning that must be identified and ordered:

- What everyone must know
- Remedial areas for those who do not know specific content
- Exemptions for those who already know content
- Optional areas for the student to chose from (p.30)

The fourth category--optional areas--as noted by Schatz were discussed in Hylbert, (1963), Redkey (1971), Steger (1974), Arsenian (1974), and Gandy and Martin's (1985) articles on undergraduate rehabilitation curriculum development. Schatz (1974) believed the education profession was ready to move forward, reconciling the following issues and make judgments regarding:

- Completeness: Is what we have done complete enough?
- Philosophical soundness: Is what we are doing enough to continue?
- Professional outcomes: Is what we are doing realistic, or have we moved away from what is possible to an unrealistic view of the educational/human service area? Does it make sense?
- Direction: Are we accomplishing what we are stetting out to do? Do we know what our goals are, and are we achieving them?

Schatz's reflection on the development of design and delivery of instruction and curricular issues demonstrates the gravity and complexity of developing a curriculum for undergraduate rehabilitation programs.

Culberson (1979) surveyed 50 state directors of Vocational Rehabilitation to determine qualification preferences for entry-level bachelor's job applicants. At the time of this survey, the NCRE directory (1978) reported 40 universities with programs in Rehabilitation Services Education or Human Services that were receiving funds from the

Rehabilitation Services Administration. Culberson (1979) reported a 70 percent usable return rate. Regarding the relevance of courses in undergraduate rehabilitation curriculum, Culberson (1979) assessed the state agencies' preferences and perceived value of the courses that might be included in an undergraduate rehabilitation curriculum. His findings were divided into (a) counseling and case management, (b) evaluation, and (c) combination of a and b. The top three coursework items of each area are reported in Tables 10–12.

Table 10

Top Three Coursework Items in Evaluation

Item	Top Three Average Rank
A course in Psychology and/or Social Aspects of Disability	1
A course in Medical Aspects of disability	2
A course in vocational development/ occupations	3

Note: Culberson, J.O. (1979). Undergraduate education for rehabilitation: Agency perceptions of training and characteristics preferred of job applicants. *Journal of Rehabilitation*, *45* (2), p.40. (modified)

Table 11

Top Three Coursework Items in Counseling and Case Management

Item	Top Three Average Rank
A course in Job Placement	1
A course in Medical Aspects of disability	2
A course in Psychology and/or Social Aspects of Disability / A Course in Counseling Theory (items tied for third)	3.5

Note: Culberson, J. O. (1979). Undergraduate education for rehabilitation: Agency perceptions of training and characteristics preferred of job applicants. *Journal of Rehabilitation*, *45*(2), 40. (modified)

Table 12

Top Three Coursework Items in Combined

Item	Top Three Average Rank
A course in Psychology and/or Social Aspects of Disability & A course in Medical Aspects of disability (tied for first)	1.5
A course in Job Placement	3

Note: Culberson, J.O. (1979). Undergraduate education for rehabilitation: Agency perceptions of training and characteristics preferred of job applicants. *Journal of Rehabilitation*, *45*(2), 40. (modified)

National Council on Rehabilitation Education Position Statement

In 1986, the NCRE Executive Board approved a position statement that described an ideal curriculum outlining the objectives of a general undergraduate rehabilitation services education delineating between graduate and undergraduate training in rehabilitation counseling. The NCRE used the graduate format from the *Accreditation Manual in Rehabilitation Counselor Education Programs* (CORE, 1983) to develop the model curriculum for undergraduate rehabilitation education.

The NCRE described the ideal undergraduate rehabilitation program as being approximately two years of Liberal Arts study (Arsenian, 1968; Gandy & Martin, 1985; Hylbert, 1963; Jaques, 1972). Of these two years, one year would concentrate on rehabilitation service courses, and the second year would focus on approved electives. The NCRE's position statement rationale that rehabilitation students would gain a holistic understanding of people and society. This holistic approach would provide the student a sound foundation in:

- Verbal and quantitative skills
- General knowledge and background
- Intellectual capabilities (reasoning and judgment) in preparation for advanced studies, professional training, and employment
- Awareness of the transgressions on society

- Understanding of the struggle of individuals and groups in society and how they dealt with these struggles
- Development of communication skills
- Understanding of medical aspects of disability
- Understanding of psychosocial aspects of disability

Interestingly, Hylbert (1963), Arsenian (1968), Jaques (1972), and Gandy and Martin (1985) suggested the same holistic rationale in each of their articles regarding the development of a model undergraduate rehabilitation curriculum.

The first year's concentration on rehabilitation services would consist of academic work in which the undergraduate student would receive core course work/study pertaining to the following core areas established by NCRE (1987):

- History and philosophy of rehabilitation, with an emphasis on legislation that has advanced the progress of people with disabilities.
- The organizational structure of the human service and rehabilitation systems, including public and private, for-profit and not-for-profit service delivery.
- Effective interviewing, interpersonal helping and human-relations skills, excluding in-depth material on counseling theories and techniques.
- Introduction to the case management process, such as case-finding, case recording, client advocacy, and routine service coordination.
- Introductory survey of basic methods and techniques utilized in vocational evaluation and work adjustment, excluding in-depth material on theories and more advanced professional applications.

- Basic knowledge of medical, psychological, and social aspects of disability, excluding in-depth materials on theories, research, and extended case studies.
- Knowledge of community resources and services.
- Routine vocational placement, follow-up and/or follow-along services.
- Introductory survey of methods and techniques utilized in research in rehabilitation, excluding development of in-depth research designs and applications.
- Legal and ethical tenets in the human services and rehabilitation field, including those related to social policy affecting persons with disabilities. (p. 5)

In addition to the core areas noted above, programs should offer students additional coursework, electives, and observational and volunteer opportunities within various rehabilitation agencies.

CORE and Registry of Disability and Rehabilitation Studies

The initiative by CORE to register undergraduate rehabilitation programs resulted in the founding of the Committee on Undergraduate Education (CUE) in 1999 which established eight specific curriculum guidelines for educational programs to meet minimal standards of excellence (Evenson & Holloway, 2006; Herbert, 2006). The purpose of these guidelines was to ensure that rehabilitation students gained basic competency to seek and work in rehabilitation careers. The first seven guidelines address primary professional areas and the eighth guideline, while encouraged, is an area where students have the opportunity to obtain an occupational specialization, such as alcohol and drug studies:

- Issues faced by Persons Experiencing Disability
- The Rehabilitation Delivery System
- Interpersonal Communication Skills
- Vocational Rehabilitation Outcomes
- Consumer Involvement and Self Management
- Ethics and Professionalism
- Field Experiences
- Specialty Practices

Undergraduate rehabilitation education has the capacity to truly be a most influential experience for students. Unlike the physical sciences, English, or Social Work, undergraduate rehabilitation education provides students with a broad humanistic and holistic education that may apply in every aspect of life, (e.g., home, work, and leisure) (Arsenian, 1968; Gandy & Martin, 1985; Hylbert, 1963; Jaques, 1972). A common element across these three curricular designs as well as other suggested curricular presented were focused on the issues affecting persons with disabilities as well as legislation and the rights of individuals with and without disabilities. What is needed throughout the United States is, perhaps, the establishment of a standard core curriculum that has the capability to progress to the next level and generation of undergraduate rehabilitation education. Some may disagree with this perspective but a unified core curriculum can promote a cohesiveness and stronger identity among currently fragmented programs. As Schatz (1974) so poignantly stated:

> There comes a point in every development project when a decision must be made to 'do it'… do not let the opportunity slip through your fingers for fear of going around in circles discussing the same point over and over. Too many educational ventures have died at this point in the process. (p. 30)

Hylbert (1963), Redkey (1971), Arsenian (1968), and Gandy and Martin's (1985) programs exhibited an interdisciplinary approach, which is a desirable component to retain in any future model curricular development. Undergraduate rehabilitation education has not significantly changed over the past 43 years. Programmatically, curriculum remains fragmented precluding the emergence of a core identity for those seeking a degree in undergraduate rehabilitation education.

Considerable differences exist among undergraduate rehabilitation education programs. Because of the paucity of research, little has been done to advance undergraduate rehabilitation education. One question that continues to plague this field relates to the purpose of undergraduate rehabilitation education, or more accurately, asks what *should* be the purpose of undergraduate rehabilitation education?

III. METHODS

Purpose of the Study

This study sought to examine the commonalities and differences of registered (see Appendix A) and non-registered undergraduate rehabilitation education programs (see Appendix B) existent in the United States. This section will describe the methodology to be employed, which consists of three phases. Because of the paucity of literature regarding baccalaureate rehabilitation and disability studies programs, an expert panel was to verify the content validity of the survey developed for the study. The first phase will focus on the development of an initial pool of items constituted through a comprehensive literature review and professional input (personal communication). A four-point Likert scale will be used to determine the significance of pooled items derived from the literature. The second phase of this study was the dissemination of a web-based questionnaire to the identified expert panel. The third phase of the study was to define the population to be surveyed. The purpose of the third phase was to examine baccalaureate rehabilitation and disability studies programs in the United States by sending notification through mail and electronically mailed questionnaires to the program coordinators of the 45 identified baccalaureate rehabilitation and disability studies programs (see Appendix B).

The goal of this study was to identify curriculum commonalities and differences among baccalaureate rehabilitation and disability studies programs, and to identify the driving purpose of baccalaureate rehabilitation and disability studies programs education within the United States.

Research Questions

The procedures detailed in this chapter are designed to address and answer the following questions:

1. Do CUE/registry programs differ from non-registry member programs in undergraduate rehabilitation education programmatic perspective pertaining to areas of preparation and education?
2. Does the purpose of undergraduate rehabilitation education programs differ between CUE/registry and non- registry member programs?
3. Do CUE/registry and non- registry programs differ in *primary focus* or programmatic direction relative to undergraduate rehabilitation internships?
4. Do CUE/registry programs differ from non- registry member programs in curriculum presented?

Research Design

Overview

These data were collected through a researcher-designed questionnaire entitled *Baccalaureate Rehabilitation and Disability Studies Programs Curriculum Questionnaire*. The researcher developed the questionnaire after a comprehensive and exhaustive review of existent literature. No appropriate previously developed instruments

were found that addressed baccalaureate rehabilitation and disability studies programs curriculum. The purpose of the instrument was to gather data, to identify curriculum commonalities and differences among baccalaureate rehabilitation and disability studies programs, and to identify the articulated primary focus of the various baccalaureate rehabilitation and disability studies programs education within the United States.

The context in which the questionnaire were presented is through a specified website on the World Wide Web. The rationale for using the World Wide Web is supported by Web Based Survey (Doherty, 2006) is the ease of administration, lower costs associated with dissemination, and ability to obtain return of data rapidly. Many researchers have noted that eventually web-based survey/questionnaire format will replace the traditional survey modes (i.e., snail mail) (Dillman, 2000, Doherty, 2006; Schonlau, Fricker, & Elliot, 2002).

Vehover, Betagel, Manfreda, and Zaletel (as cited in Doherty, 2006) have stated the main purpose or motivator for a respondent to complete a survey is the survey topic/domain being addressed. The researcher-designed questionnaire that was used consisted of three sections: (a) Demographics, (b) Curriculum, and (c) Purpose. The questionnaire provided detailed instructions for responding to questions in the beginning of each section. The potential limitation of using a web-based questionnaire as cited by Doherty (2006) is non-response from respondents. Doherty stated there are two factors contributing to responding and non-response in the application of a web-based questionnaire. These contributing factors are exogenous factors and endogenous factors. Exogenous factors are described as the Demographic characteristics (i.e., response rate), Social and Technical Environments (i.e., connectivity), and Attitudes (i.e., the participant

over-surveyed). Endogenous factors are factors that can be manipulated to minimize non-response (Doherty, 2006). Endogenous factors include Invitation (i.e., how are the respondents enticed), Survey Design (i.e., brief, single screen, pre-tested, and straightforward), and Follow-up (i.e., reminders and how are they implemented).

Questionnaire Design

Section A (Demographics) of the questionnaire included fifteen program specific items (see Appendix F).

Section B (Curriculum) of the questionnaire: programs were asked ten questions pertaining to their specific curriculum (see Appendix F).

Section C (Purpose) of the questionnaire asked programs ten specific questions pertaining to their program's purpose as they relate to undergraduate rehabilitation and disabilities education (see Appendix F).

A sample questionnaire (see Appendix F) was reviewed by expert panelists prior to survey being sent to program directors. Data collected were stored in a password-protected area of a secure server on Auburn University's main campus. The website maintained by the University utilizes Secure Server Layers (SSL) technology and all data communication is 128-bit encrypted, ensuring all participating programs remain anonymous. Physical access to the server was controlled and limited by the Office of Information Technology. Electronic access was only available to the information technology staff in the College of Education and the researcher.

Validity

The questionnaire items were developed through comprehensive review of the literature. Items were developed in conjunction with the three areas being analyzed: (a)

Demographics, (b) Program Curriculum, and (c) Program Purpose. The identification and validation of the content was accomplished by utilizing the four steps noted by Crocker and Algina (1986), which proposes:

1. Defining the domain of interest
2. Selection of the expert panel
3. Framework for evaluation of items to the domain
4. Summarizing and selecting appropriate items

After the development of the questionnaire, items for each area were distributed to five expert panel members for content validation. The initial version of the questionnaire contains 36 items divided into three sections (Demographic: 15 items, Curriculum: 10 items, and Purpose: 11 items). The selection process of the expert panel was critical to the evaluation of the content selected for the questionnaire (Yun & Ulrich, 2002). The panel of experts consisted of present and emeritus university faculty members chosen for their knowledge, scholarly work, leadership, involvement, and experience in the field of undergraduate rehabilitation and disability studies. The initial questionnaire was disseminated among these expert panel members. Panel members were asked to review the initial questionnaire and instructions to assess the clarity and content of the questionnaire's items. The questionnaire's content validity was established (i.e., the questionnaire evaluates what it was supposed to evaluate), and the content validity of the questionnaire (i.e., the items and questions are relevant and representative to the domain). The questionnaire is inclusive of all instructions/response comments from all panel members, who were asked to score each item using a 4-point Likert scale (1 = Strongly Disagree; 2 = Disagree; 3 = Agree; and 4 = Strongly Agree). The scores for each of item,

ranged (1-4) of responses, and mean for each the item were calculated. The *M* cut score used was 3 (Agree). The purpose for the establishment of *M* cut score of 3 (Agree) was so the expert panel would demonstrate agreement upon each particular question in the original questionnaire. After deleting questions that did not meet the *M* cut-off of 3 (Agree) the questionnaire was renumbered and distributed to program directors of undergraduate rehabilitation and disability studies programs.

Expert Panel

The key issue in any content validity study's success is the selection of panelists who are cooperative, knowledgeable, and will contribute valuable ideas (Gordon, 1994). Powell (2002) reported the expert panelists should be impartial to the findings while being reflective of the current knowledge and perceptions. The expert panelist should be individuals who are cooperative, possesses the relevant knowledge, experience, opinions, and is respected by peers in the respective field (Clayton, 1997; DeVilliers, et al., 2005; Fink, et al., 1984; Gordon, 1994; Goodman, 1987; Murray, & Hammons, 1995). The selection of the expert panel is determined by the researcher, but there are several sources that exist to aid in the identification of expert panel members:

- Panel members are typically identified on their publication of literature on the particular subject the study is researching.
- Panel members present evidence of significant involvement in their field or industry (Bourgeois , Pugmire, Stevenson, Swanson, & Swanson, n.d.; Gordon, 1994; & Mitchell, 1991).

Skulmoski, Hartman, and Kahn (2007) have noted that there are four critical elements to the selection of the 'expertise' requirements:

- The expert must have knowledge and experience in the topic investigated.
- The expert must be cooperative in the process.
- The expert must demonstrate effective communication skills.
- The expert must have sufficient time to participate in the study. Bourgeois et al. (n.d.) have stated that to yield more accurate results, the researcher should determine the criteria of who qualifies as an "expert" and then select panel members who are, in fact, experts in the field.

Boberg, and Morris-Khoo, (1992) reported that "experts" are actually individuals by virtue of involvement in their respective fields and who are considered to make qualified judgments. Gordon (1994) states that the actual purpose of the panel is to "represent the synthesis of opinion of the particular group, no more, no less" (p. 4).

Gordon (1994) as well has noted the researcher should anticipate an acceptance rate between 35 and 75 percent. Moore (1994) reports the ideal size for an expert panel that allows these individuals to provide effective judgments on topics and issues ranges from 5 to 9 individuals. For this study the composition of the expert panel consisted of the identification of five expert panel members. The pool of eligible expert reviewers for this study included knowledgeable participants chosen on (a) their publication record (Gordon, 1994; Skulmonski, et al., 2007) within the field of undergraduate rehabilitation education, (b) their involvement with undergraduate rehabilitation education through the undergraduate council on Rehabilitation and Disability Services and (c) on their past or current leadership role in the Committee on Undergraduate Education (CUE) of the Council on Rehabilitation Education. Criteria for the expert panel are located within Appendix C.

Participants

Two groups of participants will be utilized for this study. The first set of participants was expert panel members. These panel members were used for content validity analysis of initial questionnaire within Phase II of the study. In Phase III, the second set of participants were Program Directors for Undergraduate Rehabilitation and Disability Studies programs located in institutions of higher education throughout the United States. Programs may go by other titles, but for this study the title of Rehabilitation and Disability Studies will be used to refer to all related titles employed (e.g., *Rehabilitation Services*, *Rehabilitation Science*, *Human Services Counseling–Rehabilitation Concentration*, *Rehabilitation Major*, and *Rehabilitation and Disability Studies)* (as noted in Table 1 p. 3).

Procedure

The study consists of three separate phases. Phase I involved the preliminary development of questionnaire items through a comprehensive literature review. The second phase evaluated the content validity of the initial questionnaire and provide for the development of the final questionnaire items. The third phase will consist of survey implementation.

For this research design, Phase I of the study consisted of a comprehensive literature review and compilation of pertinent information regarding curriculum development for undergraduate rehabilitation education. A list of items was generated from a search of the literature relating specifically to undergraduate rehabilitation education. Prior to Phase II, a pool of eligible panelists was identified through their scholarly work on undergraduate education, active participation and leadership in

professional organizations within the field of undergraduate rehabilitation education. Preliminary items generated from the literature review were sent to the expert panel members, who will be asked for their professional and scholarly expert opinions regarding each item.

In phase II, each expert panelist were contacted by telephone and e-mail. Phase II involves the use of e-mail, which included a letter of invitation (see Appendix E), initial questionnaire (see Appendix F), directions for completing the initial questionnaire, and a copy of the Institutional Review Board (IRB) consent (see Appendix D). First, reviewers were asked to rate (1-4) each question for its content pertaining to undergraduate rehabilitation education, according to the expert's professional and individual perspectives of undergraduate rehabilitation education. All responses for defining core curriculum of Undergraduate Rehabilitation and Disability Studies programs from round two were compiled and analyzed.

The initial questionnaire were divided into three sections; *Demographics, Curriculum,* and *Purpose.* There are 36 items developed from the literature search for expert panelists to review. Each of the 36 items was presented in a forced choice four-point Likert scale, (1) Strongly Disagree, (2) Disagree, (3) Agree, and (4) Strongly Agree, regarding the relevance and importance of each item to undergraduate rehabilitation education. DeVilliers, DeVilliers and Kent (2005), reported that by not including a neutral answer option, respondents (expert panel) are forced to choose a clear answer.

Phase III of the study was the dissemination phase of the final version of the questionnaire to the 45 Undergraduate Rehabilitation and Disability Studies programs identified through the National Council on Rehabilitation Education (NCRE) directory,

online searches and national conference recruitment. Prior to dissemination, program coordinators were contacted via phone with notification of the questionnaire being sent via e-mail. Simultaneously a letter will be mailed through the United States Postal Service with a web address provided for program coordinators to access the questionnaire on-line. The second part of Phase III involved the dissemination of the web-based electronic questionnaire to program coordinators. Fink et al. (1984) reported the advantages of electronic communication as basically a decrease in cost, time and effort on behalf of the researcher. Program coordinators were asked to complete the survey/questionnaire and to submit the questionnaire in the allotted time (2 weeks). Program coordinators were contacted with a reminder to respond to the questionnaire and responded within the following week with the thanks and appreciation of the researcher.

Data Analysis

Research questions initially posed are categorical in nature. The Demographic Data section were analyzed and presented through descriptive statistics such as means and standard deviations. Statistical treatment of the data utilized the Statistical Package for Social Sciences (SPSS 16.0). Descriptive statistics including percentages and frequencies were used to describe, summarize, and organize the collected data. An Analysis of Variance (ANOVA) was conducted to assist in the determination regarding range of possible relationships and differences between the registered undergraduate rehabilitation programs to the non-registered undergraduate rehabilitation programs and within–group differences among both non-registered programs and registered programs. A content analysis was performed on questions, which focuses on other identified purposes of undergraduate rehabilitation and disability studies education.

Significance of the Study

The acknowledgement of the need to define the role of undergraduate rehabilitation and disability studies education in a meaningful way has been well documented in the rehabilitation literature and at recent national rehabilitation conferences (Evenson, & Holloway, 2007; Herbert, 2006; Perry, 2000). Currently there is a place of unification for undergraduate rehabilitation and disability studies programs under the Undergraduate Disability and Rehabilitation Studies Registry, which is a part of the Council on Rehabilitation Education (CORE). The Undergraduate Disability and Rehabilitation Studies Registry has proposed curriculum guidelines for qualified undergraduate programs that desire to be part of the registry. The lack of participating programs has created concern among educators who seek a stronger identity for the field of rehabilitation.

The goal of this study was to identify common and divergent purposes, perspectives, and curriculums of undergraduate rehabilitation and disability studies programs. The understanding of common and divergent philosophical and curricular goals of undergraduate rehabilitation programs can help with the unification and identity of the field. Identification of current perspectives and descriptions of undergraduate rehabilitation education curriculum will be critical in the development of the identity of current undergraduate rehabilitation programs and those to come. With a greater understanding of undergraduate programs will come a strengthening of the identity and purpose of undergraduate rehabilitation and disability studies programs and provide undergraduate students with a better and stronger understanding of their field of study.

Limitations of the Study

This study examines undergraduate rehabilitation and disability studies programs within the United States. The programs that were contacted and responded may not be representative of all undergraduate rehabilitation and disability studies programs in the United States. This may be attributed to the diversity of programmatic titles in the field of rehabilitation, therefore limiting the generalizability of this study.

IV. RESULTS

This study sought primarily to identify curriculum commonalities and differences among baccalaureate rehabilitation and disability studies programs, and secondly to identify the purpose of baccalaureate rehabilitation and disability studies programs education within the United States as identified by each participating program. The chapter begins with the content validity results from the five-person expert review panel (See Appendix C-for a listing of panel members) pertaining to the three sections of the questionnaire (Demographic, Curriculum, and Purpose). The second part of the chapter presents the results of the questionnaire sent to the 45 identified undergraduate rehabilitation and disability studies programs (See Appendix B-for a listing of the surveyed programs). The chapter will provide a description of the sample/population and its demographics; then, the analysis of data related to the research questions. Analyses were computed using the SPSS (16.0) software.

Content Validation

For content validation, an initial version of the questionnaire containing 36 items divided into three sections (Demographic: 15 items, Curricular: 10 items, and Purpose: 11 items) was distributed among five expert panel reviewers. This panel consisted of three current professors and two emeritus Professors. There were 3 male and 2 female

participants. As shown in Appendix C, the criteria for the eligible expert reviewers for this study included knowledgeable participants chosen on (a) their publication record (Gordon, 1994; Skulmonski, et al., 2007) within the field of undergraduate rehabilitation education, (b) their involvement with undergraduate rehabilitation education through the undergraduate Council on Rehabilitation and Disability Services and (c) their past or current leadership role in the Committee on Undergraduate Education (CUE) of the Council on Rehabilitation Education.

For the content validation phase of the dissertation, there was a 100% response rate return (See Table 13). This allowed for complete assessment of questionnaire items before circulation among 45 undergraduate rehabilitation and disability studies programs. Content validation was established by evaluating each item's *Mean* cut score of 3 (Agree) on a scale of 1 to 4 (1=Strongly Disagree, 2= Disagree, 3= Agree, 4= Strongly Agree). Of the 36 items presented to the expert review panel, 91% of items were agreed upon. Items 09, 14 and 15 were deleted for not meeting the established criterion of *Mean* (3.0) (See Table 14), for detailed questionnaire see Appendix F.

Table 13

Expert Panel Reviewer Response Rate

Expert Panel reviewer (gender)	Response
1 (male)	X
2 (female)	X
3 (male)	X
4 (female)	X
5 (male)	X
Return Rate:	100 %

Table 14

Mean Scores for Content Validation from Expert Panel Questionnaire Response

Questions	Reviewer Response					M
PROGRAM DEMOGRAPHICS	**1**	**2**	**3**	**4**	**5**	
Question 1.	4	4	4	4	3	3.80
Question 2.	4	4	4	3	3	3.60
Question 3.	4	4	4	4	4	4.00
Questions 4.	4	3	4	2	4	3.40
Question 5.	4	3	4	3	4	3.60

(table continues)

Table 14 (continued)

Questions	Reviewer Response					M
Question 6.	4	3	4	4	4	3.80
Question 7.	4	3	4	3	4	3.60
Question 8.	4	3	3	3	4	3.40
Question 9	3	3	3	2	3	**2.80**
Question 10.	3	3	3	-	4	3.00
Question 11.	4	3	2	2	4	3.00
Question 12.	4	3	3	2	4	3.20
Question 13.	4	3	3	2	4	3.20
Question 14.	4	3	3	1	3	**2.80**
Question 15.	**4**	3	3	1	3	**2.80**
CURRICULUM						
Question 16.	4	4	3	4	3	3.60
Question 17.	**4**	4	3	4	4	3.80
Question 18.	4	4	3	3	4	3.60
Question 19.	4	4	3	3	4	3.80
Question 20.	4	4	3	3	3	3.40
Question 21.	4	4	3	4	4	3.80
Question 22.	4	4	3	4	4	3.80
Question 23.	4	3	3	3	3	3.20

(table continues)

Table 14 (continued)

Questions	Reviewer Response					M
Question 24.	4	3	3	3	3	3.20
Question 25.	4	3	3	3	4	3.40
PURPOSE OF UNDERGRADUATE EDUCATION						
Question 26.	4	3	3	4	2	3.20
Question 27.	4	3	1	4	4	3.20
Question 28.	4	3	3	4	4	3.60
Question 29.	4	4	3	4	4	3.80
Question 30. A-U						
A. Preparation for Rehabilitation Counseling	4	3	3	3	3	3.20
B. Preparation for substance abuse intervention	4	3	3	3	3	3.20
C. Preparation for Occupation Therapy	4	3	3	2	3	3.00
D. Preparation for Law	4	3	3	2	3	3.00
E. Preparation for Public Sector	4	3	3	4	3	3.40
F. Preparation for Private Rehabilitation	4	3	3	4	3	3.40
G. Preparation for Therapeutic/ Recreational Therapy	4	3	3	3	3	3.20
H. Explore and explicate disability culture	4	4	3	4	4	3.80
I. To explore issues such as community living, housing, employment, health care, transportation, and education	4	4	3	4	4	3.80

Table 14 (continued)

Questions	Reviewer Response					M
J. Preparation for Community-Based Rehabilitation	4	3	3	4	4	3.60
K. Preparation for Social Work	4	3	3	2	3	3.00
L. Preparation for Case Management	4	4	3	4	4	3.80
M. Understanding disability is a "N*ormal* " part of society / Life Span	4	4	3	4	4	3.80
N. Accommodations are desired end to provide opportunities, work, and recreation in everyday activities	4	4	3	4	2	3.40
O. Promotes Advocacy	4	4	3	4	4	3.80
P. Preparation for Physical Therapy	4	3	3	2	3	3.00
Q. Preparation for Independent Living Specialist	4	3	3	4	4	3.60
R. Preparation for Audiology	4	3	3	2	3	3.00
S. Preparation for Speech Therapy	4	3	3	2	3	3.00
T. Preparation Special Education	4	3	3	3	3	3.20
U. List all other areas of preparation that are highly relevant to an UG degree in Rehabilitation and Disability Studies:	4	4	3	4	4	3.80
Question 31.	4	4	3	3	4	3.80
Question 32.	4	4	3	4	4	3.80

(table continues)

Table 14 (continued)

Questions	Reviewer Response					M
Programmatic Perspective, (questions 33-36) consider each of the following to be a (will use a 4 Likert scale: 1 = serious problem, 2 = moderate problem, 3 = small problem, and 4 = not a problem)						
Question 33.	4	4	4	3	3	3.60
Question 34.	4	4	3	3	3	3.40
Question 35.	4	3	4	2	3	3.20
Question 36.	4	4	4	1	3	3.20

Demographic Information

Program Descriptions

Forty-five programs were surveyed; however two of the 45 programs did not have an undergraduate program and were deleted from the analysis. Of the 43 programs surveyed, there was a 37% return rate (n = 16). Of the 16 programs that responded, one program is currently being phased out and responded only to the demographic section of the survey. Therefore, the final sample was n = 15 or 34% return. Of the programs that responded, 87.5% were members of the Undergraduate Registry sponsored by CORE (see Table 15). Of programs responding to be on the Registry, 87.5% were members of the National Council on Rehabilitation Education's (NCRE) Council on Rehabilitation Education (CORE) (see Table 16), and of those programs that identified with NCRE, 85.7% were members of the Undergraduate Registry.

Table 15

Member or Non-Member of the Undergraduate Registry(CUE)

Description	n	Percentage
Member	14	87.5%
Non-Member	2	12.5%

Table 16

Member or Non-Member of the National Council on Rehabilitation Education / Council on Rehabilitation Education

Description	n	Percentage
Member	14	87.5%
Non-Member	2	12.5%

In Table 17, information is provided on follow-up question to those programs that were members of CUE. These programs were asked what the programmatic benefits there were of being a member of Committee on Undergraduate Education (CUE) / Registry. Programs were given the choice of Professional Identity, Curricular Guidelines, and Research and Collaboration, or they could list other benefits. Fifteen of the 16 programs (93.7%) reported some benefit of being a member of CUE/ Registry. Approximately 25% of the programs chose all three choices (Professional Identity, Curricular guidelines, research and collaboration). Of the 15 reporting programs, each benefit (professional identity, professional identity and research and collaboration, and

professional identity and curricular guidelines) was chosen solely as a benefit by 18.8% of the programs reporting. Two programs chose professional identity as a sole benefit of being a member of CUE/Registry. In listing other benefits, programs reported: (a) "collaborative effort to enhance Bachelor of Science Vocational Rehabilitation training", (b) "students are aware that they are part of a larger entity — a profession", (c) "provides external validation of the quality of our program, (d) peer support of colleagues", and (e) "talking with other undergraduate program directors about their programs".

Table 17

Programmatic Benefits of CUE/Registry

	n	Percentage
Not a member	1	6.2
Professional Identity	3	18.8
Research and collaboration	2	12.5
Professional identity and curricular guidelines	3	18.8
Professional identity and research and collaboration	3	18.8
Professional Identity, Curricular Guidelines and Research and Collaboration	4	25.0
Total	16	100

Each program was asked to provide input regarding to the founding of their undergraduate program. Programs reported dates of establishment ranging from 1954 to 2007. In the 1960s there were three programs (18.8%) established. The majority of

programs, seven (43.8%) in total, were established in the 1970s. In the 1980s three programs (18.8%) were established. One program reported establishment in 1994 and one in 2007. A detailed distribution of dates in ascending order can be seen in Table 18. Table 19 reports the various titles of the academic units where the programs reside.

Table 18

Year Undergraduate Rehabilitation Program Established

Year	n	Percentage
1954	1	6.2
1968	2	12.5
1969	1	6.2
1970	2	12.5
1974	2	12.5
1975	2	12.5
1978	1	6.2
1982	1	12.5
1984	1	2.5
1987	1	6.2
1994	1	6.2
2007	1	6.2

Table 19

Title of Academic Unit (School/College) Program Resides

	Title
1.	College of Human Development
2.	College of Education / Department of Special Education and Rehabilitation Services
3.	Department of Rehabilitative Services
4.	College of Liberal Arts and Social Sciences / Department of Human Resources
5.	College of Public Affairs and Community Service
6.	College of Allied Health Sciences
7.	Education and Human Development
8.	College of Allied Health / Department of Rehabilitation and Human Services
9.	College of Health and Human Services
10.	University College
11.	School of Allied Health and Communicative Disorders
12.	College of Education / Department of Counselor Education, Counseling Psychology and Rehabilitation and Human Services
13.	Department of Rehabilitation and Disability Studies
14.	College of Education
15.	College of Education / Department of Rehabilitation and Disability Studies
16.	Sargent College / Department of Occupational Therapy and Rehabilitation Counseling

Tables 20, 21, and 22 provide detailed demographic information from respondent program's faculty members. Each of the undergraduate programs were asked about number of faculty employed full-time, part-time, and adjunct status. Those responding reported a full-time faculty load ranging from 1 to 15. Of the reporting undergraduate programs, 18.8% had between one to three full-time faculty. Approximately 31.2% of undergraduate programs had between 4 to 6 full-time faculty members, while 12.4% reported having between 7 to 10 full-time faculty members. The majority of undergraduate programs (37.5%) reported having 11 or more full-time faculty members. When addressing part-time faculty members, 13 programs (81.2%) reported not having part-time faculty, while two programs had one part-time faculty member and one program reported five part-time faculty members. Of the 16 programs 81.2% reported utilizing adjunct faculty (see Table 20). Of those programs reporting the use of adjunct faculty, 37.5% of programs noted the utilization of 1 to 3 and between 5 to 7 adjunct faculty. One program reported the employment of 11 adjunct faculty in their program.

Table 20

Number Faculty Employed as Adjunct Faculty Members

n	Frequency	Percentage
0	3	18.8
1	2	12.5
2	1	6.2
3	3	18.8
5	2	12.5
6	3	18.8
7	1	6.2
11	1	6.2
Total	16	100

For question 7 of the survey, 14 out of 16 programs responded to the percentage of faculty with primary affiliation to undergraduate education. Within the responding programs, one program did not respond to this item, which was not computed with the other respondents data and another program chose not to respond. As shown in Table 21, the percentage of primary affiliation to undergraduate education ranged from 10% to 92% with the majority of programs having 33% primary affiliation with their undergraduate programs as noted in Table 21.

Table 21

Percentage of Faculty with Primary Affiliation

Primary Affiliation	n	Percentage
10	1	7.1
20	1	7.1
23	1	7.1
25	2	14.3
33	3	21.4
35	1	7.1
40	2	14.3
50	1	7.1
77	1	7.1
92	1	7.1
Total	14	

In Table 22, information is reported regarding programs secondary affiliation of their faculty to undergraduate education, with primary teaching focus at the graduate level, ranging approximately from 2 to 80%. The majority of programs (26.7%) reported faculty with secondary affiliation ranging between 20 to 25%. Three programs (20%) reported secondary affiliation of faculty ranging between 30 to 35%, while three other programs (20%) reported percentages ranging between 60 to 66%. Twenty percent of the

programs reported faculty with secondary affiliation of 10% or less. One program reported 80% of their faculty had secondary affiliation to undergraduate education.

Table 22

Percentage of Faculty with Secondary Affiliation

Secondary Affiliation	Frequency	Percentage
2	2	13.3
8	1	6.7
20	2	13.3
25	2	13.3
30	1	6.7
33	1	6.7
35	1	6.7
50	1	6.7
60	2	13.3
66	1	6.7
80	1	6.7
Total	15	

Fifteen of the 16 undergraduate rehabilitation programs reported on student demographics. Tables 23, 24, 25, 26, 27 and 28 contain a descriptive report of students' enrollment status (full-time, part-time), percent of students with a disability, gender, and ethnicity. Twelve programs (75%) responded to student enrollment, full-time enrollment

ranged between 58 to 100 percent with *M* = 85.7 (see Table 23). Zero to 42 percent of students were considered part-time (*M* = 11.9) (see Table 24). Of those programs reporting a percentage of students currently enrolled with a disability, three programs (21.4%) did not know, 11 programs (68.7%) provided data and one program did not respond. Eleven programs (68.7%) that responded to the question regarding students with disabilities currently enrolled. Responses ranged from 2 to 65 percent (*M* = 20, SD = 17). Table 25, denotes the percentage of students in current programs for academic year 2007-2008. While 25% of programs had 10% or less students with a disability enrolled in their program, the majority (31.2%) of programs had between 18 to 20 % enrollment of students with disabilities. Four programs (25%) either chose not to report or did not know if they had students with disabilities currently enrolled in their program. One program reported that 65% of their students had a disability. Fifteen of the 16 programs (93%) responded to student gender. Programs reported a range of 0 to 85 percent males (*M* = 25.9), and a range of 15 to 100 percent females (*M* = 74.4) (see Tables 25 and 26).

As shown in Table 28, ethnicity varied among programs. African American students enrolled ranged from 0 to 100 percent, American Indian students enrolled ranged between 0 to 24 percent, Asian student enrollment ranged from 0 to 5 percent, Caucasian student enrollment ranged between 0 to 96 percent, and other ethnicities (not specified) ranged 0 to 2 percent.

Table 23

Percentage of Students Currently Enrolled Full-Time

Full-time	n	Percentage
No Response	4	25
58	1	6.25
66	1	6.25
70	1	6.25
85	1	6.25
90	2	12.5
95	1	6.25
97	1	6.25
100	4	25
Total	16	100

Table 24

Percentage of Students Currently Enrolled Part-Time

Part-time	n	Percentage
No Response	3	18.75
0	4	25
3	1	6.25
5	1	6.25
10	3	18.75
15	1	6.25
30	1	6.25
33	1	6.25
42	1	6.25
Total	16	100

Table 25

Percentage of Students with a Disability (Currently Enrolled)

Percent with Disability	n	Percentage
2	1	6.25
10	3	18.75
18	1	6.25
20	4	25.0
30	1	6.25
65	1	6.25
unknown	3	18.75
Not reported	2	12.5
Total	16	100

Table 26

Student Gender (Male)

Percent male	n	Percentage
No Response	3	18.75
0	1	6.25
10	3	18.75
11	1	6.25
12	1	6.25
20	3	18.75
21	1	6.25
25	1	6.25
30	1	6.25
35	1	6.25
80	1	6.25
85	1	6.25
Total	16	100

Table 27

Student Gender (Female)

Percent Female	n	Percentage
15	1	6.7
20	1	6.7
65	1	6.7
70	1	6.7
75	1	6.7
80	3	20
84	1	6.7
86	1	6.7
88	1	6.7
89	3	20
90	1	6.7
100		
Total	13	100

Table 28

Student Ethnicity by Percent Enrollment

Ethnicity	*M*	Range
African American	25.3	0-100
Asian	1.1	0-5
American Indian	4.4	0-24
Caucasian	58.0	0-96
Hispanic or Latino	10.9	0-87
Other	.27	0-2

Within the *Curriculum* section of the questionnaire, programs responded to ten items addressing current curriculum and program clinical structure. Unlike the demographics, the curriculum section had 15 respondents (34.8%). A total of 14 out of 15 programs (93.3%) provided links to curriculum and catalog descriptions. Table 29 provides commonalities of programmatic content. Detailed descriptions of program curriculum class titles are contained in Appendix I.

Table 29

Commonalities of Programmatic Content

Sample of Nine Content Similarities of Reporting Programs				
1.	Group Process in Human Services	Group Process in Rehabilitation Settings	Group Processes in Rehabilitation Settings	Principles of Counseling and Group Theory
2.	Introduction to Disability Studies	Introduction to Rehabilitation	Survey in Human Services	Introduction to Rehabilitation Studies
3.	Practicum in Rehabilitation and Human Services	Clinical Practicum in Rehabilitation	Peer Education Practicum	Practicum in Rehabilitation Studies
4.	Internship in Rehabilitation and Human Services	Undergraduate Internship	Human Service Field Experience	Fieldwork
5.	Casework	Case Management I/II	Rehabilitation Case Recording and Management	Case Management and Individualized rehabilitation Planning
6.	Psychosocial Aspects of Disability	Psychology of Disability	Psychosocial and Cultural Aspects of Disability	Medical, Social, and Psychological Aspects of Disability
7.	Professional Communication Skills	Professional Communication	Professional Communication in Rehabilitation Studies	Interpersonal Helping and Human Relationship Skills

Table 29 (continued)

Sample of Nine Content Similarities of Reporting Programs				
8.	Disability Policy and Independent Living	Community Living Topics	Independent Living Service in Rehabilitation	Independent Living
9.	Rehabilitation and Assistive Technology	Introduction to Therapeutic Recreation	Assistive Technology Applications Across the Lifespan	Principle of Therapeutic Recreation

Specializations

A total 15 programs responded to the question, "Does your program offer specialization?" Five programs (33%) did not have specializations, while ten or 66.7% of the programs responded that they have specializations. Programs were then asked to specifically list the programs specializations (see Table 30). One program offered 10 specializations, while another program stated, "We do not offer specializations, per se, but do offer tracks (Corrections Rehabilitation, Chemical Dependency, Occupational/Physical Therapy, Children and Youth Services, and Gerontology)". The difference is that tracts are courses taught in another major that prepare students for specific professions or graduate school".

Table 30

Program Specializations

Specializations		
Community Based Rehabilitation	Special Education Certification	Human Services Counseling – Rehabilitation
Recreational Rehabilitation	Social Work	Rehabilitation Counseling
Rehabilitation Technology	Assistive Technology	Independent Living
Individualized Psychiatric Rehabilitation	Alcohol and Drug Studies Minor	Independent Living Rehabilitation Career Services
Supported Employment	Criminal Justice	Addiction Rehabilitation
Addictions Studies Program	Therapeutic Recreation	Psychosocial Rehabilitation

Concentration in Services to Individuals who are Deaf or Hard of Hearing

Clinical

Fifteen programs responded to the questions regarding clinical education. Tables 31, 32, 33, 34, 35, 36 and 37 contain summative descriptions of practica and internships for undergraduate programs responding. Sixty-six percent of the programs offered practica. Of these programs, 40% required one practicum, 6.7% required two practica, 6.7% required three practica, and one program (6.7%) required four practica. Service hours for the practica ranged from 20 to 320 hours (M = 76, SD = 106). Seven programs (46.7%) did not report hours or do not require practica. No two programs required the same amount of practicum hours.

Table 31

Programs Require Practica

Practica	N	Percentage
Yes	10	66.7
No	5	33.3
Total	15	100

Table 32

Practicum Hours

Hours	N	Percentage
0	7	46.7
20	1	6.7
30	1	6.7
45	1	6.7
120	1	6.7
160	1	20
200	1	6.7
240	1	6.7
320	1	6.7
Total	15	100

Ten programs (66.7%) reported the requirement of internships (see Table 33). Required internship hours ranged from 160 to 600 hours (M = 295, SD = 247) (see Table 34). Credit hours for internships ranged between 6 to 12 academic credit hours (see Table 35). Of programs requiring internships, the majority (71.4%) gave 12 credit hours.

Table 33

Programs Requiring Internships

Internship	n	Percentage
Yes	10	66.7
No	5	33.3
Total	15	100

Of programs requiring internship, 26.7% have a primary focus, while 73.3% of the programs responded not to a primary focus (see Table 36). Primary focus of internships ranged between allied health fields, community rehabilitation, and rehabilitation and human services. One program reported that internships were concentration specific but did not elaborate.

Table 34

Internship Clock Hours

Hours	n	Percentage
0	5	33.3
160	1	6.7
200	1	6.7
440	1	6.7
450	2	13.3
480	1	6.7
500	1	6.7
540	1	6.7
600	2	13.3
Total	15	100

Table 35

Reported Credit Hours

Hours	N	Percentage
6	1	14.3
9	1	14.3
12	5	71.4

Table 36

Primary Focus

Primary Focus	n	Percentage
Yes	4	26.7
No	11	73.3
Total	15	100

When asked more specifically, whether there exists a primary area in which students tend to complete their internships, 60% provided detailed input. Specific primary areas of internships reported were:

- Rehabilitation Counseling
- All over the place: state vocational rehabilitation agencies, developmental disabilities services, substance abuse, placement programs, mental health agencies
- Case managers, drug and alcohol programs, special education transition students, independent living centers, mental health, mental retardation, community rehabilitation programs, primarily mental health and addictions
- Community Rehabilitation Programs
- Community Support
- No primary area. Internships are in Rehabilitation Counseling, Vocational Evaluation, SA, Occupational Therapy and Physical Therapy
- Occupational Therapy and Physical Therapy

- Rehabilitation services, agencies both community rehabilitation programs' and public
- UG affiliate in a wide-variety of human service settings and work with the broad spectrum of client populations serving children, adolescents, adults, and older adults. There is no one area or several primary areas.

Three programs (20%) reported rehabilitation counseling as a primary area where their students tended to complete internships. Three programs (20%) mentioned community rehabilitation programs/support as a primary area. One program reported there was no primary area of internship focus, but cited students go areas ranging from rehabilitation counseling, occupational therapy and physical therapy, and vocational evaluation. One program did report not having a required internship. One program failed to report.

Within the section *Purpose of Undergraduate Education* of the questionnaire, programs were provided with ten questions to delineate a clearer picture regarding the purpose of undergraduate education. To gain better understanding, each program was asked if there were related graduate degrees offered from the program's academic unit. Of the 15 programs responding, one program reported no related graduate degree program associated with their academic unit. The majority of programs (n = 15, 93.3%) had some associated graduate degree program, 53.3 % of programs (n = 8) responding had Master level graduate degrees, while the remaining 40% of programs had both Master's and Doctoral level graduate programs within the same academic unit (see Table 37). In Appendix J, associated graduate degree program titles are listed.

Table 37

Related Graduate Degrees Offered

Graduate degrees	n	Percentage
None	1	6.7
M.S. / M.Ed only	8	53.3
Ph.D / Ed.D and M.S. / M.Ed	6	40.0
Total	15	100.0

Table 38 reports undergraduate rehabilitation programs serving as feeder programs to graduate rehabilitation counseling programs. Approximately 86.7% of undergraduate programs stated that undergraduate rehabilitation and disability studies education programs function as feeder programs for graduate rehabilitation counseling programs, while 13.3% do not believe undergraduate programs should serve as feeder programs to rehabilitation counseling graduate programs. All respondents were asked to comment on their response to this question as noted in Tables 39 and 40.

While 86.7% of undergraduate rehabilitation and disability studies programs responding have the perspective of being feeder programs to graduate rehabilitation counseling programs, 20% of responding programs noted that more than 50% of their degree completers were seeking admission to graduate rehabilitation counseling programs. While 13.3% of programs had greater than 1 % but less than or equal to 10 % of degree completers who were seeking admission to graduate rehabilitation counseling programs, 13.3 % had greater than 20% but less than or equal to 29%, 20% had greater

than 30% but less than or equal to 39%, and 13.3% had greater than 40% but less than or equal to 49% of degree completers who were seeking admission to graduate rehabilitation counseling programs. Three programs declined to respond to this question (see Table 41).

Table 38

Perspective of Serving as Feeder Programs

Response	N	Percentage
Yes	13	86.7
No	2	13.3
Total	15	100

Table 39

Responses to Perspective

Yes Responses
1. We cannot accommodate all BSVR graduates in our MS Programs but some are accepted for MS study at Stout. Other students must pursue graduate education elsewhere.
2. Approximately 5 students a year matriculate from our program into MRC programs
3. Approximately 50 percent of graduating students go directly into graduate programs - typically, all but one or two attend here - others tend to leave state or enroll in a distance education program
4. I would like to see a system that allowed a 5-year degree leading to a master's degree. I think this would benefit both the undergraduate and master's programs.

Table 39 (continued)

Yes Responses
5. Yes and No. Some of our students go on into our graduate degree programs, but a lot go on into OT, PT, ST, and other human service professions.
6. In a limited sort of way. We have had one or two students per year that have gone into our graduate rehab counseling program.
7. I identify likely candidates in the undergrad program and mentor them into the MS degree.
8. Yes, well over 50% of our graduates continue their education at the master Degree level in rehabilitation or community counseling.
9. Our undergraduate program provides a "destination" for students completing a community college post high school certificate program to attain as part of their career ladder. These students may use their certificate credits toward completion of a two year degree which may then feed into our 4 year degree program and, if they wish, to our master's program. The students may also enter our disability program after completion of their certificate. We see the postsecondary process in disability and rehabilitation studies as a continuum.
10. While our program is a feeder program, approximately 60-70% of our graduate students come from other programs. The majority of our undergrads seek employment in the field following graduation.
11. Undergraduate (UG) emphasis is combination of disability studies and rehab services-support of a "career ladder" from UG to Graduate studies is stressed

Table 40

Responses to Perspective

No Responses
1. We strongly encourage students to go out and work in the field for several years before returning to graduate school. I would estimate that about 10% of our graduate RC classes are students who were RHS UG's from ****. Also, we encourage students to explore other programs to get other perspectives and experiences. For this reason, our graduate class is quite diverse and, from our perspective, adds to the quality of their training experience.
2. We have a small number of students who do continue on with their Masters in Rehab. Counseling but the majority of our students are seeking this degree as an entryway into occupational and physical therapy graduate programs.

Table 41

Percentage of Undergraduates Going on to Rehabilitation Counseling Programs

Percent	n	Percentage
No Response	1	6.7
Not Applicable	2	13.3
1–10	2	13.3
20–29	2	13.3
30–39	3	20
40–49	2	13.3
< 50	3	20
Total	15	100

Tables 42, 43, and 44 provide information regarding the programmatic perspective of responding undergraduate rehabilitation and disability studies programs regarding the top three purposes of an undergraduate degree in rehabilitation and disability studies. Fourteen of the 15 programs responded to the question. Table 42 identifies each program's first choice perspective for purpose of an undergraduate education. Table 43 identifies each program's second choice perspective and Table 44 provides each program's third choice perspective.

Table 42

Top Three Purposes of Undergraduate Education (First Choice)

First Choice Perspective
1. Student pre-service training for varied jobs serving persons with disabilities
2. Disseminate rehab philosophy to direct service providers
3. Prepare community rehabilitation personnel
4. Train students to work with individuals with disabilities
5. Prepare students to work in community rehabilitation programs
6. As a feeder into graduate degree programs in RC, VE, and Substance Abuse.
7. To prepare students to work in community rehab agencies that promote employment and independent living for persons with disabilities.
8. Employment in mental health services
9. To prepare students to enter the field in community rehabilitation programs
10. Pre-professional (including bachelor's level workers as well as master's level programming) preparation in disability related field
11. Prep. for M.A. training
12. Prepare students for entry-level human service professions serving persons with disabilities
13. Understanding issues relating to being disabled in U.S.
14. Occupational / Physical Therapy graduate school entry

Table 43

Top Three Purposes of Undergraduate Education (Second Choice)

Second Choice Perspective
1. Competency development to promote quality service provision
2. Provide skilled service providers to the field
3. Prepare specialists; substance abuse, and Individuals who are Deaf or Hard of Hearing
4. Train students in areas that they might be successful in graduate programs
5. Prepare students for a graduate counseling program — rehabilitation and counselor education
6. As a feeder into other Allied Health professions.
7. To prepare students to be effective advocates and to promote social justice for persons of all ages who have disabilities.
8. Employment as chemical dependency counselors
9. To prepare students for entering graduate school in rehabilitation counseling
10. Broadening pre-professional backgrounds for those who choose non-disability related fields preparation in disability related field
11. Prepare paraprofessionals to serve clients
12. Prepare students for graduate training in counseling and allied health fields.
13. People skill development, interviewing, Case management
14. Human Services field

Table 44

Top Three Purposes of Undergraduate Education (Third Choice)

Third Choice Perspective
Purpose
1. Prepare students for graduate study
2. Improve services to people with disabilities by graduating skilled service providers
3. Encourage students to obtain a masters in the field
4. To create an awareness of disability culture
5. Prepare students to enter an allied health master's program
6. To train Human Service Workers for employment. .
7. To prepare students for graduate study in rehab related fields.
8. Prepare for graduate studies in RC
9. To enable students to obtain a Bachelor of Science level education
10. Broadening educational opportunities for general education of college graduates
11. Provide undergrad. degree broad enough to work in human services
12. Develop greater awareness, knowledge, and skills to improve quality of life for persons with disabilities.
13. Promoting Advocacy
14. Rehabilitation Counseling masters program entry

Table 45 presents comprehensive data from a programmatic perspective regarding the relevancy of 20 stated areas of preparation, education, and exploration to

undergraduate rehabilitation and disability studies education. Regarding two of the 20 items (Understanding disability is a "Normal" part of society / Life Span, and Promotes Advocacy) all respondents (100%) noted as highly relevant (M = 2.00) to undergraduate rehabilitation education. Two of the 20 items (Accommodations are a desired end to provide opportunities, work, and recreation in everyday activities (M = 1.80) and Explore and explicate disability culture (M = 1.87)) all respondents noted with 80% and above as highly relevant. For two of the 20 items (Preparation for community based rehabilitation and to explore issues such as community living, housing, employment, healthcare, transportation, and education) all respondents noted 73.3% as highly relevant (M = 1.73). Regarding three items (Preparation for rehabilitation, Preparation for public sector, and Preparation for case management) all respondents noted 60% to 66%, highly relevant (M = 1.60). Preparation for substance abuse and preparation for independent living specialist were highly relevant (53.3%, M = 1.53). Seven areas had a *Mean* below 1.00. These programs were; Preparation for law, Preparation for Therapeutic/ Recreational therapy, Preparation for social work, Preparation for physical therapy, Preparation for speech therapy and preparation for special education.

Table 45

Programmatic Perspective: Areas of Preparation, Education, and Exploration

Areas	Not Relevant	Relevant	Highly Relevant	Total Responding
Preparation for Rehabilitation Counseling				
n	1	4	10	15
Percentage	6.7	26.7	66.7	
Preparation for substance abuse intervention				
n	0	7	8	15
Percentage		46.7	53.3%	
Preparation for Occupation Therapy				
n	4	7	4	15
Percentage	26.7	46.7	26.7	
Preparation for Law				
n	5	8	2	15
Percentage	33.3	53.3	13.3	

(table continues)

Table 45 (continued)

Areas	Not Relevant	Relevant	Highly Relevant	Total Responding
Preparation for Public Sector				
n	0	0	9	15
Percentage		40.0	60.0	
Preparation for Private Rehabilitation				
n	2	8	5	15
Percentage	13.3	53.3	33.3	
Preparation for Therapeutic/ Recreational Therapy				
n	4	9	2	15
Percentage	26.7	60.0	13.3	
Explore and explicate disability culture				
n	0	2	13	15
Percentage		13.3	86.7	

(table continues)

Table 45 (continued)

Areas		Not Relevant	Relevant	Highly Relevant	Total Responding
To explore issues such as community living, housing, employment, health care, transportation, and education					
	n	0	4	11	15
	Percentage		26.7	73.3	
Preparation for Community-Based Rehabilitation					
	n	0	4	11	15
	Percentage		26.7	73.3	
Preparation for Social Work					
	n	5	9	1	15
	Percentage	33.3	60.0	6.7	

(table continues)

Table 45 (continued)

Areas	Not Relevant	Relevant	Highly Relevant	Total Responding
Preparation for Case Management				
n	0	6	9	15
Percentage		40.0	60.0	
Understanding disability is a "Normal" part of society / Life Span				
n	0	0	14	14
Percentage			100	
Accommodations are desired end to provide opportunities, work, and recreation in everyday activities				
n	0	3	12	15
Percentage		20.0	80.0	

(table continues)

Table 45 (continued)

Areas		Not Relevant	Relevant	Highly Relevant	Total Responding
Promotes Advocacy					
	n	0	0	15	15
	Percentage			100	
Preparation for Physical Therapy					
	n	4	9	2	15
	Percentage	26.7	60.0	13.3	
Preparation for Independent Living Specialist					
	n	0	7	8	15
	Percentage		46.7	53.3	
Preparation for Audiology					
	n	8	5	2	15
	Percentage	53.3	40.0	6.7	

(table continues)

Table 45 (continued)

Areas		Not Relevant	Relevant	Highly Relevant	Total Responding
Preparation for Speech Therapy					
	n	7	7	1	15
	Percentage	46.7	46.7		
Preparation Special Education					
	n	5	7	3	15
	Percentage	33.3	46.7	20.0	

Programs were asked if there were other areas deemed highly relevant to undergraduate education that were not listed. Seven of the fifteen responding programs (43.3%) provided additional areas thought to be highly relevant to undergraduate rehabilitation education. These areas were:

1. Community support services for people with developmental disabilities and mental illness
2. Placement for people with disabilities, testing and assessment of people with disabilities
3. Mental health service preparation
4. Writing skills, logic, liberal arts

5. American Sign Language, Family dynamics, and Understanding adjustment to disability/loss
6. Assistive Technology, Research Methods, and Statistics
7. Independent Living and Supported employment

Another focus of the questionnaire was to determine if accreditation for undergraduate rehabilitation education was favored by undergraduate rehabilitation and disability studies programs surveyed. Seventy-three percent of responding programs were strongly opposed to the accreditation of undergraduate rehabilitation education, while one program (6.7%), strongly favored undergraduate rehabilitation education accreditation. Ninety-three percent of programs opposed undergraduate rehabilitation education accreditation (see Table 46). No reasons were set forth by those responding.

Table 46

Extent Program Favor or Oppose Undergraduate Rehabilitation Education Accreditation

	n	Percentage
Strongly Favor	1	6.7
Somewhat Oppose	3	20.0
Strongly Oppose	11	73.3

Table 47 provides information regarding issues undergraduate rehabilitation programs are currently facing. Programs were asked to rank order six areas of priority (1 being most important priority to 6 being least important priority) concerning

undergraduate education. A total of 14 programs responded to the question, while one program did not respond. The six areas were rank ordered related to expressed priority noted by undergraduate rehabilitation education programs:

- Establishing primary focus
- Establishing core curriculum
- Establish an international perspective
- Creating a sound identity
- Creating stronger feeder programs for graduate rehabilitation programs
- Accreditation of undergraduate Rehabilitation and Disability Studies programs

Table 47

Rank Order Undergraduate Priority, Most Important to Least Important

Rank Order	*M*	SD
1. Establishing core curriculum	2.21	.98
2. Creating a sound identity	2.93	1.4
3. Accreditation of undergraduate Rehabilitation and Disability Studies programs	3.07	1.9

Table 47 (continued)

Rank Order	*M*	SD
4. Establishing primary focus	3.14	1.9
5. Creating stronger feeder programs for graduate rehabilitation programs	4.29	1.1
6. Establish an international perspective	5.36	.86

From a programmatic perspective, programs were asked to report on four items determined to be of issue to undergraduate rehabilitation education programs:

- A lack of identity
- A lack of core curriculum
- A lack of unification among undergraduate programs
- A lack of understanding from graduate programs

Programs were asked to use a four-point Likert scale (1 = serious problem, 2 = moderate problem, 3 = small problem, and 4 = not a problem) to weight each issue presented. Fifty-seven percent of the programs responded that a lack of identity was a small problem, Forty two percent of the programs deemed lack of unification of undergraduate programs as a small problem, while 26.7% believed it to be a serious problem. Five of the responding programs noted "Lack of understanding from graduate schools" as being a moderate problem (35.7%). Six of the 15 responding programs

considered “Lack of a core curriculum” as a small problem (42.9%) (see Table 48). Issues concerning undergraduate education ranged from a Mean of (2.3) to a Mean of (2.7) (see Table 49). With this data, it seems the issues presented were of moderate to small concern to all responding programs.

Table 48

Programmatic Perspective: Issues Concerning Undergraduate Education

Issue	Serious Problem	Moderate Problem	Small Problem	Not a problem
A lack of identity				
n	2	2	8	2
Percentage	14.3	14.3	57.1	14.3
A lack of core curriculum				
n	1	5	6	2
Percentage	7.1	35.7	42.9	14.3
A lack of unification among undergraduate programs				
n	4	3	6	1
Percentage	26.7	21.4	42.9	6.7

(table continues)

Table 48 (continued)

Issue	Serious Problem	Moderate Problem	Small Problem	Not a problem
A lack of understanding from graduate programs				
n	2	5	3	4
Percentage	14.3	35.7	21.4	26.7

Table 49

Programmatic Perspective: Issues Concerning Undergraduate Education

	M
1. A lack of unification among undergraduate programs	2.29
2. A lack of core curriculum	2.64
3. A lack of understanding from graduate programs	2.64
4. A lack of identity	2.71

Summary

This chapter provided a detailed description of a questionnaire administered to undergraduate rehabilitation and disability studies education programs representative in the United States regarding perspectives on the purpose of undergraduate education. Data presented are more indicative of programs affiliated with CUE/Registry than other non-affiliated programs based on the programs that responded. No comparisons were possible relative to relationships and differences between the registered undergraduate rehabilitation programs due to the low response rate. Data collected provide a description of the current environment of undergraduate rehabilitation and disability studies education. The next chapter will discuss these findings. Summary of findings, conclusion, limitations, and recommendation for future research will be addressed.

V. SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This study sought to identify curricular commonalities and differences among baccalaureate rehabilitation and disability studies programs within the United States and secondly to identify the purpose of such programs as reported by each respondent. The questionnaire administered sought input relative to each of the following elements (a) *Demographics*, (b) *Curriculum*, and (c) *Program Purpose of Undergraduate Education*.

The questionnaire was administered during the months of May 2008 to June 2008, with three follow-ups during the same time period. Of the 45 programs surveyed, 16 programs completed the questionnaire, 2 reported not having an undergraduate program, and 1 program was in the process of being phased out. The final sample contained 16 usable responses for the (a) program demographic section of the questionnaire and 15 usable responses for (b) curriculum, and (c) program purpose of undergraduate education for an overall return rate of 37%.

Findings

This study produced six notable findings. Each is discussed below.

First Overwhelmingly (70+%) undergraduate rehabilitation and disability studies program directors surveyed indicated that the following areas of study and preparation were most essential and relevant to curricular development.

- To understand that disability is a *normal* part of society / life span (100%)
- To Promote, understand, and assume responsibility for advocacy (100%)
- To Explore and explicate disability culture (i.e., psychosocial and political aspects of disability)(86.7%)
- That accommodations are an appropriate and desired end to provide opportunities, work, and recreation in everyday activities (80%)
- To explore issues that affect persons with disabilities such as community living, housing, employment, healthcare, transportation, and education (73.3%)
- Occupational preparation for community-based rehabilitation jobs (73.3%)

The second finding was the establishment of a core curriculum was reported to be the *most important priority* for the continued development of undergraduate rehabilitation and disability studies programs. The noted priorities were rank ordered in six areas (1 being most important priority to 6 being least important priority) concerning undergraduate education, The priorities were ranked as follows: creating a sound identity (M = 2.8), establishing a primary focus (M = 3.1), accreditation of undergraduate disability studies programs (M = 3.1), creating stronger feeder programs (M = 4,2), and establishing an international perspective (M = 5.4). The Establishment of an international perspective was deemed to be least important to the development of a consistent curriculum model within the United States by program respondents.

The third notable finding resulted in the majority of the surveyed programs (86.7%) perceived the purpose of undergraduate rehabilitation education to be a feeder program for graduate study in Rehabilitation Counseling. This was at odds with student

outcomes, where less than 3 out of 10 graduates pursued a graduate degree in rehabilitation counseling.

The fourth notable finding determined from the results that clinically there appeared to be an inconsistency in the types of practices, number of required hours, and the number of required practica and internships within the reporting 15 programs.

The fifth notable finding determined from the results were that faculty resources for the majority of the surveyed undergraduate rehabilitation and disability studies programs were deployed primarily as adjunct or borrowed faculty, rather than as full-time dedicated faculty for the operation of the undergraduate programs.

The sixth notable finding resulted in the determination that no comparisons could be made between registered and non-registered programs due to the paucity of responses from non-registered undergraduate rehabilitation and disability studies programs.

Discussion of Findings and Conclusions

The lack of specifically assigned faculty and the diffusion of faculty resources in the operation of undergraduate rehabilitation and disability studies education is currently an impediment to further growth and development. The need for faculty to be dedicated at full-time, not adjunct or part-time employment, is necessary for the successful development of a core curriculum. This does not mean that the usage of adjunct or part-time faculty are less important but rather faculty who are full-time may lead to greater consistency in programmatic direction. Part-time faculty should be utilized for specialty courses that strengthen the program or add depth to existing faculty expertise. For example, programs may utilize adjunct faculty who have experiential experiences in

specific subject areas such as, independent living. By utilizing a qualified individual with these experiences and knowledge, the program can be strengthened and gain an added layer of expertise.

In terms of a curricular model, an *Allied Health Occupations Model* as reported in the literature review, may be a more appropriate model for programs to emulate. The literature suggested that student occupational outcomes, which were broad-based and not specifically directed to any one occupational area, accomplished the priority of diffusion of disability knowledge. The literature, as well, noted that a broad-based curriculum for undergraduate rehabilitation education provides a structure for students to enter into a greater number of health related occupations (Hylbert & Kelz, 1972; Gandy & Martin, 1985). Rather than preparing students for specific occupations, students may be prepared for a broader skill-set and for varying occupational career paths. This broader educational experience accomplishes (a) an infusion of disability culture into the broader aspects of occupations and society, and (b) students have a diversity of career path options to pursue.

While the majority (86.7%) of reporting programs believed undergraduate rehabilitation education programs were preparatory programs for graduate study in rehabilitation counseling, in actuality, students selected other related rehabilitation occupational careers. This is a significant paradoxical finding. Because students are entering or preparing for other rehabilitation related fields, this finding supports the notion that a broader-base curriculum can prepare persons to enter a greater number of rehabilitation related occupations.

A need for consistency within clinical education is evident by the current inconsistencies among undergraduate rehabilitation programs concerning the number of required practica ranging from 0 to 4 and the number of required clock hours for internships ranging from 160 to 600 clock hours. Based on the literature, it seems that a varied practica schedule with discussion and reflection over two years contributes to the goal of understanding disability in varied settings. An internship should provide a foundation and learning experiences that assist students with specific preparation for graduate studies or work. The notion of a broad-based curriculum and a structured clinical experience is reinforced by the reporting programs ranking of priorities: (a) exploration and explication of disability culture, (b) understanding disability is a *normal* part of society and life span, and (c) accommodations are a desired end to provide opportunities, work, and recreation in everyday activities.

The notion of a broad-based curriculum, in fact, presents itself as more of a *Systems Change, Leadership, and Advocacy Model* (see Appendix K). This type of preparation infuses students with a sound understanding of not just being a more aware citizen but an understanding of all people, especially individuals with disabilities and their role in society. This focus leads to what Martin (2001) calls "Systems Change, Leadership, and Advocacy". Martin's focus is on the values, issues, life roles, and outcomes that relate to individuals with disabilities. The main priorities reported by the undergraduate rehabilitation programs discussed previously, parallel what Martin's model presents. The priorities contain evidence of the teachings of values, issues, life roles, and outcomes of persons with disabilities. Through the Systems Change, Leadership, and Advocacy Model, individuals learn that independence, productivity and

inclusion are key components that all value in today's society. These values then are associated with the issues effecting education, transportation, health care, employment, housing, and leisure/recreation. These values and issues affect the life span (Life Roles) of all individuals, thus have an impact on services and quality of life and legislation. This type of broad preparation infuses undergraduate rehabilitation and disability studies students with the skills and tools to enter various rehabilitation related occupations and or graduate school and, in turn, possibly make a greater contribution to society.

The notion of a broad-based curriculum, in fact, presents itself as more of a psychosocial and liberal arts perspective to disability studies. The focus of undergraduate rehabilitation education in actuality may have broader and greater impact on society than program directors believe. Undergraduate rehabilitation programs appear to not to be specific feeder programs but instead broad feeder programs to other rehabilitation related occupations and graduate studies. The priorities of undergraduate education prepares a more rounded and knowledgeable student about the issues effecting persons with disabilities in the areas of education, transportation, health care, employment, housing, and leisure/recreation. This type of preparation infuses students with a more sound understanding of not just being a better citizen but an understanding of all people especially individuals with disabilities and their role in society.

A major impediment to the achievement of a core curriculum relates to the diffusion of faculty resources. Without a core curriculum, the identity and unity of undergraduate rehabilitation and disability studies will remain fragmented. Conversely, the fragmentation of programs and a lack a dedicated faculty does not move undergraduate rehabilitation and disability studies programs forward.

Limitations

The current study presented with several limitations. The first limitation was the small sample size (N = 43) and this limits the generalizability of the research. The second limitation was the issue of a low return rate (37.5%). This may have been due to the implementation of the questionnaire during the summer semester. Another possible reason for the low return rate may be due to the lack of interest from the non-registry programs. The response rate from Registered programs was 54%. Another factor complicating response rate may have been the utilization of a web-based questionnaire. The web-based questionnaire posed several dilemmas; (a) perceived questionnaire accessibility, (b) respondents access to the web, and (c) respondent's institutional servers perceiving the initial e-mail with the link as spam. Third, the questionnaire would not allow respondents to proceed without responding to all questions. A forth limitation to the research related to question design. Respondents were not given the alternative choice of not applicable on the questionnaire, which had the effect of forcing a response. Future researchers would well be advised to take into consideration these previously noted issues surrounding web-based software prior to engaging in on-line research.

Recommendations for Future Research and Practice

This dissertation research was a preliminary study of undergraduate rehabilitation and disability studies programs in the United States designed to determine: (a) *curricular models* of undergraduate rehabilitation programs, (b) *programmatic priorities* from the perspective of program directors, (c) *dedicated faculty resources*, full time versus part-

time, deployed in the operation of undergraduate rehabilitation programs and (d) *purpose* of undergraduate rehabilitation education from the perspective of program directors.

The major finding of the survey questionnaire revealed that a broad-based educational experience (*Systems Change or Allied Health Professions Models*) accomplishes (a) an infusion of disability culture into the broader aspects of rehabilitation related occupations and society, and (b) students who experience these models have a greater diversity of career path options to pursue, rather than a more narrow interpretation of rehabilitation—that is, a curriculum focused only on vocational rehabilitation.

The notion of a broad-based curriculum, in fact, presents a psychosocial and liberal arts perspective to disability studies rather than a vocational rehabilitation curriculum that results in a greater diversity of occupational choices for students while infusing disability culture into the fabric of American society. In order to accomplish this undergraduate programs must be staffed with full-time dedicated positions, not with adjunct or part-time positions, in order to ensure continuity in the further growth and development of a core curriculum.

Based on this major finding, the following three recommendations are presented for review and consideration. First, the adoption of a *Systems Change, Leadership, and Advocacy Model* or an *Allied Health Occupations Model* or a blend of both for undergraduate rehabilitation and disability studies programs. A combination or blending of both models may provide for a broader infusion of disability culture into related rehabilitation occupations and graduate studies, while not decreasing the value of vocational rehabilitation. This type of model change meets the needs and direction of undergraduate rehabilitation students, while having the capability to modify and

introduce the notion of a disability friendly culture within American society (*Systems Change/Allied Health Model*).

The second recommendation, full-time dedicated faculty positions should form the basic infrastructure of all baccalaureate rehabilitation education programs. Programs should be funded at levels that allow programs to be supplemented with adjunct and specialized faculty to add additional layers of specialty expertise. This would have the effect of strengthening and enriching programs along the dimensions reported in the ranking of programmatic priorities by undergraduate program directors. Consistency in faculty resources creates a better opportunity for the development of a core curriculum as well as a sense of identity among undergraduate rehabilitation education programs.

The third recommendation, proposes the Council on Rehabilitation Education (CORE)/Committee on Undergraduate Education (CUE) should re-examine the eight areas of articulated curriculum guidelines set forth for undergraduate programs seeking registry status, reviewing each guideline for adjustments to reflect curricular consistency with either a *Systems Change, Leadership, and Advocacy Model* or an *Allied Health Occupations Model*.

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APPENDICES

APPENDIX A

2006–2007 UNDERGRADUATE REGISTRY: AS OF 10-01-06

2006-2007 UNDERGRADUATE REGISTRY: AS OF 10-01-06

1. Arkansas Tech University
2. Auburn University
3. Boston University
4. East Central University
5. East Stroudsburg University
6. Emporia State University
7. Southern Illinois University
8. Southern University
9. Springfield College
10. Stephen F. Austin State University
11. Tipperary Institute **
12. Troy University
13. University of Arizona
14. University of Calgary **
15. University of Illinois
16. University of Maine-Farmington
17. University of Maryland Eastern Shore
18. University of Memphis
19. University of North Dakota
20. University of North Texas
21. University of Texas Pan American
22. University of Wisconsin-Stout
23. Wilberforce University
24. Wright State University

** International Program

APPENDIX B

IDENTIFIED BACCALUAREUTE REHABILITATION AND DISABILITY STUDIES PROGRAMS

IDENTIFIED BACCALUAREUTE REHABILITATION AND DISABILITY STUDIES PRORAGMS

1. University of Arizona *
2. Stephen F. Austin State University *
3. San Diego State University
4. Wright State University *
5. East Stroudsburg University *
6. Thomas University
7. University of North Dakota
8. Florida State University
9. LSU-HSC
10. University of Memphis *
11. Northern Illinois University
12. Western New Mexico Univ.
13. Univ. Arkansas-Pine Bluff
14. Coppin State College
15. Pennsylvania State Univ.
16. University of Connecticut
17. University of Florida
18. University of Maine-Farmington *
19. Hilbert College
20. University of Northern Colorado
21. University of Maryland-ES *
22. University of Scranton
23. Arkansas Tech University *
24. Montana State University
25. Southern University *
26. East Carolina University
27. CSU-Los Angeles
28. Emporia State University *
29. Maryville University of St. Louis
30. Boston University *
31. University of Medicine & Dent of NJ
32. Southern Illinois University *
33. Auburn University *
34. East Central University *
35. Troy State University *
36. Winston-Salem State Univ.
37. University of Pittsburgh
38. University of Wisconsin
39. Wilberforce University *
40. Assumption College
41. University of Wisconsin-Stout *
42. University of North Texas *
43. Springfield College *
44. University of Texas-Pan American *
45. University of Illinois *

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* 2006-2007 Undergraduate Registry: As of 10-01-06

APPENDIX C

CRITERIA FOR SELECTION OF EXPERT PANEL

CRITERIA FOR SELECTION OF EXPERT PANEL

Names	Publications	Leadership:	Faculty Status
Chrisann Schiro-Geist, Ph.D., C.R.C. Professor, Office of the Vice Chancellor for Public Engagement and Institutional Relations	Schiro-Geist, C. (1987). Curriculum development for training rehabilitation counselors in business and industry. [Special Edition, guest editor: M. Kundu]. *Rehabilitation Education, 1*(2/3), 173–176.	Committee on Undergraduate Education: Committee Member; Director, Disability and Rehabilitation Education and Training; Member, Boards of the Council on Rehabilitation Educations' Commission on Standards and Accreditation; Member, Council on Rehabilitation Education's Committee on Undergraduate Education; Past Managing Director of Disability Research Institute	University of Memphis

CRITERIA FOR SELECTION OF EXPERT PANEL (continued)

Michelle Marmé, Ph.D., CRC, LCPC	Marmé, M. (2001). In review: Pediatric rheumatic diseseas. *Journal of Rehabilitation,67*(3), 62.	Committee on Undergraduate Education: Committee Member	Professor Emeritus / Private Consultant
Tom Evenson, Ph.D., CRC	Evenson, T., & Holloway, L. (2000). Competencies of baccalaureate-level rehabilitation workers in community rehabilitation programs. *Rehabilitation Education, 14,* 115–130. Evenson, T., & Holloway, L. (2007). Undergraduate education: An essential rung on the rehabilitation career ladder. *Rehabilitation Education, 21*(2), 73–86.	Committee on Undergraduate Education: Committee Member	University of North Texas
David Perry, Ph.D., CRC, Rehabilitation Program Director	Perry, D. (2000). Undergraduate curriculum: A success. *Journal of Rehabilitation, 37*(6), 15-17.	Committee on Undergraduate Education: Committee Member,	

CRITERIA FOR SELECTION OF EXPERT PANEL (continued)

	Perry, D. (2000). Understanding and appreciating undergraduate rehabilitation education. *Rehabilitation Education, 14(1),* 3–11.	National Council on Rehabilitation Education, Past President (2007)	University of North Dakota
Gerald Gandy, Ph.D.	Gandy, G.L. (1983). Graduates of an undergraduate rehabilitation curriculum. *Rehabilitation Counseling Bulletin, 24,* 357–359. Gandy, G. L., & Martin, D. E. (1985). Undergraduate rehabilitation education: A humanistic approach. *Rehabilitation Literature, 46*(11-12), 321–324. Gandy, G. L. (1987). *Towards a clearer definition of undergraduate rehabilitation education*. Richmond VA: Commonwealth Papers, Center for Public Affairs, Virginia Commonwealth University.	Past-President of the Faculty, School of Community and Public Affairs, Virginia Commonwealth University;	Professor Emeritus, Department of Rehabilitation Counseling, School of Allied Health Professions, Medical College of Virginia

APPENDIX D

INSTITUTIONAL REVIEW BOARD CONSENT FORM

1856 2006
AUBURN
UNIVERSITY
Sesquicentennial

Office of Human Subject Research
307 Samford Hall
Auburn University, AL 36849

Telephone: 334-844-5966
Fax: 334-844-4391
hsubjec@auburn.edu

October 10, 2007

MEMORANDUM TO: Chad Duncan
Department of RSED

PROTOCOL TITLE: "The Purpose of Undergraduate Rehabilitation Education: Implications for Curricular Development"

IRB FILE NUMBER: 07-202

Thank you for submitting your protocol to the Institutional Review Board for review. According to your description of this project and the intended use, the IRB has determined that your activities as described **do not constitute "human subjects research"** according to the existing guidelines and statutes (45 CFR 46.102).

> *Research* means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program, which is considered research for other purposes. For example, some demonstration and service programs may include research activities.
>
> *Human subject* means a living individual about whom an investigator (whether professional or student) conducting research obtains:
>
> (1) data through intervention or interaction with the individual, or
> (2) identifiable private information.

If there are any changes made which would constitute human subjects research, or if there are any events adverse or otherwise which concern the investigator(s), we encourage you to contact this office for further consultation.

We wish you success in your endeavors and look forward to working with you in your future research activities.

Sincerely,

Niki L. Johnson, JD, MBA, Director
Office of Human Subjects Research
Research Compliance Auburn University

cc: Dr. Phillip Browning

APPENDIX E

LETTER OF INVITATION

AUBURN
UNIVERSITY

COLLEGE OF EDUCATION

REHABILITATION AND SPECIAL EDCATION

1228 HALEY CENTER

AUBURN, AL 36849-5226

TELEPHONE:

334-844-5943

FAX:

334-844-2080

WWW.AUBURN.EDU

To Expert Panel:

Thank you for taking time in participating on this important topic. Below are instructions to the process you are agreeing to take part in. The survey is divided into three sections: Demographic, Curriculum, and Purpose totaling 36 questions. The survey may be accessed via web. Below are provided directions for the first phase of this study. Each subsequent phase will have its particulars provided at the time of each section/phase.

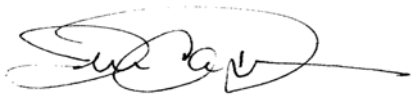
First Phase:

1. Please evaluate survey
2. After evaluating the survey, using the four point Likert scale provided, assign a weight regarding to the relevance to undergraduate rehabilitation education.

Upon receiving your response to the survey, I will compile each expert reviewer's responses and suggestions. You will get an e-mail notice once all reviewers have returned their survey. Once all surveys are completed and compiled, a final survey will be sent to the identified undergraduate rehabilitation education programs.

Again, thank you for agreeing to participate in this study.

Sincerely,



J. Chad Duncan

APPENDIX F

CONTENT VALIDATION: UNDERGRADUATE REHABILIATION AND DISABILITY STUDIES QUESTIONNNAIRE RESPONSE SHEET

UNDERGRADUATE REHABILIATION AND DISABILITY STUDIES QUESTIONNNAIRE RESPONSE SHEET

Currently I am doing a content validation of the initial questionnaire according to the relevance to the domain of Undergraduate Rehabilitation and Disability Studies Education. This initial survey has been developed from an extensive literature review. The 36 item questions are divided into three sections (Demographic: 15 items, Curricular: 10 items, and Purpose: 11 items).

Please review the initial 36 questionnaire items for their content validity of the instrument (relevance to the field of Undergraduate Rehabilitation and Disability Studies Education). Provided is a Four Point Likert scale to each question. The Items (1=*Strongly Disagree, 2= Disagree,3= Agree,4= Strongly Agree)* apply to the relevance of Undergraduate Rehabilitation and Disability Studies Education.

PROGRAM DEMOGRAPHICS		Strongly Disagree	Disagree	Agree	Strongly Agree
1.	**Is the program a member of the Undergraduate Registry sponsored by the Council on Rehabilitation Education (CORE)?** ☐ Yes ☐ No	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
2.	**Is the program a member of the National Council on Rehabilitation Education's (NCRE) Council on Rehabilitation Education?** ☐ Yes ☐ No	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
3.	**What are the programmatic benefits of being a member of Committee on UG Education (CUE) / Registry?** Please Check: ☐ Professional identity ☐ Curricular guidelines ☐ Research and collaboration ☐ Please list other benefits:	○	○	○	○

PROGRAM DEMOGRAPHICS CONTINUED					
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
4.	**Year undergraduate rehabilitation program was established?** Date:_____	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
5.	**Title of academic unit (school/college) in which program located?**	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
6.	**Number of faculty employed in home department?** Full time: ___ Part-Time: ___ Adjunct: ___	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
7.	**Percentage of faculty with primary affiliation to the undergraduate program (main focus of teaching is UG education):** Percentage: _____	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
8.	**Percentage of faculty with secondary affiliation to the undergraduate program (primary teaching focus at graduate level):** Percentage: _____ Not Applicable: _____	○	○	○	○

		Strongly Disagree	Disagree	Agree	Strongly Agree
9.	**Percentage of faculty with a disability:** ☐ Yes: Percentage: ____ ☐ None	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
10.	**Percentage of students with a disability in current program:** ☐ Yes: Percentage: ____ ☐ None	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
11.	**Percentage of students currently enrolled in undergraduate program.** **Spring 2008:** _____ Full-Time: ____ Part-Time	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
12.	**Student gender (percentage):** Male: _____ Female: ____	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
13.	**Student ethnicity (percentage):** Caucasian: _____ African American: _____ Asian: _____ American Indian: _____ Hispanic or Latino: _____ Other Please List/percentage: ____	○	○	○	○

		Strongly Disagree	Disagree	Agree	Strongly Agree
14.	**Age range of students enrolled:** Range: _____ to _____	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
15.	**Average age of student enrolled:** _____	○	○	○	○
CURRICULUM		**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
16.	**Please attach all the required class titles for your curriculum (plan of study, program of study**).	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
17.	**Please attach a copy of the most recent catalog descriptions for courses in the program. (please highlight required courses).**	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
18.	**Does the program offer specializations?** ☐ Yes: **If so, please list the specializations and the requires course titles. ___** ☐ None	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
19.	**Does the program require practica?** ☐ Yes ☐ No	○	○	○	○

		Strongly Disagree	Disagree	Agree	Strongly Agree
20.	**Number of required practica:** ☐ None ☐ One ☐ Two ☐ Three ☐ Four	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
21.	**Clock hours required per practica:** 1. required:____ 2. required:____ 3. required:____ 4. required:____	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
22.	**Does the program require an Internship?** ☐ Yes ☐ No **If so, how many clock hours are required and how many credit hours are assigned? _____** ☐ None required	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
23.	**Is there a primary focus to the internship (e.g., rehabilitation counseling, Allied Health careers)** ☐ Yes: **If so, what is the program's primary focus?** ☐ No	○	○	○	○

		Strongly Disagree	Disagree	Agree	Strongly Agree
24.	**Is there a primary area in which students tend to complete their internships?** ☐ Allied Health careers: Please list specific Allied Health careers: ☐ Rehabilitation Counseling ☐ Vocational Evaluation ☐ Other: Please list:_____	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
25.	**Are related graduate degrees offered from the program's academic unit?** ☐ None ☐ M.S. / M.Ed **If so, Please list degrees offered (e.g. Rehabilitation Counseling, Community Counseling, …):** _____ ☐ Ph.D / Ed.D If so, Please list degrees offered: _____	○	○	○	○

PURPOSE OF UNDERGRADUATE EDUCATION		Strongly Disagree	Disagree	Agree	Strongly Agree
26.	**From a programmatic perspective does your Undergraduate Rehabilitation Education program serve as feeder program to Graduate Rehabilitation Counseling programs?** ☐ Yes ☐ No	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
27.	**PLEASE comment on response above!**_____ _____	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
28.	**What is the approximate percentage of undergraduates going on to Rehabilitation Counseling programs? Approximate percentage: _____**	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
29.	**From programmatic perspective, what are the top three purposes of an UG degree in rehabilitation and disability studies?** Please List: 1. _____ 2. _____ 3. _____	○	○	○	○

		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
30.	**From programmatic perspective, how relevant are the below mentioned areas of preparation, education, and exploration? 3 point Likert scale: (0 = not relevant, 1 = relevant, 2 = highly relevant)**	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	Preparation for Rehabilitation Counseling	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	Preparation for substance abuse intervention	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	Preparation for Occupation Therapy	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	Preparation for Law	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	Preparation for Public Sector	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	Preparation for Private Rehabilitation	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	Preparation for Therapeutic/ Recreational Therapy	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**

	Explore and explicate disability culture	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	To explore issues such as community living, housing, employment, health care, transportation, and education	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	Preparation for Community-Based Rehabilitation	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	Preparation for Social Work	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	Preparation for Case Management	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	Understanding disability is a "N*ormal* " part of society / Life Span	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	Accommodations are desired end to provide opportunities, work, and recreation in everyday activities	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	Promotes Advocacy	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	Preparation for Physical Therapy	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**

	Preparation for Independent Living Specialist	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	Preparation for Audiology	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	Preparation for Speech Therapy	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	Preparation Special Education	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
	List all other areas of preparation that are highly relevant to an UG degree in Rehabilitation and Disability Studies: _____ _____	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
31.	**To what extent does your program favor or oppose accreditation for undergraduate rehabilitation and disability studies programs?** ○ Strongly Favor ○ Somewhat Favor ○ Somewhat Oppose ○ Strongly Oppose	○	○	○	○

		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**

32.	**Rank order 1-6 (1 being most important to 6 being least important) Of the following, which are undergraduate priority?** ☐ Establishing primary focus ☐ Establishing a core curriculum ☐ Establishing international perspective ☐ Creating a sound identity ☐ Creating stronger feeder programs for graduate rehabilitation programs ☐ Accreditation of undergraduate Rehabilitation and Disability Studies Programs	○	○	○	○
	Programmatic Perspective, (questions 33-36) consider each of the following to be (will use a 4-point Likert scale: 1 = serious problem, 2 = moderate problem, 3 = small problem, and 4 = not a problem)				
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
33.	**A lack of identity**	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
34.	**A lack of core curriculum**	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
35.	**A lack of unification among undergraduate programs**	○	○	○	○
		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
36.	**A lack of understanding from graduate programs**	○	○	○	○

THANK YOU FOR YOUR TIME AND PARTICIPATION!

APPENDIX G

LETTER TO UNDERGRDAUATE REHABILITATION AND DISABILITY STUDIES PROGRAM COORDINATORS

AUBURN
UNIVERSITY

COLLEGE OF EDUCATION

REHABILITATION AND SPECIAL EDCATION

1228 HALEY CENTER

AUBURN, AL 36849-5226

TELEPHONE:

334-844-5943

FAX:

334-844-2080

WWW.AUBURN.EDU

May 13, 2008

Dear Undergraduate Coordinator,

I am currently working on my dissertation, which is analyzing undergraduate rehabilitation education relative to purpose and implications for continued curriculum development. The information gathered will be analyzed for the purpose of making recommendations that address the current and future status of undergraduate rehabilitation education. Just recently, Linda Shaw, President of the Council on Rehabilitation Education (CORE) and the CORE Board have cited the importance of re-examining the role of undergraduate education in the preparation of qualified rehabilitation professional in several capacities.

I would greatly appreciate your time in the completion of the survey questionnaire regarding this important issue. The questionnaire will take about **10-15 minutes** to complete. You may access the questionnaire on a secure site at:

http://Chad-Duncan.dissertation.sgizmo.com

This proposed research has been cleared by the Auburn University Institutional Review Board for implementation (see attached letter). Your participation is voluntary. If you decide to participate, **please complete questionnaire by June 1, 2008.** Please complete all of the items. Your responses will be confidential and cannot be traced back to you. If I have inadvertently sent this to the incorrect person, would you please forward this survey questionnaire to the correct person?

Thank you in advance for your time and input to such an important topic.

Sincerely,

J. Chad Duncan
Doctoral Candidate
Auburn University

APPENDIX H

UNDERGRADUATE REHABILIATION AND DISABILITY STUDIES

QUESTIONNNAIRE

UNDERGRADUATE REHABILIATION AND DISABILITY STUDIES QUESTIONNNAIRE

UNDERGRADUATE REHABILIATION AND DISABILITY STUDIES QUESTIONNNAIRE

1. Is the program a member of the Undergraduate Registry sponsored by the Council on Rehabilitation Education (CORE)?
Please Check:

	Yes
	No

2. Is the program a member of the National Council on Rehabilitation Education's (NCRE) Council on Rehabilitation Education?
Please Check:

	Yes
	No

3. What are the programmatic benefits of being a member of Committee on UG Education (CUE) / Registry?
Please Check:

	Professional identity Curricular guidelines
	Curricular guidelines Please list other benefits:
	Research and collaboration
	Please list other benefits:

4. Year undergraduate rehabilitation program was established?
Please type date in box provided below:

5. Title of academic unit (school/college) in which program located?

6. Number of faculty employed in-home department?

Full time:	
Part-Time:	
Adjunct:	

7. Percentage of faculty with primary affiliation to the undergraduate program (main focus of teaching is UG education):

Percentage:

8. Percentage of faculty with secondary affiliation to the undergraduate program (primary teaching focus at graduate level):

	Not Applicable:
	Percentage:

9. Percentage of faculty with a disability:

	None
	Yes: Percentage:

10. Percentage of students with a disability in current program:

	None
	Yes: Percentage:

11. Percentage of students currently enrolled in undergraduate program.

Spring 2008:

Full-Time:	
Part-Time:	

12. Student gender (percentage):

Male:	
Female:	

13. Student ethnicity (percentage):

African American:	
American Indian:	
Asian:	
Caucasian:	
Hispanic or Latino:	
Other Please List /percentage:	

14. Age range of students enrolled:

Range:

15. Average age of student enrolled:

16. Please provide link to the required class titles for your curriculum (plan of study, program of study).

17. Please provide link to the most recent catalog descriptions for courses in the program.

18. Does the program offer specializations?

	None
	Yes

19. If you answered Yes to question 18, please list the specializations and the required course titles.

20. Does the program require practica?

	Yes
	No

21. Number of required practica:

	None (0)
	One (1)
	Two (2)
	Three (3)
	Four (4)

22. Clock hours required per practica:

1. 0ne required:	
2. Two required:	
3. Three required:	
4. Four required:	

23. Does the program require an Internship?

	None Required
	Yes, If so, how many clock hours are required and how many credit hours are assigned?

24. Is there a primary focus to the internship (e.g., rehabilitation counseling, Allied Health careers)

	No
	Yes: If so, what is the program's primary focus?

25. Is there a primary area in which students tend to complete their internships?

	Rehabilitation Counseling
	Vocational Evaluation
	Allied Health careers, Please list specific
	Other, Please list:

26. Are related graduate degrees offered from the program's academic unit?

	None
	M.S. / M.Ed:If so, Please list degrees offered (e.g. Rehabilitation Counseling, Community Counseling, …):
	Ph.D / Ed.D; If so, Please list degrees offered:

27. From a programmatic perspective does your Undergraduate Rehabilitation Education program serve as feeder program to Graduate Rehabilitation Counseling programs?

	Yes
	No

28. Please comment on response above !

29. What is the approximate percentage of undergraduates going on to Rehabilitation Counseling programs?

Approximate percentage:

30. From programmatic perspective, what are the top three purposes of an UG degree in rehabilitation and disability studies?
Please List:

1.	
2.	
3.	

31. From programmatic perspective, how relevant are the below mentioned areas of preparation, education, and exploration? 3 point Likert scale: (0=not relevant, 1= relevant, 2= highly relevant)

	0 = not relevant	1 = relevant	2 = highly relevant
Preparation for Rehabilitation Counseling			
Preparation for substance abuse intervention			
Preparation for Occupation Therapy			
Preparation for Law			
Preparation for Public Sector			
Preparation for Private Rehabilitation			
Preparation for Therapeutic/ Recreational Therapy			
Explore and explicate disability culture			
To explore issues such as community living, housing, employment, health care, transportation, and education			
Preparation for Community-Based Rehabilitation			
Preparation for Social Work			
Preparation for Case Management			
Understanding disability is a "Normal" part of society / Life Span			

	0 = not relevant	1 = relevant	2 = highly relevant
Accommodations are desired end to provide opportunities, work, and recreation in everyday activities			
Promotes Advocacy			
Preparation for Physical Therapy			
Preparation for Independent Living Specialist			
Preparation for Audiology			
Preparation for Speech Therapy			
Preparation Special Education			

32. List all other areas of preparation that are highly relevant to an UG degree in Rehabilitation and Disability Studies:

33. To what extent does your program favor or oppose accreditation for undergraduate rehabilitation and disability studies programs?

	Strongly Favor
	Somewhat Favor
	Somewhat Oppose
	Strongly Oppose

34. Rank order 1-6 (1 being most important to 6 being least important) Of the following, which are undergraduate priority?

1]	Establishing primary focus		
2]	Establishing a core curriculum		
3]	Establishing international perspective		
4]	Creating a sound identity		
5]	Creating stronger feeder programs for graduate rehabilitation programs		
6]	Accreditation of undergraduate Rehabilitation and Disability Studies Programs		

35. Programmatic Perspective, consider each of the following to be a (will use a 4 Likert scale: 1 = serious problem, 2 = moderate problem, 3 = small problem, and 4 = not a problem)

	Strongly Disagree	Disagree	Agree	Strongly Agree
A lack of identity				
A lack of core curriculum				
A lack of unification among undergraduate programs				
A lack of understanding from graduate programs				

UNDERGRADUATE REHABILIATION AND DISABILITY STUDIES QUESTIONNNAIRE

Thank you for taking our survey. Your response is very important to us.

APPENDIX I

DETAILED PROGRAM CURRICULUM WITH DESCRIPTIONS

PROGRAM 1

Requirements (For course descriptions click on a course number below)

MAJOR REQUIREMENTS

REH 110 Introduction to Disability Studies	4
REH 200 Counseling and the Helping Relationship	4
REH 205 Group Process in Human Services	4
REH 310 Casework	4
REH 380 Seminar in Professional Practice	4
REH 395 Practicum in Rehabilitation and Human Services	4
REH 480 Seminar in Rehabilitation and Human Services	4
REH 495 Internship in Rehabilitation and Human Services	12
REC 140 Introduction to Therapeutic Recreation	4

NOTE: Students are required to earn a grade of "C" or better in these courses

Subtotal: 44

PROGRAM RELATED COURSES

A total of 12 credits from within the major. This grouping of courses may satisfy specialization mandates see section on rehabilitation specializations).
Certain courses may satisfy more than one requirement. Courses are 4 credits unless specified.

REH 210 Family Relations
REH 220 Multiculturism (2)
REH 230 Surviving and Thriving as Human Service Professionals
REH 240 Expressive Arts Therapy (2)
REH 242 Animal Assisted Therapy (2)
REH 270 Vocational Counseling and Placement
REH 277 Topics in Rehabilitation (1-4)
REH 297 Independent Study in Rehabilitation (1-4)
REH 320 Addiction Rehabilitation
REH 330 Psychosocial Rehabilitation
REH 350 Rehabilitation Administration*
REH 381 Grantwriting*
REH 477 Topics in Rehabilitation (1-4)
REH 497 Independent Study & Research in Rehabilitation (1-4)
REC 200 Strategies & Techniques in Therapeutic Recreation
REC 210 Aquatics Therapy
REC 220 Adaptive Recreation for Children
REC 225 Outdoor Recreation for Special Groups (2)
REC 297 Independent Study in Recreation (1-4)
REC 315 Programming in Therapeutic Recreation

*Courses have prerequisites

Subtotal: 12

Total credits of the Major: 56

RELATED ARTS AND SCIENCES REQUIREMENTS

This grouping of courses may partially satisfy minor, specialization, general education and/or honors requirements. Certain courses may satisfy more than one-degree requirement (see advisor for details).

ANT 2XX one 4 credit Peoples and Cultures course at the 200 level
ANT 301 Culture and Personality
BUS 210 Principles of Management
BUS 220 Principles of Marketing
BUS 310 Human Resources Management
BUS 311 Management and Organizational Behavior
BUS 320 Consumer Behavior
GEO 325 Geography of Health and Disease
HON 2XX one 4 credit Honors course at the 200 level or above
POS 200S Public Policy
POS 302 Civil Liberties
PSY 2XX one 4 credit Psychology course at the 200 level or above
SOC 2XX one 4 credit Sociology course at the 200 level or above

Total credits: **12**

Rehabilitation Specializations

Many Rehabilitation Services majors continue to choose the option of specializing in Addiction Rehabilitation, Career Services, Psychosocial Rehabilitation, or Therapeutic Recreation. With an interest in working with particular populations and/or problem areas, these specializations provide a framework for pertinent coursework to help the student develop relevant knowledge and skills. The specializations also may aid the student in the attainment of a specific proven credential, such as state licensure, and state or national certification. Each specialization requires 20 credits: 16 in specialized coursework (course substitutions must be approved by your REH program advisor), and a relevant field experience (minimum 4 credits) working in the specific area. Students are required to earn a grade of "C" in these courses. On rare occasions an advisor may make course substitutions for the listed requirements. The following are the four specializations, available to all majors in the rehabilitation services program:

Addiction Rehabilitation

REH 210 Family Relations	4
REH 320 Addiction Rehabilitation	4
One of the following:	
REH 270 Vocational Counseling and Placement	
BUS 310 Human Resources Management	
REH 330 Psychosocial Rehabilitation	
PSY 455 Crisis Identification and Stabilization	4
One of the following:	
REC 315 Programming in Therapeutic Recreation (4)	
REH 381 Grantwriting (4)	
HEA 211 Substance Abuse Prevention (2)	2 or 4
One of the following courses has to be specific to Addiction Rehabilitation:	
REH 395 Practicum in Rehabilitation and Human Services (4)	
REH 495 Internship in Rehabilitation and Human Services (12)	4 or 12
Minimum credits:	**20**

Career Services

REH 270 Vocational Counseling and Placement	4
REH 350 Rehabilitation Administration	4
PSY 237S Career Counseling	4
One of the following:	
BUS 310 Human Resources Management	
BUS 311 Management and Organizational Behavior	4
One of the following courses has to be specific to Career Services:	
REH 395 Practicum in Rehabilitation and Human Services (4)	
REH 495 Internship in Rehabilitation and Human Services (12)	4 or 12
Minimum credits:	**20**

Psychosocial Rehabilitation

REH 210 Family Relations	4
REH 320 Addiction Rehabilitation	4
REH 330 Psychosocial Rehabilitation	4
One of the Following:	
REH 320 Surviving and Thriving as Human Services Professionals	
REH 270 Vocational Counseling and Placement	
REC 200 Strategies and Techniques in Therapeutic Recreation	
REC 315 Programming in Therapeutic Recreation	4
One of the following courses has to be specific to Psychosocial Rehabilitation:	
REH 395 Practicum in Rehabilitation and Human Services (4)	
REH 495 Internship in Rehabilitation and Human Services (12)	4 or 12
Minimum credits:	**20**

Therapeutic Recreation

REC 200 Strategies and Techniques in Therapeutic Recreation	4
REC 225 Outdoor Recreation for Special Groups	2
One of the following:	
REC 315 Programming in Therapeutic Recreation	
REH 350 Rehabilitation Administration	
REH 381 Grantwriting	4
One of the following:	
REH 240 Expressive Arts Therapy (2)	
REH 242 Animal Assisted Therapy (2)	
REC 210 Aquatics Therapy (4)	
REC 220 Adaptive Recreation for Children (4)	2 or 4
One of the following courses has to be specific to therapeutic recreation:	
REH 395 Practicum in Rehabilitation and Human Services (4)	
REH 495 Internship in Rehabilitation and Human Services (12)	4 or 12
Minimum credits:	**20**

NOTE: Students must earn a grade of a C or better in speciality courses for the specialization they apply for.

GENERAL EDUCATION REQUIREMENTS

General education requirements at UMF include foundation courses and distribution courses. The total number of credits required to fulfill these requirements will differ depending on the courses you select; your advisor will help you choose courses that are appropriate to your program and your interests. UMF's general education requirements also include expectations related to writing skills, technology skills, research skills, and public presentation skills. You will typically satisfy these requirements through your normal coursework in general education and your major. For specific information about general education requirements and expectations, see the General Education Requirements in the Academic Programs section of this catalog.

NOTE: Rehabilitation students will be required to take BIO 150N Human Anatomy and Physiology as one of their natural sciences.

MINIMUM TOTAL CREDIT FOR THE DEGREE	**128**
REHABILITATION MINOR	
REH 110 Introduction to Disability Studies	4
REH 310 Casework	4
REC 140 Introduction to Therapeutic Recreation	4
One of the following: REH 200 Counseling and the Helping Relationship **OR** REH 205 Group Process in Human Services	4
One of the following: Upper level courses in rehabilitation **OR** Upper level selected courses in recreation with a therapeutic emphasis. All selections must be approved by the Rehabilitation Services minor advisor.	4
Total credits for the Minor:	**20**

PROGRAM 2

DEGREE PLAN

Bachelor of Science in Rehabilitative Services
Revised – Effective Fall 2003

PROGRAM 1**Required Major Concentration Courses** (48 hrs.)

REHS 2301 Introduction to Rehabilitation
REHS 4301 Vocational Assessment
REHS 2321 Introduction to Addictions Studies
REHS 4302 Job Placement
REHS 2331 Psychology of Disability
REHS 4303 Case Management II
REHS 3303 Case Management I
REHS 4310 Rehabilitation Research
REHS 3311 Disability Policy and Independent Living
REHS 4330 Clinical Topics in Rehabilitation
REHS 3320 Family and Disability
REHS 4360 Assistive Technology
REHS 3325 Medical Aspects of Rehabilitation I
REHS 4602 Clinical Practicum in Rehabilitation
REHS 3330 Medical Aspects of Rehabilitation II

The Department of Rehabilitation offers two options for the Bachelor of Science Degree. Choose Option 1 or 2.

Option 1: GENERAL REHABILITATION
B.S. in Rehabilitative Services
Support Courses (9 hrs.)
MANA 3361 Principles of Management and Organizational Behavior
PSY 4313 Abnormal Psychology
REHS 4355 Multicultural Issues in Human Services
Major Elective (3 hrs.) *(choose one from below)*
REHS 3340 Intermediate Aspects in Addictions Studies
REHS 4340 Clinical Issues in Addictions Studies
REHS 4345 Special Populations in Addictions Studies
REHS 4350 Special Topics in Rehabilitation

Option 2: ADDICTIONS CONCENTRATION
B.S. in Rehabilitative Services with a Concentration in Addictions
Addiction Courses (9 hrs.)
REHS 3340 Intermediate Aspects in Addictions Studies
REHS 4340 Clinical Issues in Addictions Studies
REHS 4345 Special Populations in Addictions Studies
Support Course (3 hrs.)
PSY 4313 Abnormal Psychology

A minimum of 124 hours is required for the B.S. Degree in Rehabilitative Services.

PROGRAM 3

MAJOR REQUIREMENTS

Rehabilitation Studies Required Courses (33 Hours)
RHAB 2500 Disability and Society
RHAB 3400 Aspects of Disability II
RHAB 3000 Microcounseling
RHAB 4500 Assessment in Rehabilitation
RHAB 3050 Drugs and Society
RHAB 4600 Rehab. Case Management (was 3600)
or 4450 Substance Abuse and Rehabilitation
RHAB 4700 Employment Services
RHAB 3200 Physical and Psychosocial Aspects
RHAB 4860 Pre Practicum of Disability I
RHAB 4880 Practicum (6 Hours)

Supporting Required Courses (9 hours)
SOWK 3500 Human Behavior and the Social Environment
PSYC 4610 Abnormal Psychology
(3 hours) Supporting Elective chosen with Advisor

Rehabilitation Studies Electives
(May be taken as additional electives or towards a minor in Substance Abuse and Addictions Studies)

RHAB 3050 Drugs in Society
RHAB 4250 Group Issues
RHAB 4050 Assessment in Chemical
Dependency Treatment
RHAB 4350 Contemporary Issues and Research in Chemical Dependency
RHAB 4125 Addiction Counseling Models
RHAB 4450 Substance Abuse and Rehabilitation
RHAB 4150 Addiction Counseling Practice
RHAB 4800 Topics in Rehabilitation Studies

HUMAN SERVICES COURSES (HS)

HS 2230 **Survey of Human Services (3)**
A survey of the major human service delivery systems to include historical development, populations served, professional roles, and interrelationships between targeted social problems and services delivered. Introduction to the ecological/systems perspective as a tool for understanding these relationships. Includes observations and field trips.

HS 2231 **Peer Education-Drug Abuse Prevention (2)**
Introduction to peer education as a preventive procedure in working with campus drug and alcohol abuse. Techniques of peer teaching and peer counseling.

HS 2232 **Peer Education Practicum (1)**
Supervised experience in the Campus Peer Education - Drug Abuse Prevention Program. *Prerequisite: HS 2231 (May be repeated for a total of three hours credit).*

HS 3310 **Human Behavior In the Social Environment I (3)**
The biopsychosocial aspects of human growth and development throughout the life cycle. Emphasis is placed on understanding the individual in interaction with major social systems. Knowledge, skill, and value bases necessary for biopsychosocial assessment are built.

HS 3370 **Professional Communication Skills (3)**
Principles and techniques of interviewing for human services professionals. Major emphasis is the building of empathic skills.

HS 3390 **Introduction to Manual Communication (3)**
Students will learn basic signing techniques. This course is open to all students. Persons interested in learning manual communication who do not intend to complete an undergraduate degree are encouraged to audit or to enroll as special students.

HS 3391 **Intermediate Manual Communication (3)**
Students will build upon the skills learned in HS 3390 and will begin to develop conversational styles of manual communication. *Prerequisite: HS 3390.*

HS 3392 **Advanced Manual Communication (3)**
Students will learn an advanced conversational style of manual communication and will become proficient in advanced communication with the hearing impaired. *Prerequisite: HS 3391.*

HS 3393 **Orientation to the Hearing Impaired (3)**
This course will provide an understanding of the medical, psychological, social, educational and vocational issues that professionals must understand to work effectively with persons who are hearing impaired.

HS 4400-4410-4420 **Human Service Field Experience I (3), II (3) and III (3)**
Provides experiences in a variety of social and rehabilitation settings with an emphasis on the multiple natures of human problems and the impact these problems have on the disabled and disadvantaged. Includes a weekly seminar plus a minimum of 40 clock hours per semester hour spent in a particular agency setting. Clinical hours and responsibilities will be determined by internship supervisor. *Prerequisites: Senior level, HS 2230 and HS 3370 or permission of instructor. The field site must be approved by the practicum director by mid-term of the semester prior to the field experience.*

HS 4491-4492 **Guided Independent Research (1 to 3 credit hours per course per semester)**
Additional information is indexed under Guided Independent Research and Study.

HS 4493-4494 **Guided Independent Study (1 to 3 credit hours per course per semester)**
Additional information is indexed under Guided Independent Research and Study.

HS 4498 **Honors-Independent Study (1 to 3 credit hours per course per semester)**
Advanced research and study for outstanding students in their major field. Culminates in a report to a departmental committee which includes invited faculty members in related fields. *Prerequisite: Senior level, 3.5 overall average, permission of guiding professor, and approval of department chair and dean. NOTE: A written request must be submitted to the department chair at least six weeks in advance of the term the research is to be undertaken.*

PROGRAM 5

B.S. IN REHABILITATION AND HUMAN SERVICES

Required 125 credits which must include the following:

I. General Education Requirements (see University GER listing).

II. College of Education and Human Development requirements (see EHD listing).

III. Core Curriculum (35 credits):

RHS 200	Helping Skills in Community Services	(3)
RHS 250	Contemporary Issues in Rehabilitation	(3)
RHS 309	Medical and Psychosocial Aspects of Disability I	(3)
RHS 310	Medical and Psychosocial Aspects of Disability II	(3)
RHS 455	Rehabilitation Process	(3)
RHS 457	Vocational Development in Rehabilitation	(3)
RHS 465	Professional Issues in Rehabilitation	(2)
RHS 475	Testing and Assessment	(3)
RHS 491	Rehabilitation Field Seminar	(2)
RHS 497	Internship in Rehabilitation	(10)

IV. Extra Departmental Requirements (44 credits):

BAdm 101	Introduction to Business	(3)
Engl 125	Technical and Business Writing	(3)
History	Any Course	(3)
Literature	Any Course (English department)	(3)
Mgmt 305	Managerial Concepts	(3)
Politcal Science	Any Course	(3)
PSYC 250	Developmental Psychology (plus 6 credits 200-level or above)	(10)
SWk 317	Social Work Research	(3)
Soc 361	Social Psychology (plus 6 credits 200-level or above)	(10)
Statistics	Any Course	(3)

V. At Least One Concentration from the Following (10 credits):

1. *Substance Abuse*
   SWk 315 Substance Use and Abuse (2)
   Plus a minimum of 8 credits from the following:

T&L 350	Development and Education of the Adolescent	(3)
RLS 201	Leisure and Society	(3)
RLS 360	Inclusion in Recreation Settings	(3)
PPT 315	Introduction to Pharmacology	(3)
PPT 410	Drugs Subject to Abuse	(2)
Psyc 270	Abnormal Psychology	(3)
Soc 355	Drugs and Society	(3)

   Other courses as approved by Program Coordinator

2. *Mental Health*
   RHS 375 Community Living Topics: Severe Mental Illnesses (3)
   Plus a minimum of 7 credits from the following:

RLS 201	Leisure and Society	(3)
RLS 360	Inclusion in Recreation Settings	(3)
Psyc 270	Abnormal Psychology	(3)
Psyc 360	Introduction to Personality	(3)
T&L 319	Introduction to ED, LD and C/DD	(3)

   Other courses as approved by Program Coordinator

3. *Gerontology*
   SWk 313 Orientation to Gerontology (3)
   Plus a minimum of 7 credits from the following:

CSD 365	Aging in the Communication Process	(3)
RLS 201	Leisure and Society	(3)
RLS 360	Inclusion in Recreation Settings	(3)
RLS 363	Therapeutic Recreation for the Elderly	(3)
Nurs 418	Physical Changes in Aging	(3)
Psyc 355	Adulthood and Aging	(3)
Soc 352	Aging	(3)

   Other courses as approved by Program Coordinator

4. *Developmental Disabilities*

RHS 375	Community Living Topics: Developmental Disabilities	(3)

Plus a minimum of 7 credits from the following:

RLS 201	Leisure and Society	(3)
RLS 360	Inclusion in Recreation Settings	(3)
T&L 315	Education of Exceptional Students	(3)
T& L 319	Introduction to ED, LD and C/DD	(3)
T&L 421	Transition to Adult Life	(2)
CSD 101	American Sign Language I	(2)

Other courses as approved by Program Coordinator

VI. Cultural Diversity (6 credits from the following):

Anth 171	Introduction to Cultural Anthropology	(3)
Anth 379	Culture Area Studies	(3)
Anth 465	Culture, Illness and Health	(3)
IS 121	Introduction to Indian Studies	(3)
IS 151	White Images of Native Americans	(3)
IS 345	Contemporary American Indian Issues	(3)
IS 370	North American Indians	(3)
RELS 101	Introduction to Religion (West)	(3)
RELS 102	Introduction to Religion (East)	(3)
RELS 116	Women and Religion	(3)
Soc 250	Diversity in American Society	(3)
Soc 340	Sociology of Gender and Sex Roles	(3)
Soc 436	Social Inequality	(3)
CSD 101	American Sign Language I	(2)

Other courses as approved by RHS advisers

MINOR IN REHABILITATION AND HUMAN SERVICES
(20 credits)

I. Required Courses (15 credits):

1.	RHS 250	Contemporary Issues in Rehabilitation	(3)
2.	RHS 309	Medical and Psychosocial Aspects of Disability I	(3)
	or		
	RHS 310	Medical and Psychosocial Aspects of Disability II	(3)
	or		
	OT 432, PT 409, or Nurs 360 for respective majors		(3)
3.	RHS 455	Rehabilitation Process	(3)
4.	RHS 457	Vocational Development in Rehabilitation	(3)
5	RHS 475	Testing and Assessment	(3)

II. Elective Courses (5 credits from the following):

Anat 204	Anatomy for Paramedical Personnel	(3-5)
CSD 343	Language Development	(3)
CSD 353	Language Disorders	(3)
Nurs 490	Transcultural Health Care Theories, Research and Practice	(3)
Psyc 270	Abnormal Psychology	(3)
RHS 200	Helping Skills in Community Living	(3)
RHS 375	Community Living Topics	(3)
RLS 360	Inclusion in Recreation Settings	(3)
RLS 361	Principles of Therapeutic Recreation	(2)
SWk 311	Child Welfare	(3)
T&L 315	Education of Exceptional Students	(3)
T&L 421	Transition to Adult Life	(2)
T&L 428	Assistive Technology	(1)
CSD 101	American Sign Language I	(2)

Courses

200. Helping Skills in Community Services. 3 credits. This course provides the student with the basic knowledge and skills associated with the helping process, including interviewing skills, as practiced in a variety of community services settings. A special focus will be on the problem-solving process and interaction skills used indirect service activities with individuals. Helping skills require a knowledge of interpersonal relationships and the effective use of interpersonal behaviors. This combination of knowledge and skills will benefit any individual wanting to increase effectiveness when working with people. S/U grading. F, SS

250. Contemporary Issues in Rehabilitation. 3 credits. This course introduces students to the profession of rehabilitation and examines how persons with disabilities are treated in our society. Topics include: community and national rehabilitation agencies, political and social influences on rehabilitation programs, conceptualization of disability, attitude development and change, building accessible and inclusive communities, and transforming the media. Opportunities for involvement with agencies providing rehabilitation services will be provided. S, SS

309. Medical & Psychosocial Aspects of Disability I. 3 credits. This course provides a basic medical and psychosocial understanding of physical disability for human service workers. It is the first of a two-course sequence which covers medical terminology; causes, treatment, and prognosis of major disabilities; and the vocational and psychosocial impact of these disabilities. F

310. Medical and Psychosocial Aspects of Disability II. 3 credits. This course provides a basic medical and psychosocial understanding of developmental, psychiatric, and learning disabilities for human service workers. It is the second of a two-course sequence which covers medical terminology; causes, treatment, and prognosis of major disabilities; and the vocational and psychosocial impact of these disabilities. S

375. Community Living Topics. 3 credits. Repeatable to a maximum of 6 credits. This course provides an introduction to independent living for special populations, such as individuals with physical disabilities, developmental disabilities, or serious emotional disturbances. Topics include community-based programming, the deinstitutionalization movement, legislative issues, and the concepts of integration, inclusion, and normalization. S

455. Rehabilitation Process. 3 credits. This course examines the history, philosophy, and ethical standards of the rehabilitation profession. Topics include the following: experiences of people with disabilities throughout history, legislation affecting persons with disabilities, public and private rehabilitation systems, case management principles, role and function of rehabilitation counselors, principles of independent living, and community resources utilized in rehabilitation programs. F

457. Vocational Development in Rehabilitation. 3 credits. This course examines the relationship between work and disability in American society. Topics include the following: theories of career decision making, work values, employment opportunities and barriers for people with disabilities, sources of occupational information, job accommodations, vocational planning and job development, work adjustment training, affirmative action guidelines, and vocational placement strategies. S

465. Professional Issues in Rehabilitation. 2 credits. Prerequisites: Consent of instructor. This course is designed to provide an integrative experience for the senior Rehabilitation and Human Services student. The focus of the course will be on the exploration of the philosophical and ethical base of the profession and professional education. Professional issues and ethical dilemmas will provide the context for further development and application of critical thinking and decision making skills. F

475. Testing and Assessment. 3 credits. This course introduces the student to basic principles of testing and assessment that can be used with individuals who have disabilities. Various approaches to evaluation are explored, including assessment interviewing, psychometric testing, work samples, and situational assessment. F

491. Rehabilitation Field Seminar. 2 credits. Prerequisite: RHS 465. Corequisite: RHS 497. This seminar is designed to integrate the rehabilitation curriculum content with actual rehabilitation practice while in the internship. This is accomplished through journals, written assignments, presentations, and seminar discussions. F,S,SS

497. Internship in Rehabilitation. 10 credits. Prerequisite: RHS 465. Corequisite: RHS 491. S/U grading only. This course consists of a one semester block placement requiring 480 total hours (40 hours weekly) in an approved rehabilitation agency with an approved rehabilitation field instructor. The agency-based practicum, guided by a student's learning plan, provides students with learning opportunities to develop and to integrate rehabilitation knowledge, values and skills at the beginning level of generalist practice. Learning opportunities emphasize the integration of research, problem solving processes and skills, knowledge of rehabilitation programs and policies, understanding disability issues, use of self, and values and ethics of the rehabilitation profession. Upon completion of the internship, students will have experienced practice with individuals, groups, families, organizations and communities. Field instructors in conjunction with department faculty complete midterm and final evaluations of student performance. Applications for Field Instruction are submitted two semesters preceding the beginning of this course. F,S,SS

499. Special Topics. 1-3 credits, repeatable to 12. Prerequisite: consent of instructor. Supervised instruction or research which explores topics related to rehabilitation and human services. F, S, SS

PROGRAM 6

Emphasis 2. Rehabilitation Services

Students in this emphasis are usually preparing as paraprofessionals or professionals providing human/social services to persons with disabilities. The required courses provide a basic background in disability and rehabilitation concepts, psychological principles and statistics. Paraprofessional positions (e.g., job coach, rehabilitation aide) can be obtained by students with the baccalaureate degree. Students desiring professional positions must obtain a master's degree. The undergraduate curriculum is preparatory to graduate study which meets the course requirements of the Commission on Rehabilitation Counseling Certification.

Requirements in School (28)

- AHCD 318 - Medical Terminology Credits: 3
- AHRS 200 - Disability in Society Credits: 3
- AHRS 327 - Introduction to Rehabilitation Services Credits: 3
- AHRS 426 - Introduction to Clinical Procedures in Deafness Rehabilitation Credits: 1
- AHRS 430 - American Sign Language I Credits: 3
- AHRS 482 - Post-Employment Services in Vocational Rehabilitation Credits: 3
- AHRS 492 - Medical Aspects of Disability in Rehabilitation Credits: 3
- AHRS 493 - Counseling in Communicative Disorders Credits: 3
- COMD 220 - Introduction to Communicative Disorders Credits: 3
- COMD 403 - Language Development Credits: 3

Requirements outside School (36-37)

- Course work chosen with adviser's approval from at least three departments (27)

- PSYC 102 - Introduction to Psychology Credits: 3
  (Available for general education credit)
- PSYC 225 - Lifespan Development: Childhood Through Adulthood Credits: 3
  (Available for general education credit)
- STAT 208 - Basic Statistics Credits: 3
  (Available for general education credit)
  or
- STAT 301 - Elementary Statistics Credits: 4

Total Hours for Emphasis 2, Rehabilitation Services: 64-65

PROGRAM 7
CURRICULUM:

The BS degree in rehabilitation services requires a minimum of 121 semester hours of credit including 42 semester hours of foundations curriculum, 5 semester hours of cognate courses, 48 semester hours in the major, and the remaining semester hours in a minor or structured electives.

COGNATE COURSES:

BIOL 2130 Survey of Human Physiology and Anatomy

BIOL 2131 Survey of Human Physiology and Anatomy Laboratory

REQUIRED COURSES:

REHB 2000 Survey of Community Resources in Rehabilitation and Health Care

REHB 2003 Alcohol and Drug Abuse: Health and Social Problems

REHB 3010 Case Management in Rehabilitation

REHB 4000 Interviewing Techniques for Health and Rehabilitation Settings

REHB 4993-6 Rehabilitation Services Internship

BIOS 1500 Introduction to Biostatistics

SOCW 2010 Introduction to Social Work Practice with Special Populations

HLTH 3010 Health Problems IPSYC 2275 Psychology of Adjustment

PSYC 4375 Abnormal Psychology

PSYC 5325 Introduction to Psychological Testing

ELECTIVES (select two courses for 6 semester hours)

REHB 5000 Introduction to Rehabilitation

REHB 5100, 5101 Occupational Analysis and Career Counseling

REHB 5400 Introduction to Vocational Evaluation

PROGRAM 8

REQUIREMENTS HOURS REQUIREMENTS HOURS

I. General Education (45 HOURS)

6 hours (PSYCH 1113 and SOC 1113) counted in the Major

Other hours needed 39

Includes recommended Math course--MATH 1413

II. Concentration in Rehabilitation 45

__ HURES2083 Human Behavior and Social Environment
__ HURES2103 Interviewing Techniques
__ HURES2183 Fundamentals of Counseling
__ HURES2213 Introduction to Rehabilitation Counseling
__ HURES3083 Med, Soc, and Psych Aspects of Disability
__ HURES3183 Assessment and Case Management
__ HURES3203 Vocational Testing and Evaluation
__ HURES3213 Employment and Placement Techniques
__ HURES3763 Group Processes and Practice
__ HURES4443 Counseling Services
__ HURES4453 Intervention Techniques
__ HURES4946 Internship--Human Services Counseling
__ HURES4946 Internship--Human Services Counseling

III. Related Work 6

Required General Education 6

__ PSYCH1113 General Psychology (Satisfies gen ed requirements and must be completed prior to enrollment in HURES 2083Human Behav and Soc Env, HURES 2103 Interviewing Techniques, and HURES 2213 Intro to Rehab Counseling.)

__ SOC 1113 Introduction to Sociology (Satisfies gen ed requirements and must be completed prior to enrollment in HURES 2083 Human Behav and Soc Env, HURES 2103 Interviewing Techniques, and HURES 2213 Intro to Rehab Counseling.)

IV. Minor (Required) 16-21

It is recommended that the Human Services Counseling major select a minor from the Department of Human Resources or a related field.

V. Electives 13-18

VI. Total Hours Required 124

PROGRAM 9

REHAB Vocational Rehabilitation

REHAB-101 Introduction to Rehabilitation (3 cr.)□Fall and Spring□An introduction to serving people with disabilities. Philosophy, history, legislation, concepts and processes, and careers in rehabilitation services.

REHAB-102 Community Resources (3 cr.)□Fall and Spring□Role of community resources in rehabilitation.

REHAB-205 Rehabilitation Practicum (3-4 cr.)□Fall and Spring□Community based learning in application of rehabilitation concepts and principles. Includes weekly seminar for critique and skill development.□Prerequisites: take REHAB-101 minimum grade C; take REHAB-102 minimum grade C.

REHAB-230 Psychosocial Aspects of Disability (3 cr.)□**ESC** Fall and Spring□Subjective, objective, ethnic/cultural, and environmental factors related to the disability experience.□Prerequisites: take REHAB-101.

REHAB-300 Special Topics in Rehabilitation(1-2 cr.)□Special topics not available through regular courses. **R**

REHAB-300G Grantsmanship in the Helping Professions (1-2 cr.)□Summer□Explore grant writing in human service occupations and the necessity for such proposals as an element of change in society. Methods used to seek funding sources and evaluate requests for proposals.

REHAB-300N Community-Based Rehabilitation Services (1 cr.)□An examination of national priorities for community-based services designed to enhance competitive employment options for severely disabled persons.

REHAB-305 Sign Language I (3 cr.)□**COMSK LANG** Fall□Basic course in manual communication with persons who are deaf. Intensive practice in expressive and receptive communication.

REHAB-306 Sign Language II (3 cr.)□COMSK LANG Spring□Intermediate course in manual communication with persons who are deaf. American sign language, increasing sign vocabulary and communication speed.□Prerequisites: take REHAB-305.

REHAB-309 Introduction to Biofeedback (3 cr.)□Spring□Theory and applications of biofeedback in psychology, rehabilitation, medicine and education; in-depth review of the field; appropriate uses of biofeedback as a referral possibility; preparation for supervised clinical biofeedback experience.

REHAB-310 Vocational Evaluation (3 cr.)□Fall and Spring□Development of an individualized approach to conducting vocational evaluations with individuals with disabilities. Skill development in planning, selecting, and using assessment to OLS/techniques, and communicating findings.□Prerequisites: take REHAB-101 and REHAB-102.

REHAB-315 Rehabilitaiton and Criminal Justice (3 cr.)□Fall□Criminal justice system: Process and individual rights. Crime data and criminal law, policing, adjudication. Process roles of corrections and professionals. Disability: Demographics, issues and responses.

REHAB-320 Rehabilitation and Chemical Dependency (3 cr.)□Fall□Chemical use and abuse with emphasis on the rehabilitation of persons who are chemically dependent and the historical and sociological implications of drug usage.

REHAB-321 Rehabilitation of Public Offenders (3 cr.)□Spring□Emphasis on programs designed to rehabilitate persons who are public offenders and sociological issues connected with the judicial system.

REHAB-325 Rehabilitation and Sensory Disability (3 cr.)□Introduction to persons with hearing and visual impairments or both. Methods and techniques used in sensory disability rehabilitation are discussed.

REHAB-327 Psychiatric Rehabilitation (3 cr.)□Fall□Goals and processes of psychiatric rehabilitation.Knowledge and application of skills for integrating diagnosis into planning and intervention with a focus on rehabilitation services for individuals with long-term mental illness in community-based settings.□Prerequisites: take PSYC-361 and REHAB-230.

REHAB-333 Adolescent Substance Use and Abuse (2 cr.)□Summer□Major concepts, current trends, and culturally sensitive approaches in the assessment, prevention and treatment of adolescent alcohol and drug addiction.

REHAB-350 Independent Living (2 cr.)□Fall□An overview of independent living programs in this country including evolution, goals, methods of service delivery, and management of the independent living program.

REHAB-355 Rehabilitation of the Older Disabled Worker (2 cr.)□Develop awareness and understanding of older disabled workers with a focus on implementing rehabilitation planning that enables continued participation in the work force or reinsertion into it following disability.

REHAB-360 Assistive Technology (2 cr.)□Spring□Provision of technology to enhance the lives of persons with disabilities. Delivery system, legislation, and issues related to funding are examined. Specific applications in communication, computers, mobility, and workstations and other technologies are reviewed.

REHAB-361 Microcomputer Applications in Rehabilitation (2 cr.)□Applications of microcomputer technology and adaptive devices in vocational evaluation, work adjustment, placement and administration.

REHAB-365 Laboratory in Rehabilitation Technology (2 cr.)□Spring□Experience utilizing technological aids/devices developed for persons with disabilities. Modify/adapt equipment to meet specific functional requirements. Construct switch/control mechanisms for equipment. Develop prototype solutions to vocational and independent living problems.□Prerequisites: take REHAB-360.

REHAB-401 Principles and Techniques of Caseload Management (2 cr.)□Fall and Spring□Principles and techniques of implementing case load management in service of clients of state vocational rehabilitation counseling agencies or rehabilitation facilities.□Prerequisites: take REHAB-230.

REHAB-402 Management of Non-Profit Organizations (3 cr.)□Spring□Principles and practices in the operation of non-profit organizations. Comparison of how non-profit and for-profit operations are affected by organizational structures and authority, budgeting practices, sources of income, personnel issues, strategic planning and program evaluation, and marketing. Application to community agencies.

REHAB-410 Job Placement Processes (3 cr.)□Fall and Spring□Placement theory and methods used to assist people with disabilities to obtain appropriate employment.□Prerequisites: take REHAB-230.

REHAB-420 Psychological Testing People With Exceptional Needs (2-3 cr.)□Fall, Spring and Summer□Use of common psychometric tests with specific emphasis on selection, evaluation, administration, scoring, and interpretation of standardized tests for individuals who are disabled, including those from various ethnic and cultural groups.

REHAB-452 Group Processes in Rehabilitation Settings (2 cr.)□Fall□Theory and application of group processes in rehabilitation settings; direct experience as member and facilitator of a group.

REHAB-459 Workforce Development, Disability, and Socioeconomics (3 cr.)□Macro/micro influences that keep people unemployed and underemployed, including community, services, providers, employers, and families. Interface among legislative initiatives, disability, and life/work. Policy, strategies, and skills that promote effective intervention and change. Intended for professionals in the field.

REHAB-460 Rehabilitation in the Private Sector (3 cr.)□Spring□Case coordination to support maximum medical recovery and/or vocational rehabilitation of an injured person involved in insurance funded cases. Differences between public and private rehabilitation processes. Interviewing, planning, assessing transferable skills, placing in suitable work, and communicating with other involved individuals. Business practices, professional roles, and ethical issues.□Prerequisites: take REHAB-310.

REHAB-461 Forensics For the Human Service Professional (2 cr.)□Spring□Terminology and practices associated with forensic for human service professionals. Strategies and materials related to preparation for testimony and expert witness testimony in a court of law and other legal settings.

REHAB-462 Disability Management in Business and Industry (3 cr.)□Spring□Orientation to workers with disabilities in business and industry. Focus on reducing disability related costs, and the elimination of attitudinal and environmental barriers as they pertain to hiring, productivity, and retention of workers with disabilities. Governmental require- ments, linkage between business, community resources, and rehabilitation.

REHAB-470 Work Adjustment Services (2-3 cr.)□Fall and Summer□Principles and procedures of adjustment services. Emphasis upon the change and improvement of behavior. Supervised practical experience in interviewing, behavior observation, individual work adjustment planning, lesson plan development and report writing.□Prerequisites: take REHAB-310.

REHAB-480 Advanced Rehabilitation Practicum (2-6 cr.)□Fall and Spring□Advanced experience in service delivery to persons with disabilities in varied agency/service settings related to student's designated rehabilitation concentration. Instructor's consent required. **R**

REHAB-482 Sexuality and Disability (2 cr.)□Spring
Investigate sexuality as an integral part of the disability experience. Explore programs, techniques and personal biases in relation to sexuality of persons with disabilities.

REHAB-483 Vocational Counseling Issues (2 cr.)□Summer□Theoretical and applied approaches to vocational counseling and current research in vocational choice and career development as related to vocational counseling.

REHAB-488 Developing Collaborative Partnerships (3 cr.)□Fall□Development of professional relationships that are characterized by collaboration and respect for the consumer or student. Role of team members including human service professionals, consumer student, family members, school personnel, and community organization staff in collaborative decision making. Enhanced service delivery responsiveness through application of collaborative principles.

PROGRAM 10

Courses (hours):

PSYC 210	General Psychology	3 Hours
PSYC 274	Elementary Statistics	3 Hours
REHB 340	Introduction to Rehab.	3 Hours
PSYC 360	Psychological Testing	3 Hours
REHB 361	Rehabilitation Evaluation	3 Hours
REHB 372	Occupational Information	3 Hours
REHB 390	Physical Aspects	3 Hours
REHB 391	Psychosocial Aspects	3 Hours
REHB 410	Community Resources	3 Hours
REHB 415	Rehabilitation Research	4 Hours
REHB 493	Special Problems	3 Hours
REHB 481	Principles of Counseling	3 Hours
REHB 485	App. Behavior Analysis	3 Hours
REHB 300	Pre-Field Experience	3 Hours
REHB 301	Field Experience I	3 Hours
REHB 302	Field Experience II	3 Hours
	Elective from designated disciplines	9 Hours

PROGRAM 11

*CN ED 403 FOUNDATIONS OF GUIDANCE AND COUNSELING PROCESSES (3) Factors in personal choicemaking; rationale for and elements of guidance and counseling processes in school, college, and rehabilitation settings. Prerequisite: 6 credits in psychology and/or sociology.

*REHAB 408 INTRODUCTION TO VOCATIONAL REHABILITATION (3) Disability, public and private rehabilitation agencies, case study and handling, resources for training; observations in rehabilitation settings. Prerequisite: 6 credits in psychology and/or sociology.

*REHAB 409 MEDICAL INFORMATION FOR COUNSELORS (3) Common disabling illnesses, injuries, and congenital defects; their symptomatology, prognosis, and treatment; implications for personal, social, and vocational adjustment. Prerequisite: 6 credits in psychology and/or sociology.

*REHAB 412 PROFESSIONAL PREPARATION IN REHABILITATION SETTINGS (3) Practices related to evaluation and integration of facilities and services appropriate to vocational rehabilitation; internship selection and professional preparation. Prerequisite or concurrent: REHAB 408. This course is only offered in the spring

*REHAB 413W REHABILITATION CASE RECORDING AND MANAGEMENT (3) Principles and practices of obtaining, recording, evaluating, and utilizing case data in vocational rehabilitation planning; implementation of rehabilitation plans. Prerequisite or concurrent: REHAB 412.
*REHAB 425 ASSESSMENTS AND TESTS IN REHABILITATION PRACTICE (3) Overview of the nature and use of tests in rehabilitation, with particular focus on vocational rehabilitation and independent living. Prerequisite or concurrent: 3 credits in statistics.

*REHAB 495A FIELD WORK IN VOCATIONAL REHABILITATION (15) Full-time practicum in agencies and institutions providing educational-vocational and related services essential to employability and/or employment. Prerequisite: students must have completed all other required coursework before they can begin their internship; a grade of C or higher in all specified and professional courses.

Additional Courses (27-29 credits): PSY 213 (GS), HD FS 239 (GS), or EDPSY 10

Select 3-4 credits from BI SC 1-4 (GN), or BIOL 110 (GN)

ANTH 21 (GN) or BIOL 33 (GN)

EDTHP 115 or other EDTHP selection

REHAB 425 or EDPSY 450

EDPSY 101 (GQ) or STAT 200 (GQ)

PSY 412 or 437

Select 9 credits from ADMJ, BB H, HD FS, KINES, PSY, or SOC

CN ED 404 & 410 - Recommended electives for students requiring group work for chemical dependency and mental health fields.

PROGRAM 12

Required Freshman/Sophomore year supporting courses
ZYWL 2500 Human Anatomy & Physiology I (4)
ZYWL 2510 Human Anatomy & Physiology II (4)
STAT 2010 Social Behavioral Science (3)
PSYC 3570 Theories of Personality (3)
COM 100 Speech Communications (3)

Junior Year (Fall Semester) 14–17 hours
RSED 3020 Introduction to Rehabilitation Studies (4)
RSED 5010 Medical Aspects of Disability (3)
RSED 5200 Vocational Evaluation in Rehabilitation (3)
RSED 4910 Practicum Rehabilitation Studies I & II (2)*
and/or Required Core Courses or Electives (3-6)**

Junior Year (Spring Semester) 16 hours
RSED 3120 Assessment in Rehabilitation Studies (3)
RSED 5020 Psychosocial Aspects of Disability (3)
RSED 5210 Occupational Information (3SH)
RSED 5230 Rehabilitation Assistive Technology (3)
RSED 4910 Practicum Rehab Studies III (1)*
and/or Required Core Courses or Electives (3)**

Senior Year (Fall Semester) 16 hours
RSED 4120 Independent Living Services in Rehabilitation (3)
RSED 4130 Ethical Practices in Rehabilitation Studies (3)
RSED 5170 Transition from School to Community (3)
RSED 5220 Career and Placement Services (3)
Practicum Rehab Studies IV (1)*
and/or Required Core Courses or Electives (3)**

Senior Year (Spring Semester) 12–15 hours

RSED 4100 Professional Communication in Rehabilitation Studies (3)
RSED 4920 Internship in Rehabilitation Services (9)*
and/or Required Core Courses or Electives (3)**

*Practica and Internship are offered each academic term including summer. **Electives must be approved by the student's academic advisor. Some university core courses and departmental required courses and electives are offered during the summer semester.

PROGRAM 13

Baccalaureate Degree in Rehabilitation Services

Sequencing of Courses
Fall

REHAB 4602 Rehabilitation Programs and Community Resources	**3**
REHAB 4611 Interpersonal Helping and Human Relationship Skills	**3**
REHAB 4628 Testing and Measurement in Rehabilitation	**3**
REHAB 5601 Foundations of Rehabilitation Counseling	**3**
REHAB 5602 Medical Aspects of Disability	**3**
	15

Spring

REHAB 4604 Case Management and Individualized Rehabilitation Planning	**3**
REHAB 4613 Fieldwork	**3**
REHAB 5603 Psychosocial and Cultural Aspects of Disability	**3**
REHAB 5611 Foundations of Rehabilitation Counseling II	**3**
REHAB 5653 Human Behavior Management	**3**
	15

Summer

REHAB 4630 Undergraduate Internship	**12**
REHAB 5658 Substance Abuse in Rehabilitation	**3**
	15

Total Hours	**45**

IV. PROGRAM DESCRIPTION Part B. --Course Descriptions

REHAB 4602. Rehabilitation Programs and Community Resources 3 cr.
Detailed review of the variety of rehabilitation programs and their interface with community resource agencies including counseling, adjustment, training and evaluation programs in the various settings in which these programs are generally found. Emphasis will be placed on program descriptions, programmatic goals, and methods of achieving goals. Students will conduct several site-studies at rehabilitation agencies.

REHAB 4604. Case Management and Individual Rehabilitation Planning 3 cr.
Introduction to the case management process, such as advocacy, case-finding, case-recording, caseload management as well as funding and routine service coordination. This course will also acquaint the student with the planning process as it relates to rehabilitation goals and objectives. Students will become acquainted with the process of problem analysis, long range and short-term planning, and the provision of services in order to reach rehabilitation objectives.

REHAB 4611. Interpersonal Helping and Human Relationship Skills 3 cr.
This course focuses on the skills and issues involved in the helping process. Interpersonal helping and human relations skills include effective communication skills, i.e., the ability to hear and understand verbal messages, perceive nonverbal messages, listen responsively, and empathic understanding and responding. Development of these skills will help students progress through the initial stage of helping during which rapport and trust develops (working alliance) the second stage which is definition and clarification of the problem, and empowering the client to act. Issues that are addressed during the helping process include value clarification, resistance, missed opportunity and unused potential, and self-efficacy.

REHAB 4613. **Fieldwork 3 cr.**
Designed to give the student first-hand knowledge of the purpose, function, services and clientele of an agency. Students will be on-site for 12 hours per week during the spring semester in rehabilitation settings and participate in scheduled seminars. All fieldwork experiences are unpaid. Permission of Department is required. **P/F grading.**

REHAB 4628. Testing and Measurement in Rehabilitation 3 cr.
Introductory survey of methods and techniques utilized in vocational evaluation and work adjustment, including basic testing concepts, the relationship of testing to service planning and delivery, qualifications to administer various assessment measures, and understanding and interpreting assessment results.

REHAB 4630. Undergraduate Internship 12 cr.
On-site experiences consistent with BS level training. All internships are unpaid. Students are required to complete 40 hours of internship in a rehabilitation setting involving the following features:

1. specific learning objectives agreed upon by faculty supervisor, on-site supervisor, and student;
2. periodic meetings with the faculty supervisor as well as the on-site supervisor; and
3. an evaluation of the student by the faculty supervisor and on-site supervisor, as well as a self-evaluation by the student. Permission of Department is required. **P/F grading**

REHAB 5601. Foundations of Rehabilitation Counseling 3 cr.
Students learn the legislative, historical, and philosophical roots of rehabilitation. Topics covered include federal and local mandates for the rehabilitation of individuals with disabilities, independent living concepts, and the basic principles of human services and helping techniques. A comprehensive review of the variety of rehabilitation programs across the public, private non-profit, and proprietary settings is provided. Emphasis is placed on ethical decision-making related to working with people who have disabilities and the development of a case management approach to providing services. Students make field site visits to various rehabilitation settings for practical exposure to actual functioning of rehabilitation systems and the disability groups they serve.

REHAB 5602. Medical Aspects of Disability 3 cr.
Knowledge and understanding of the medical and functional implications of a wide variety of disabilities are acquired. Curriculum components include learning medical terminology and the use of medical information for facilitating the vocational rehabilitation and independent living of people with physical, sensory, and cognitive disabilities. The medical and psychological needs as well as individual and community resources typically associated with treating and managing these conditions are reviewed. Emphasis is placed on assessing, discussing and resolving the personal, professional, and environmental challenges each disability presents.

REHAB 5603. Psychosocial and Cultural Aspects of Disability 3 cr.
Students acquire knowledge and understanding of the myriad psychosocial facets of the status and experience of disability. Curriculum components include identification and discussion of psychological and sociological issues associated with disability and their impact on vocational rehabilitation, community living and social perception. The focus of the course is analysis of the total situation of living with a disability, including: environmental and attitudinal barriers and resources; multicultural and other counseling process issues; personal reflection about one's attitudes and motivations as a helping professional; educational, vocational and socio-economic opportunities; adjustment to disability and interpersonal interaction; influences of the family, popular culture, technology, and the consumer empowerment movement.

REHAB 5611. Foundations of Rehabilitation Counseling II. 3 cr.
This course focuses on the relationship between disability and the legal and insurance systems, the similarities and differences between traditional rehabilitation practices and the private-for-profit setting. Students learn strategies for rehabilitation needs assessment and to apply techniques of job and labor market analysis, job development, placement and supported employment, and the development of life care planning services for people with catastrophic injuries or severe disabilities. In addition, the course focuses

on issues that necessitate careful ethical consideration across the various roles and work settings both in the public and private-for-profit sectors.

REHAB 5653. Human Behavior Management 3 cr.
This course introduces the principles of human behavior and techniques for managing behavioral change in a variety of rehabilitation settings. Students learn to target socially significant behaviors, to select behavioral strategies to improve targeted behaviors and to demonstrate a reliable relationship between the behavior change strategy and the improved behavior.

REHAB 5658. Substance Abuse in Rehabilitation. 3 cr.
This course explores rehabilitation issues of a variety of substance abuse-related disabilities. Emphasis is placed on the 8-core competencies that rehabilitation counselors would practice in a substance abuse treatment setting. Each counseling core competency is highlighted with an examination of various theories and types of substance abuse counseling interventions. Other topics covered include the psychopharmacology of commonly abused drugs and issues accompanying a co-existing substance related disability and other disability. Lastly, policy issues pertaining to the services provided to individuals with substance abuse-related disabilities are examined.

PROGRAM 14

Required Courses	
*REHA 201 Introduction to Diversity	3
REHA 215 Psychosocial Aspects of Disability	3
REHA 301 Principles of Counseling and Group Theory	3
HS/REHA 345 Legal, Ethical & Professional Issues in the Human Services	3
REHA 406 Assessment and Case Conceptualization in Rehabilitation and Human Services	3
REHA 453 Case Management and Community Resources	3
REHA 490 Internship: Rehabilitation Agency	6
REHA 490 Internship: Community Agency	6
Total Required Course credits	**30**

Additional Required Courses for Extended Major	
Additional required courses, totaling 15 semester credits, must be selected from the following list in consultation with the faculty advisor:	
HS 335 Introduction to Counseling	3
REHA 418 Counseling for Loss and Bereavement	3
REHA 425 Psychiatric Rehabilitation	3
SPED 375 Teaching, Learning and Behavior in Schools	3
SPED 405 Assessment of Students with Disabilities	3
Total Additional Required Credits	**15**

*** REHA 201 Introduction to Diversity 3 cr.** Introduces multicultural knowledge, skills, awareness, and attitudes. The course focuses on perspectives for understanding and interacting with diverse groups, and will examine theoretical and research literature concerning cultural characteristics and differences related to disability, gender, race/ethnicity, sexual orientation, religion, geography, advanced aging, and social class. Students will be provided the opportunity to explore scholarly as well as practical resources for interacting with diverse individuals and families.

REHA 215 Psychosocial Aspects of Disability 3 cr. Provides overall knowledge of psychological and social factors affecting adjustment to disability. Examines the unique characteristics of specific disability groups and their implications for intervention.

REHA 290 Internship V 1-6 cr. Prerequisite: An application for field experience is required with prior approval from the field placement supervisor. Provides freshmen and sophomores with a supervised field experience in an appropriate setting specifically related to the students' major/minor area. In-field contact time is 45 hours per semester credit.

REHA 291 Independent Study V 1-3 cr. Provides an experience for students of superior academic standing to explore material not covered by regular college courses.

REHA 292 Seminar V 1-3 cr. Provides students an opportunity to intensively investigate topics pertinent to the field of Rehabilitation.

REHA 296 Cooperative Education/Internship 3 cr. Prerequisite: Permission of Instructor. Provides university credit for a sophomore level field experience in the area of Rehabilitation and Related Services supervised by faculty. Learning agreement must be completed prior to registration.

REHA 301 Principles of Counseling and Group Theory 3 cr. Prerequisite: upper division standing. Develops an understanding of group process, provides an introduction to conducting interviews and skills in the helping process, and emphasizes group membership skills for rehabilitation clients.

REHA 303 Assistive Technology Applications Across the Lifespan 3 cr. Prerequisite: REHA 201. Examines applications of Assistive Technology (AT) to maintain or increase levels of functioning and independence for individuals across the life span. The spectrum of low to high technology options in several life domain areas for children and adults with disabilities, those with chronic illness, and the aging population will be explored. Assessment, public policy, universal design, and multicultural considerations are also addressed.

REHA/HS 345 Legal, Ethical and Professional Issues in the Human Services 3 cr. Prerequisites: HS 201 or REHA 201. Presents a review of the current and historical legal decisions which effect client rights and service provisions. Legal and ethical issues of due process and appropriate treatment in the least restrictive settings, the right to treatment and other significant legal ramifications relative to client advocacy and professional responsibility are discussed. Students are exposed to various professional standards in Human Services. Similarly, legal and professional issues such as confidentiality and privileged communication are discussed.

REHA 406 Assessment and Case Conceptualization in Rehabilitation and Human Services 3 cr. Applies empirical principles to appraisal of client characteristics, needs, and potential. Provides practice with assessment data recording, interpretation, and application to an overall view of a case.

REHA 418 Counseling for Loss and Bereavement 3 cr. Prerequisite: consent of instructor. Examines the process of adjustment to losses of many different kinds that frequently occur in the lives of consumers serviced by counselors and human service agencies. Course will discuss counseling techniques and strategies to facilitate successful adjustment to loss.

REHA 425 Psychiatric Rehabilitation 3 cr. Prerequisite: upper division standing. Provides an orientation to the field of psychiatric rehabilitation. Includes historical antecedents, philosophical and traditional connections with the field of rehabilitation counseling, assessment, planning and service delivery methods for those intending to work in rehabilitation focused programs serving persons with psychiatric disabilities.

REHA 453 Case Management and Community Resources 3 cr. Prerequisite: upper division standing. Covers methods for effectively managing a case and caseload. Areas covered include writing a case history, treatment planning, and writing case notes. Aids counselors serving consumers, determining appropriate community resources, and making a proper referral.

REHA 458 Community Advocacy for Persons with Disabilities 1 cr. R-3. Provides students with experience in providing advocacy for individuals with disabilities.

REHA 490 Internship: Rehabilitation Agency 6 cr. Prerequisite: upper division standing. Provides a supervised field experience within a Rehabilitation or allied agency setting. An application is required with prior approval needed for registration. In-field contact time is 45 hours per semester credit.

REHA 490 Internship: Community Agency 6 cr. Prerequisite: upper division standing. Provides a supervised field experience within a community agency which provides people services. An application is required with prior approval needed for registration. In-field contact time is 45 hours per semester credit.

REHA 491 Independent Study V 1-3 cr. Provides an experience for students of superior academic standing to explore material not covered by regular college courses.

REHA 492 Seminar V 1-3 cr. Investigates special topics pertinent to the area of Health and Human Services.

REHA 493 Workshop V 1-3 cr. Provides an opportunity for experimental study in an area of Health and Human Services.

REHA 496 Cooperative Education/Internship 3 cr. Prerequisite: Permission of Instructor. Provides university credit for a junior or senior level field experience in the area of Rehabilitation and Related Services supervised by faculty. Learning agreement must be completed prior to registration.

REHA 497 Capstone in Chemical Dependency Rehabilitation 2 cr. Prerequisite: permission of instructor. Reviews competencies and knowledge essential to the field of chemical dependency rehabilitation. Examines current trends and issues in the field as evidenced by periodicals and other literature. Requires integration and synthesis of knowledge and experiences developed through the program. The course will prepare students for the Montana chemical dependency counseling licensure examination.

APPENDIX J

ASSOCIATED GRADUATE DEGREE PROGRAM TITLES

ASSOCIATED GRADUATE DEGREE PROGRAM TITLES

Doctorate degree level

Counseling Psychology

Ph.D- Rehabilitation counselor education

Ph.D. in Counseling Psychology

Ph.D. in Counselor Education (CACREP approved); Ph.D. in Counseling Psychology (APA-approved)

Ph.D. in Rehabilitation

Master degree level

Rehabilitation Counseling general + specialty in psychiatric

Rehabilitation Counseling/ Community Counseling

Rehabilitation Counseling, Vocational Evaluation, Mental Health Counseling

Rehabilitation Counseling

Rehabilitation Counseling and Administration

Rehabilitation Counseling, Vocational Evaluation, Substance Abuse and Clinical Counseling

Rehabilitation Counseling, School Counseling

MS in Rehabilitation and Mental Health Counseling

Master of Arts in Counseling with an emphasis in Rehabilitation

APPENDIX K

SYSTEMS CHANGE, LEADERSHIP, AND ADVOCACY MODEL

Systems Change, Leadership and Advocacy

Values	Issues	Life Roles	Research/Outreach
	Living in the Community	Child/Youth	I. Targets for Improving Services
		Student	Financial Well Being
	Education		Supports/Independence
		Leisure/Social	Full Service
	Employment		
Independence		Worker	
	Housing		
Productivity		Citizen	
	Transportation		II. Targets for Improving QoL
Inclusion		Spouse	Availability of Work
	Health Care		Social Support Networks
		Parent	Satisfaction with Life Roles
Community Living		Involvement in Real Life Roles	
		Homemaker	
		Retiree	

Pertinent Legislation

1987 DD Bill of Rights Act (as amended); 1973 Rehabilitation Act (as amended); PL 94-142 IDEA (as amended); The Technology Related Assistance Act of 1988; 1990 ADA; and 1999 Workforce Investment Act and The Ticket to Work and Work Incentives Act.