REHABILITATION OF DEAF-BLIND PERSONS

EDWIN K. HAMMER, Ph.D., Project Director, South Central Regional Center for Services to Deaf-Blind Children.

Problems that exist in education of deaf-blind persons are dwarfed by those problems which arise when one tries to develop rehabilitation services. Rehabilitation services have been defined by Bauman (1) as being oriented toward providing the individual not only with vocational independence but also with some degree of social and emotional independence, and with the ability to manage his own affairs. If the deaf-blind person is to move toward some level of independent functioning, services must be available to help him achieve this goal.

Just as the educational field had to change its methods of delivery of services to meet the needs of the larger population of deaf-blind persons, so rehabilitation services must adjust to the requirements of this expanded group. The traditional approach to rehabilitation services has been based upon a medical/treatment model of:

1. Diagnosis.................................... Disability Determination
2. Prognosis .... Eligibility for Services
3. Treatment .... Vocational Training
4. Cure .... Closure

Deaf-blind persons, as well as many other multihandicapped individuals, do not fit this model of service.

Disability determination (diagnosis) is often impossible to describe in terms of acuity scores. Other factors which detract from the efficiency of describing the problem in terms of disability include:lack of professional expertise to define the problem, social/cultural/economic components of the client's life which may dominate the definition of the problem, and degrees of function which cannot be defined in terms of traditional evaluations. All of these tend to cloud the path to development of effective services for a deaf-blind person.

Not only is eligibility for services (prognosis) dependent upon restrictive or punitive regulations unrelated to the needs of the client, but also upon such factors as the ability of the client to communicate with rehabilitation workers; the receptivity of the counselor and the community to the idea of undertaking rehabilitation services for so difficult a case; and past experiences in education, training, or habilitation which make the client unsuitable to be considered for further services.

Training (treatment) in the medical method of rehabilitation services has been single-goal oriented. It has treated the "movement toward independence" by the client as an underlying assumption resulting from specific training rather than as the primary goal.

Closure (cure), in the traditional sense, has little meaning when applied to the deaf-blind client. Even when job placement happens, the client continues to need supportive services. Cases must be re-opened, and new plans developed. Even though it may seem to be an overly charged emotional statement, closure often represents the achievement of frustration tolerance by the counselor or client rather than attainment of a really satisfactory goal.

Instead of the medical/treatment model, a different approach to rehabilitation services for deaf-blind persons would seem to be more realistic (and productive). This approach would be behaviorally based, with the goal of moving the person toward a relatively high level of independent functioning with substantially reduced dependence upon help. In this model, disability determination would rely upon the diagnostic information which established that the client would require long-term case management, and that, unless services were developed, he would become even more dependent upon social and community resources. The behavioral model may be compared with the treatment model as follows:

1. Disability Determination......... Recognition of long-term need for services
2. Eligibility for Services .. Elaboration of possible services (long and short term)
3. Training .... Development of sequential plan(s) to reduce dependence
4. Closure........... Monitoring of progress in attaining level of independence

The basic departure in the behavioral model would be in establishment of a sequential plan to reduce dependence and foster independence. In the behavioral model, training would become an intervention through sequentially arranged steps which would take into account the total picture of the client's needs. Using a behavioral objective approach, each step would be outlined so that the rehabilitation plan of services would become a profile of organized tasks leading to greater total independence, rather than a single job skill with ancillary or implied independence.

In this manner, closure or cure, as envisioned under the medical/treatment model, would not be an all-or-nothing experience. Rather, the counselor would be able to monitor the client's progress, reporting, for example, that he had achieved 4 of 10 objectives of the rehabilitation plan, or 40% of the movement toward rehabilitation and independence. Such a behavioral approach would bring into perspective the rehabilitation problems of the deaf-blind persons (or the chronically unemployed, low-achieving, or other categories which the closure/cure component of the traditional treatment cannot handle in a realistic manner). It would allow the counselor and client to judge at any time exactly where the client is in his movement toward independence.

Where Does Rehabilitation Start?

If a behavioral approach to rehabilitation can be developed for deaf-blind persons, several dilemmas may be reduced to a more manageable (and realistic) level for resolution. First of all, the question of when rehabilitation services can begin is no longer based on the client's chronological age. Rehabilitation services begin, in the behavioral model, at the time of onset of disabilities, which may mean at birth. At this point, rehabilitation workers recognize (a) that a client needing services will become the responsibility of Vocational Rehabilitation, (b) that planning for use of funds and personnel will become more efficient as records reveal the numbers of new clients nearing adulthood and the types of disabilities this population present, (c) that the rehabilitation services program will no longer have to rely upon itself to provide all services since training, evaluation, and physical restoration may be begun at the onset of the disability.

What services would rehabilitation provide in a behavioral model? Coordination would become a principal function of the rehabilitation counselor. Time and effort

would be expended to develop local funding sources and use of existing community resources. An illustration of such a service may be found in the program for visually handicapped children of the Texas Commission for the Blind. This state agency has caseworkers throughout Texas who search out children needing physical restoration and educational service. The program is for children from birth to ten years of age. While state funds are used for physical restoration, caseworkers actively pursue support from civic clubs, family health insurance programs, school systems, and other community resources to provide needed services for visually impaired children. Caseworkers for visually handicapped children must know of existing federally funded programs which could aid the child's habilitation program — social security benefits, community welfare programs, veterans' benefits, service-related families' benefits, health delivery programs. Through maximum use of all these resources, caseworkers for visually handicapped children were able in 1972 (8) to provide services to 3,152 Texas children. Of these, 548 were helped to the extent that visual problems no longer impeded their development. Surely this type of preventive effort indicates how coordination in the beginning can reduce rehabilitation costs and efforts in later years.

Not only are there obvious benefits from the prevention of disabling conditions, but also children who will need rehabilitation services throughout their lives are known to the agency from the time of initial casefinding. This knowledge allows for planning staff efforts, and programming for the future. As a visually handicapped child nears the age for vocational planning and vocational training, a detailed prognosis of potential employment abilities and educational needs has been developed. Community resources have been alerted to the existence of the client. Parents have received counseling along with the client as to what may be expected and achieved. Rehabilitation becomes just one more step toward independence instead of being a new experience and a new effort to find appropriate service for the visually impaired client.

A second service which rehabilitation can provide through a behavioral model is that of long-term case management. Some clients — such as multihandicapped, deaf-blind persons — will never achieve total independence. Many times these clients are not accepted for services because a vocational goal cannot be defined. If the hard-to-serve client is accepted for services, it is thought that closure must be the goal, and the counselor and client become frustrated as the case is closed, re-opened, and closed in a pattern of alternating hope and despair. Management of difficult cases, such as deaf-blind persons, must include developing community resources for sheltered work settings, providing residential facilities with supervision of clients, and working out meaningful home programs for clients who will never be able to enter competitive or sheltered employment.

Case management in the behavioral model also recognizes that rehabilitation will be a life-long need of the client. Permanent closure may not be achieved in the traditional sense; however, if reduction of dependence can become the target, movement toward independence will be a reportable achievement. In this sense, reportable means that vocational rehabilitation has been able to show that for each dollar spent in vocational rehabilitation services, there has been a several-dollar or greater return in revenue by the employed, rehabilitated worker. If percent of movement toward independence may be compared on a dollar basis to the costs of total care in institutions, this may also provide evidence of the need for expenditure of funds on difficult-to-serve clients. In other words, it seems to be a question, not of *whether* money will be spent in providing services to difficult cases, but of *how* these funds will be used.

One further service that rehabilitation can provide which will aid the deaf-blind client to become independent is that of training and informing other professionals. In

a survey of Texas rehabilitation service for deaf-blind persons (5), a number of agencies were asked what they would need to develop a vocational or prevocational training program for deaf-blind clients. Most requested were staff persons to develop communication skills, specifically in manual language. These agencies already had programs to provide vocational training to blind or multihandicapped persons, and many of them accepted deaf or hearing-impaired clients. Most of the agencies had accepted a deaf-blind client at one time, or had deaf-blind clients currently enrolled. These agencies did not find the complex problems of the deaf-blind clients so greatly different that they could not be integrated into some phase of the existing programs. The agencies did feel, however, that their staffs needed extra training in learning to communicate with the deaf-blind clients. Modifications or minor adjustments, such as staff development, could be made to accommodate deaf-blind clients. If the professional rehabilitation workers for deaf-blind adults can assist in training others in such skills as communication, local resources for this group can be expanded. A spirit of willingness rather than the expected reluctance to provide services to deaf-blind clients has been demonstrated by the various agencies surveyed.

What Are the Prospects for Success?

At present, the prospect for success in the rehabilitation of deaf-blind adults seems negligible. Those who conduct vocational rehabilitation programs in the various states do not seem to be aware that children born during the rubella epidemic are now eight to ten years old. This means that if services are to be available for this population of deaf-blind persons when they need them, pre-vocational training programs are imperative now, and planning for vocational services has a very short time to get under way.

The National Center will provide a valuable resource by training 50 deaf-blind persons each year, and will be able to provide short-term training to professional workers to teach them more about deaf-blind persons. However, the Center will not be able actually to serve the large numbers of deaf-blind persons who have been identified at the present time. This means that local resources must be developed, and that statewide services for deaf-blind persons must be coordinated.

Success also depends upon institutions and individuals that serve the deaf extending their missions to include the deaf-blind. Someone should conduct a study of why programs for deaf-blind persons have traditionally been conducted in facilities for the blind. Are deaf-blind persons so routinely served in programs for the deaf that this is taken as a matter of course? Are there attitudes among those working with deaf persons that cause the multihandicapped deaf person — including deaf-blind individuals — to be ignored or denied?

It may be of interest to note that of the ten regional centers for deaf-blind children in the country, only one is primarily concerned with the education of deaf children; the other centers are in facilities for blind children or in state departments for exceptional children. The National Center is sponsored by a facility for the blind.

The professional workers who serve deaf adults have much to offer toward success of rehabilitation of deaf-blind persons. It will require a commitment from individual workers, and state and national leaders, to achieve this success. Time is a critical factor, and the time to begin is now.

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