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Rehabilitation Services for Deaf-Blind Individuals: Need for Planning

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REHABILITATION SERVICES FOR DEAF-BLIND INDIVIDUALS: NEED FOR PLANNING

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Rehabilitation services have been described as being oriented toward providing the individual independence—not only vocational independence, but also, some degree of social and emotional independence, and independence in terms of total management of personal affairs. If the deaf-blind person is to move toward some level of independent living, planning must begin early in the client's life and be based upon a continuum of services leading to a level of independent function. Therefore, it does not seem to be a question of whether rehabilitation services for deaf-blind persons will be needed in the United States, but rather a question of how soon these services will be needed, where they will be made available, and by whom these services will be provided.

PROCESS TOWARD INDEPENDENCE

The need for rehabilitation planning begins with the onset of a disabling condition. Planning must begin as soon as a condition is recognized which could lead to eventual handicaps. The first area centers on the home and family. This involves helping parents and siblings adjust to having the impaired person as a part of the family unit. In the early childhood education setting, skills assessment should begin with the concept in mind that independent living must be based upon potential abilities and upon skills which can be developed over a long range intervention program. It should not be considered premature to begin looking at the very young impaired child in terms of independent living skills, and thus in terms of eventual vocational rehabilitation. In the school setting, the information gathered in the early childhood setting, the attitudes of the family, and the plans for independent living can form the core of educational activities for the impaired child. From this setting, an introduction to vocational settings may

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begin during the pre-teen years to familiarize the child with work stations and various opportunities which might be available to utilize his potential abilities. These prevocational skills seem to require concentrated efforts if vocational placement is to be achieved. This actualization process of vocational rehabilitation does not occur in clear cut stages but seems to evolve over a long period of time and requires flexible programming if the child is to attain some level of independent living.

POPULATION NEEDING PLANNING AND SERVICES

Figure 1 presents types of programs needed and numbers of known deaf-blind persons in the United States as of June, 1974. Planning must be based upon the fact that as this population grows older, more deaf-blind persons will be needing vocational rehabilitation services in this country. By 1977, few deaf-blind children will require home programs or early childhood education programs (Figure 2). More children will be in need of school programs, which should include prevocational and vocational services. By

LEVELS OF FUNCTION AVAILABLE TO THE DEAF-BLIND CHILD THROUGH PROGRAMMING

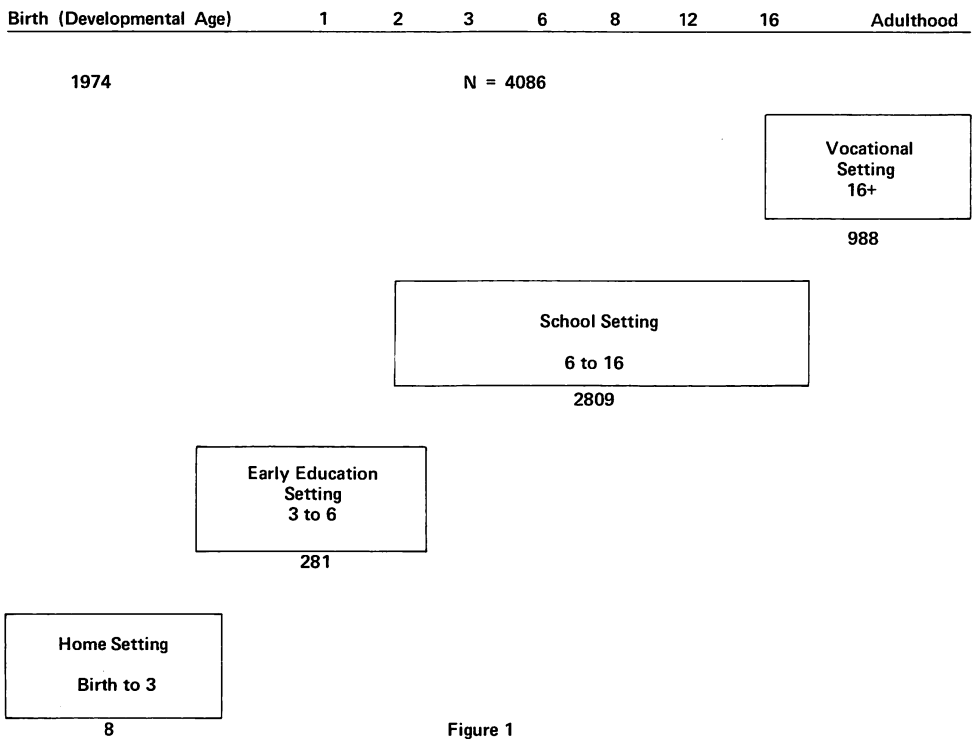

Figure 1

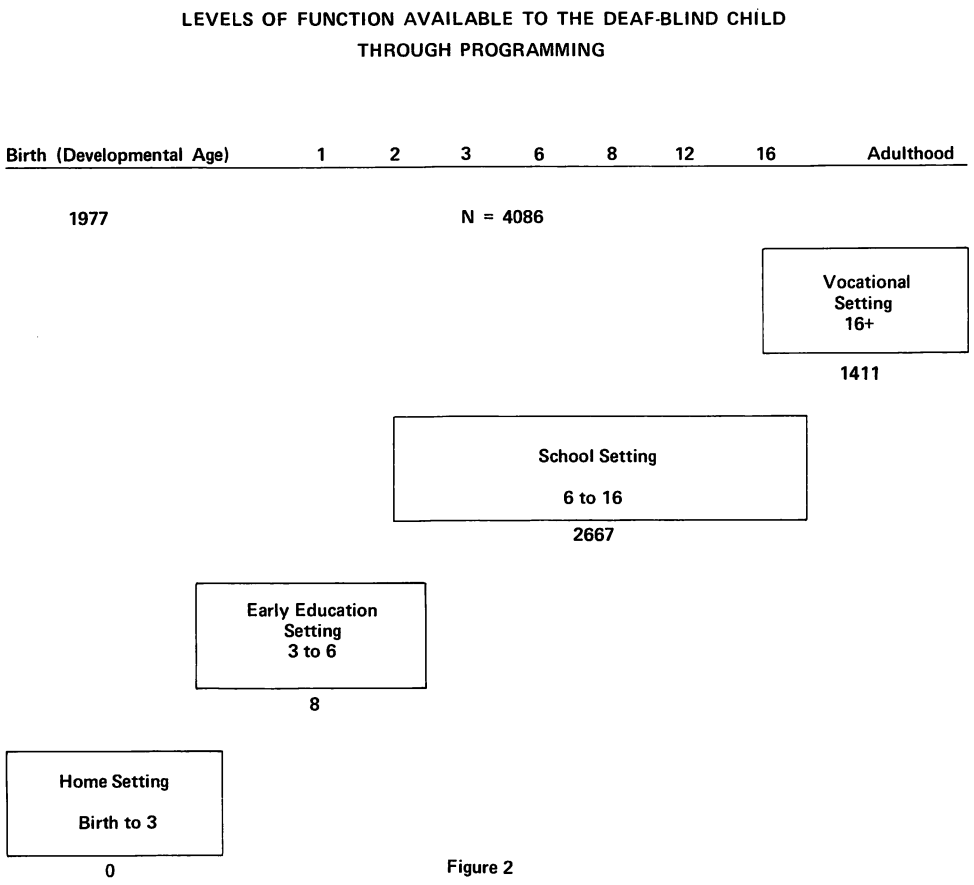

Figure 2

1980, the needs of the population will have shifted once again (see Figure 3). Compared to 1977, there will be a minimum number of very young children needing programs, if the rubella vaccine continues to prove its effectiveness, and there will be greater emphasis upon prevocational and vocational services. By 1980, for instance, there will be an estimated 2841 deaf-blind adolescents and young adults in the United States.

CATEGORIES OF THE DEAF-BLIND POPULATION

The population of deaf-blind individuals needing rehabilitation services may be divided into four categories.

1. Congenitally deaf-blind: in this area, the rubella population has increased the number of deaf-blind children congenitally impaired.
2. Adventitiously deaf-blind: includes post-meningitis cases where children had normal development and became impaired during childhood.

3. Usher's Syndrome: a type of adventitiously acquired disability characterized by congenital deafness and progressive loss of vision through retinitis pigmentosa.
4. Geriatric deaf-blind: usually found in deaf persons who are losing their vision or in blind people who are losing their hearing as a result of the aging process.

Due to the rubella epidemic of 1963-65, the largest known group of deaf-blind persons are the congenitally impaired group ranging in age from 9 to 12 years. Most programs have had to give priority to this group in developing services, thus most programs which have been developed in the past few years have been preschool level programs. For the congenitally impaired group, home programs which center on activities of daily living form the necessary services at this time.

For the adventitiously impaired group services in mobility training and communications skills are needed. For the Usher's Syndrome group, it seems important to plan for additional services which will build visual memory and imagery so that clients can learn to use their gradually weakening visual channels. It seems important to begin planning vocational programs for this group very early. For the smaller group who acquire visual and hearing

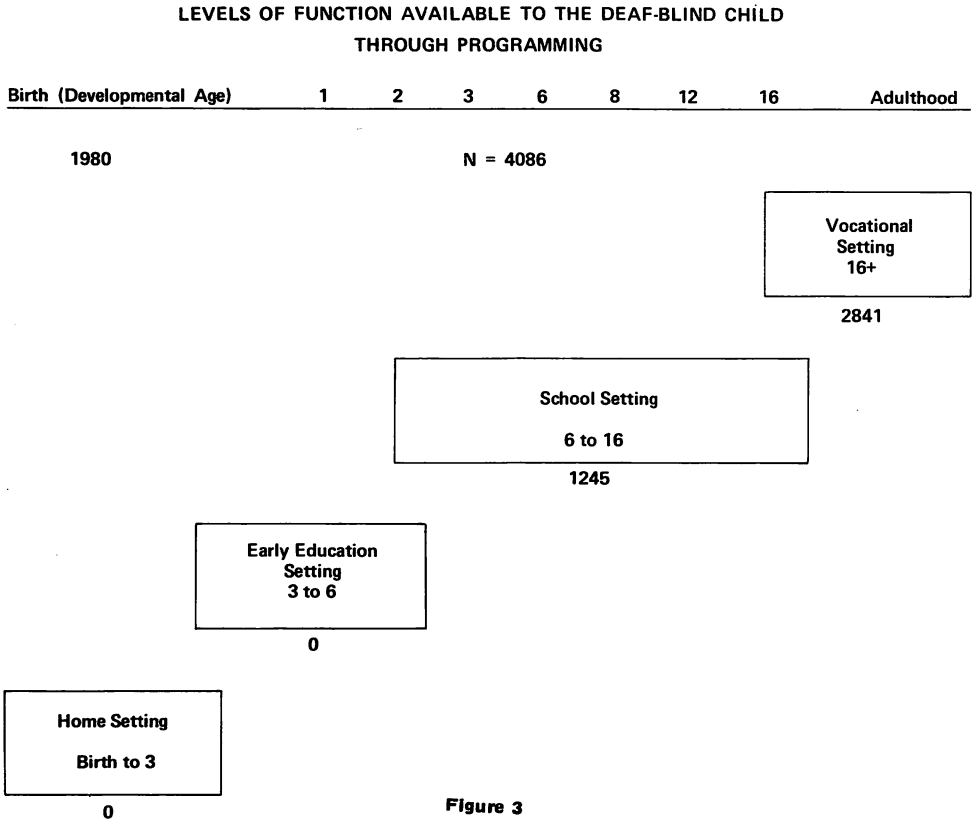

Figure 3

losses through accidents or trauma due to infections, personal and social adjustment training would also be required.

There seems to be an ever growing number of geriatric deaf-blind persons. While this group may not need vocational training, per se, there is a need for training in communication and mobility. There is a need for personal counseling and for adaptation of homemaking skills for this group. Among the four groups of deaf-blind people in need of prevocational and vocational training, there is as much diversity and as many degrees and kinds of problems as there are individuals.

Current incidence studies (Dantona, 1974) indicate that there are 4086 individuals who are deaf and blind in the United States. Within the country are many agencies and individuals concerned about meeting the needs of the deaf-blind population. Thus far, most efforts have been toward meeting educational needs. It is now time to address the problem which deaf-blind individuals will face in the near future, vocational rehabilitation.

PLANNING ACTIVITIES FOR REHABILITATION

The education field was late in developing programs for deaf-blind children. The field of rehabilitation should not make the same mistake. Unfortunately, it was not until 1968 that the education profession fully realized the impact of this group of rubella children on a national level. The delay in educational services has been compounded by the Numbers of children needing services immediately. In order to avoid many of the problems faced by educators, rehabilitation must begin planning and programming at once.

State by state planning will help rehabilitation programs evolve using local and state resources. However, it seems to be necessary to review the approaches to vocational rehabilitation of deaf-blind persons in this country and to look for new alternatives for services to deaf-blind clients. It may be possible, for instance, to modify existing programs in each state to include deaf-blind persons in these programs. There may be enough deaf-blind clients in a state to warrant development of special programs for the rehabilitation and placement of deaf-blind clients as a separate unit. There may be enough adventitiously deaf and blind individuals in the region to establish personal adjustment programs and placements for deaf-blind persons in competitive employment or sheltered settings. The important point seems to be that no one approach is accepted *in toto* and that the unique needs of this diverse population are kept as the focus of planning and program development. The implication seems to be to identify and utilize all available resources which might be brought to bear on the problem. One of the major obstacles to providing these services is that of coordinating programs and services so that they are available to the individual as they are needed. One solution to the problem of coordination may be to establish either regional or state offices to be responsible for coordinating services to this select group of adults.

REMAINING QUESTIONS AND RECOMMENDATIONS

A formidable population of deaf-blind individuals has been identified in the United States. Unless action is initiated now, rehabilitation will be caught, like education, six years late in programming for this population. Some of the areas which need immediate attention are:

1. A system of referral of the deaf-blind adult among agencies must be established.
2. A structure for coordinating services must be identified.
3. One person should be designated to coordinate the total rehabilitation program of the deaf-blind client.
4. Agencies must have information regarding needed modifications of currently existing training programs.
5. Agencies must have resources available to meet needed inservice training programs for staff who are working with deaf-blind clients.
6. Studies must be implemented to provide long term followup of the deaf-blind rehabilitation client.
7. There is a need to undertake studies to identify potential employment situations: sheltered workshops, half-way houses, and competitive employment.
8. Surveys must be initiated on the regional, state and local levels to identify available training programs for deaf-blind adults; vocational rehabilitation facilities, prevocational training programs, inservice training programs and work adjustment training programs.
9. Ancillary services which might be available to the deaf-blind client must be identified.
10. Studies must be undertaken to identify needed ancillary services for deaf-blind adults.

The question remains with us:

How soon will rehabilitation services be provided to deaf-blind adults?
Where will rehabilitation services be provided to deaf-blind adults?
By whom will rehabilitation services be provided to deaf-blind adults?

Time seems to be a critical factor. Unless planning and coordination is begun immediately, vocational services, the capstone of the continuum of services needed by deaf-blind persons, will not be available to the number of deaf and blind adults needing these services.

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