Employment Rehabilitation Services in Michigan

Michigan Advisory Committee to
the United States Commission on Civil Rights

March 2000

A report of the Michigan Advisory Committee to the United States Commission on Civil Rights prepared for the information and consideration of the Commission. This report will be considered by the Commission and the Commission will make public its reaction. The findings and recommendations in this report should not be attributed to the Commission but only to the Michigan Advisory Committee.

The United States Commission on Civil Rights

The United States Commission on Civil Rights, first created by the Civil Rights Act of 1957, and reestablished by the United States Commission on Civil Rights Act of 1983, is an independent, bipartisan agency of the Federal Government. By the terms of the 1983 act, as amended by the Civil Rights Commission Amendments Act of 1994, the Commission is charged with the following duties pertaining to discrimination or denials of the equal protection of the laws based on race, color, religion, sex, age, disability, or national origin, or in the administration of justice: investigation of individual discriminatory denials of the right to vote; study and collection of information relating to discrimination or denials of the equal protection of the law; appraisal of the laws and policies of the United States with respect to discrimination or denials of equal protection of the law; investigation of patterns or practices of fraud or discrimination in the conduct of Federal elections; and preparation and issuance of public service announcements and advertising campaigns to discourage discrimination or denials of equal protection of the law. The Commission is also required to submit reports to the President and the Congress at such times as the Commission, the Congress, or the President shall deem desirable.

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Letter of Transmittal

Michigan Advisory Committee to
the U.S. Commission on Civil Rights

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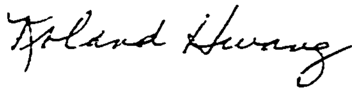
The Michigan Advisory Committee submits this report, *Employment Rehabilitation Services in Michigan,* as part of its responsibility to advise the Commission on civil rights issues within the State. The report was unanimously adopted by the Advisory Committee by a 14–0 vote.

This report contains information received by the Michigan Advisory Committee at a public fact-finding meeting and a statistical analysis of the provision of rehabilitation services in Michigan. The Advisory Committee is indebted to the individuals who testified at the public meeting for their time and expertise and to the staff of the Midwestern Regional Office, U.S. Commission on Civil Rights, for the preparation of this report and the statistical analysis.

The Advisory Committee understands the Commission is charged to study and collect information relating to denials of the equal protection of the law, and trusts the Commission and the public will find the material in this report informative.

Respectfully,



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Chapter 1

Introduction

Rehabilitation Services

In passing the Americans with Disabilities Act, Congress found that, historically, society has tended to isolate and segregate individuals with disabilities. Despite improvements, discrimination in employment against individuals with disabilities continues to be a serious and pervasive social problem. Within the provision of services to individuals with disabilities, additional forms of discrimination may exist on the basis of the individual's race, ethnicity, and/or severity of disability. Each year this Nation spends billions of tax dollars and private monies to rehabilitate persons with disabilities in order to support their entry or reentry into the work force. In Michigan these efforts are directed by the Michigan Jobs Commission, Rehabilitation Services (MJC–RS)[1] and the Michigan Commission for the Blind (MCB). MJC–RS and MCB receive the vast majority of their funding from the State and Federal Governments. The Federal dollars allotted to the MJC–RS are primarily allocated under title I of the Rehabilitation Act of 1973. State dollars are used to match Federal dollars and also provide some nonfederally supported services. There are 35 MJC–RS offices throughout the State.

MJC–RS works with individuals with a wide range of disabilities except for those legally blind, who are served by the Michigan Commission for the Blind. The MJC–RS clients need vocational rehabilitation services in order to work, and all applicants for MJC–RS services are presumed able to work. A person with a disability is eligible for MJC–RS services if the disability causes substantial problems in obtaining or keeping a job. MJC–RS services are based on the availability of State and Federal funds.

[1] The Michigan Jobs Commission, Rehabilitation Services, is now the Michigan Department of Career Development, Rehabilitation Services.

MJC–RS provides medical and vocational evaluations, counseling, job placement, and followup services. Each Michigan Rehabilitation Services (MRS) client follows a four-step process. First, the client's individual abilities, rehabilitation needs, and job interests are assessed. Second, an "Individual Written Rehabilitation Program" (IWRP) is developed to assist the client in making an informed choice concerning an employment goal. Third, the client receives the services set out in the IWRP. Fourth, the client and the agency work together to find employment. Once the client is employed, a followup is done for 60 days to ensure both employer and employee satisfaction. Some of these—as well as other services—are coordinated through public and private agencies in the community.

Race and Disability

The 1990 census of the United States reports whites to be 76.3 percent of the population, African Americans 11.5 percent, Hispanics 8.6 percent, Asians 2.8 percent, and American Indians approximately 1 percent. Though the exact incidence of various disabling conditions among the population is unknown, studies have been conducted to try to learn the prevalence of disability among racial and ethnic groups.[2]

African Americans

Among working-age adults, 13,420,000 are estimated to have a disability that impairs their ability to work. Approximately 2,512,000 of these individuals, 18.7 percent, are African Americans. This represents roughly 13.7 percent of African Americans in this age group (16–64) who account for only 11.7 percent of the overall work-

[2] Census data on the incidence of disability is not considered definitive with respect to rehabilitation services because the census survey does not purport to determine the severity of the disability or whether the disability restricts an individual's opportunity for employment.

ing-age population.[3] Moreover, approximately 1,803,000 of the working-age individuals, 24.2 percent, with severe disabilities are African Americans. African Americans with a severe disability account for a high 71.8 percent of all African Americans with a disability. Whites, by contrast, are just 63 percent of persons with severe disabilities, and only 52 percent of whites with a disability are severely disabled.[4]

African Americans account for 22 percent of persons with a disability who are unemployed or not working. In fact, the unemployment rate for African Americans with a disability is almost double the overall 14.2 percent rate among individuals with a disability. By contrast, African Americans are underrepresented among persons with disabilities who participate in the labor force. They account for only 12.9 percent of individuals with disabilities who are working, below their 13.7 percent of individuals with disabilities.[5]

Service delivery to and employment outcomes of African Americans with a work-related disability who participate in the State vocational rehabilitation programs have been shown to reflect inequalities. For example, a larger percentage of African American applicants were not accepted for services; and of the applicants accepted for services, African American clients were considered less likely to be rehabilitated. They were frequently screened out without receiving much needed services. African Americans received less vocational rehabilitation educational services, training, and financial aid for colleges, universities, business schools, and vocational schools than their white counterparts. Such inequalities were found to exist throughout all regions of the country.[6]

Hispanics

Of the estimated 13,420,000 working-age Americans with disabilities, approximately 1,012,000, 7.5 percent, are Hispanic. This is 8.2 percent of all Hispanics in this age group. Nine percent of the working-age population with disabilities are Hispanic, and Hispanics with a severe disability are 67.8 percent of all Hispanics with disabilities.[7]

Among working-age Hispanics with a disability, 777,000, 76.8 percent, do not work. Hispanics are also underrepresented among persons with disabilities who participate in the labor force. Hispanics account for only 5.5 percent of individuals with a disability who are working, which is below 7.5 percent of all individuals with a disability in this age group. Further, almost half, 47.5 percent, of Hispanic adults with disabilities have less than 12 years of schooling, which creates a further impediment to employment opportunities.[8]

Similar to African Americans, the service delivery to and employment outcomes of Hispanics with a work-related disability who participate in State vocational rehabilitation programs have also been shown to reflect inequalities. An analysis of participation and outcome characteristics for Hispanics with disabilities who participated in public vocational rehabilitation programs in 1989 found that of the 49,630 Hispanic applicants, 46 percent were not accepted for services. Further, of those accepted for services, 36 percent were closed without being rehabilitated.[9]

Asian Americans and Pacific Islanders

No studies on disability incidence rates among Asian Americans and Pacific Islanders have been conducted. The annual report of the U.S. Department of Education, Rehabilitation Services Administration (RSA), reports that of those persons receiving rehabilitation services in 1990, Asian Americans accounted for 1.3 percent of the total. This is lower than the Asian American 2.8 percent of the total population, suggesting a lower participation rate in rehabilitation programs. Other data from the RSA annual re-

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[3] F. Bowe, *Black Adults with Disabilities: A Portrait*, prepared for the President's Committee on the Employment of People with Disabilities (Washington, DC: Government Printing Office, 1991).

[4] Ibid.

[5] Ibid.

[6] B.J. Atkins and T. N. Wright, "Vocational Rehabilitation of Blacks," *Journal of Rehabilitation*, vol. 36, no. 2, pp. 42–46; and S. Walker et al., "Frequency and Distribution of Disabilities among Blacks," in *Equal to the Challenge, Howard University*, Washington, DC, 1986.

[7] F. Bowe, *Disabled Adults of Hispanic Origin: A Portrait*, prepared for the President's Committee on the Employment of People with Disabilities (Washington DC: Government Printing Office, 1991).

[8] Ibid.

[9] A. Leal-Idrogo, "Vocational Rehabilitation of People of Hispanic Origin," *Journal of Vocational Rehabilitation*, vol. 3, no. 1, 1991, pp. 27–37.

port also suggest lower participation rates of Asian Americans.

The profile of clients served by State independent living agencies for FY 1991 indicates the percentage of Asian Americans or Pacific Islanders at 1 percent. Only 1.3 percent of the clients served in FY 1991 under client assistance programs, receiving advocacy or ombudsman assistance, were of Asian descent.[10]

American Indians

There are approximately 500 federally recognized American Indian tribes and Alaskan native villages. These tribes and native villages greatly vary in size, population, language, religious practices, economic activities, and geographic location. Nevertheless, American Indians as a subpopulation share many common characteristics in terms of culture, education, social status, health, employment, and income.

Although American Indians are less than 1 percent of the total population, they have the highest disability rate, 21.9 percent, compared with all other major racial and ethnic groups.[11] Among those who have severe disabilities, American Indians have a disability prevalence rate of 9.8 percent, second only to the prevalence rate of 12.2 percent for African Americans.[12]

Even as American Indians are overrepresented among persons with disabilities, they are underrepresented among those who receive State and Federal services because of poor economic conditions and low educational attainment. In addition, American Indians with disabilities lack easy access to services due to distance, cultural, and sometimes, language problems.[13]

In general, American Indians living on reservations or in urban areas have lower incomes compared with the general population. Poor economic conditions are even more pronounced for American Indians with disabilities. In recent studies conducted by the American Indian Rehabilitation Research and Training Center, 40 to 50 percent of American Indians with disabilities living in selected communities reported annual incomes of less than $5,000.[14] Despite having a high prevalence of disabling conditions, American Indians are less likely to seek vocational rehabilitation services, and are less likely to be successfully rehabilitated compared with the general population.[15]

Incidence of Disability in Michigan

The census reports on disability as part of its decennial count. The 1990 census reported 203,865 individuals between the ages of 16 and 64 in Michigan with a disability and in the labor force.[16] The unemployment rate for this group was 16 percent, a rate more than twice that of the nondisabled labor force. An additional 331,951 individuals between the ages of 16 and 64 in Michigan have a disability and are not in the labor force.

MRS collects data on all clients. These data are maintained in a central database, which contains 66 specific data items on each client, including: name, address, gender, race, number of times client has been through the system, case type, disability, severity of disability, health insurance, education, marital status, dependents, intake date, referrals, work status, employer, hours worked, and occupation. These data are also reported to the Department of Education, Rehabilitation Services Administration, in Washington, D.C., which is the primary Federal grant agency.

The Rehabilitation Service Issue: Purpose and Design of the Study

Persons with disabilities wishing to access rehabilitation services could face two limiting factors on the availability and quality of services.

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[10] United States Department of Education, Rehabilitation Services Administration, 1990 Annual Report.

[11] J.M. McNeil, "Americans with Disabilities: 1991–92," U.S. Bureau of the Census, Current Population Reports (PLO–33) (Washington, DC: Government Printing Office, 1993).

[12] Ibid.

[13] J.R. Joe, "Government Policies and Disabled People in American Indian Communities," *Disability, Handicap, and Society*, vol. 3, 1989, pp. 253–62.

[14] C.A. Marshall, M.J. Johnson, and R.C. Saravanabhaven, *The Assessment of a Model for Determining Community-Based Needs of American Indians with Disabilities*, (Flagstaff, AZ: American Indian Rehabilitation Research and Training Center, Northern Arizona University, 1990).

[15] J.C. O'Connell, ed., *The Special Problems and Needs of American Indians with Handicaps both on and off the Reservation*, vol. 1 (Flagstaff, AZ: American Indian Rehabilitation Research and Training Center, Northern Arizona University, 1987).

[16] The labor force is defined as the total number of individuals between the ages of 16 and 64 who are employed and those not employed but seeking employment.

Table 1
Disability and Employment Status by Gender for Michigan, Persons 16 Years and Over

Male		Female	
16 to 64 years with a work disability		**16 to 64 years with a work disability**	
In labor force:		*In labor force:*	
Employed	100,973	Employed	69,962
Unemployed	20,476	Unemployed	12,454
Not in labor force:		*Not in labor force:*	
Prevented from working	130,507	Prevented from working	145,474
Not prevented from working	21,158	Not prevented from working	34,812
No work disability		**No work disability**	
In labor force:		*In labor force:*	
Employed	2,099,786	Employed	1,795,410
Unemployed	191,422	Unemployed	144,467
Not in labor force	317,723	*Not in labor force*	840,298

SOURCE: U.S. Commission on Civil Rights, Midwestern Regional Office, from 1990 Census, File Tape Summary STF–3A.

The first possible limiting factor is severity of disability, and the second is race and/or ethnicity.

Because individuals with more severe disabilities may be more difficult to place and more expensive to serve, it can be plausibly hypothesized that the more severe a person's disability the less likely it is that the individual will be found eligible for services. Furthermore, the person is likely to receive a lower quality outcome. In general parlance this phenomenon is called "creaming," i.e., persons who are expected to cost less and have a higher likelihood of a quick, successful placement are given services.

The Michigan Advisory Committee also theorizes that race and/or ethnicity may be a factor in the determination of eligibility and quality of services. Specifically, the Committee believes that minorities may receive a lower quantity and quality of rehabilitation services than nonminorities.

The purpose of this study by the Michigan Advisory Committee to the U.S. Commission on Civil Rights is to examine whether persons with disabilities wishing to access rehabilitation services face limiting factors on the availability and quality of services with regard to severity of disability and/or race and ethnicity. The study was a three-step process, with each step set out as an individual section of the report.

The first part of the study examines the legislation, administration, and monitoring activities pertinent to the delivery of rehabilitation services. The second part is a presentation of perspectives on the delivery of rehabilitation services. The information in this part is drawn from a public factfinding meeting held in Lansing, Michigan, in June 1998.

The third step of the study is an analysis of data. The data analysis was limited to the tri-county MJC–RS service area of Clinton, Eaton, and Ingham Counties. This area was selected as a representative area because of its central location, relatively sizable population that is racially and ethnically diverse, and the area's mixture of rural and urban populations. Services provided by the Michigan Commission for the Blind were not analyzed as part of this study.

Based upon its (1) understanding of the legislation, administration, and regulation of rehabilitation services; (2) testimony received at its factfinding meeting and other submitted material; and (3) analysis of the rehabilitation service delivery data, the Michigan Advisory Committee made findings as to whether the severity of disability, race, and/or ethnicity is a factor in the provision of employment and rehabilitation services to individuals with disabilities. These findings along with recommendations are set out in part 5 of the report.

Authority of the U.S. Commission on Civil Rights and State Advisory Committees

The U.S. Commission on Civil Rights is charged with the duty to study and collect information concerning legal developments constituting discrimination or a denial of equal protection of the laws under the Constitution because of race, color, religion, gender, age, disability, or national origin. The Commission is also to appraise Federal laws and policies with respect to discrimination or a denial of equal protection of the laws.

An Advisory Committee to the U.S. Commission on Civil Rights has been established in each of the 50 States and the District of Columbia. Advisory Committees are to advise the Commission of all relevant information concerning their respective States on matters within the jurisdiction of the Commission, and receive reports, suggestions, and recommendations from individuals, public and private organizations, and public officials upon matters pertinent to inquiries conducted by the State Advisory Committee.

Chapter 2

Background

Rehabilitation Services Legislation

The Rehabilitation Act of 1973,[1] as amended, authorizes over $2 billion in Federal support for training and placing persons with mental and physical disabilities into full-time, part-time, or supported employment. The program is a joint State and Federal effort, with the Federal Government providing 80 percent of the funding to State vocational rehabilitation programs, and States providing the remaining 20 percent.

The origins of the Federal-State rehabilitation program can be traced back to 1920 when Congress enacted the National Vocational Rehabilitation Act of 1920, the first civilian program assisting persons with disabilities in regaining work skills. Since that time, the act has been gradually expanded to include services to persons with a wide array of disabling conditions, and, in recent years, to focus increased attention on the need of individuals with severe disabilities. Specifically, the Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978[2] placed a stronger emphasis on provision of rehabilitation services to clients with severe disabilities.

Title I of the Rehabilitation Act of 1973[3] authorizes formula grants to designated State vocational rehabilitation agencies to provide services to rehabilitate persons with disabilities. In fiscal year 1997, $2.1 billion was appropriated by Congress for vocational rehabilitation programs throughout the United States under the act. Of that amount, the Michigan Jobs Commission, Rehabilitation Services (MJC–RS) received $66.9 million and the Michigan Commission for the Blind (MCB) was allocated $9.1 million. During fiscal year 1998 the Federal appropriation for vocational rehabilitation services was $2.2 billion, with $67.3 million allocated to the MJC–RS and $9.1 to the MCB.

The Federal-State vocational rehabilitation program is an eligibility-based program, not an entitlement program. To receive vocational rehabilitation services, an individual must meet three eligibility criteria. First, the individual must have a disability that causes an impediment to employment.

The second criterion is the presumption of employability. This criterion is a major change made by Congress in the 1992 amendments to the act. Prior to that date, State vocational rehabilitation agencies determined whether a person could benefit from vocational rehabilitation services. Congress determined in 1992 that that particular eligibility criterion was weeding out individuals with severe disabilities on the assumption that, in fact, they were too severe to be employable. So in 1992, Congress said State vocational rehabilitation agencies will assume that everybody who has a disability can work. The onus was placed on the State vocational rehabilitation agencies to rebut that presumption.

The third eligibility criterion is that the individual requires vocational rehabilitation services in order to become employed. In Michigan the MJC–RS and MCB provide services to individuals who have difficulty preparing for, obtaining, or retaining employment.

Title II of the act establishes the National Institute on Disability and Rehabilitation Research (NIDRR).[4] Title III of the act authorizes grants and loans to cover the cost of constructing rehabilitation facilities and to support training projects designed to increase the numbers of qualified personnel available to provide services to persons with disabilities. Title IV authorizes the establishment of an independent National Coun-

[1] P.L. 93-112 as amended by P.L. 93-516, P.L. 94-230, P.L. 96-374, and P.L. 99-506, 29 U.S.C. §§ 701–703.

[2] P.L. 95-602.

[3] Title I, Rehabilitation Act of 1973, P.L. 93-112.

[4] 29 U.S.C. § 762.

cil on Disability.[5] The council and its staff are charged with reviewing all Federal statutes related to persons with disabilities. Title V advances employment opportunity for individuals with disabilities with the Federal Government. Title VI establishes programs aimed at enhancing employment opportunities for persons with disabilities in such areas as community service employment and funding joint projects with industry. Title VII of the Rehabilitation Act authorizes several programs aimed at assisting persons with mental, physical, and sensory disabilities in achieving and maintaining independent living.[6]

The Rehabilitation Act of 1986[7] amended the definition of a "severe handicap" to include functional as well as categorical criteria.[8] In addition, a definition of "employability" was inserted in the act for the first time, to clarify that part-time work is a viable outcome of rehabilitation services.[9] Prior to 1986, each State vocational rehabilitation agency exercised its own discretion in determining whether a person was employable, and thus qualified for rehabilitation services.

In addition, the 1986 amendments required the States not only to provide evidence that they have policies governing the order in which clients are selected for services, but also to justify these policies. Moreover, the amendments added a new supplementary formula grant program under which the States were authorized to conduct interagency collaborative projects to provide supported employment services to persons with severe disabilities.

The Rehabilitation Act Amendments of 1992[10] mandated that priority in service be provided to individuals with the most severe disabilities. In implementing the act, States interpret who are the individuals with the most severe disabilities. Under the act, priority in service must be given to those individuals with the most severe disabilities, especially if the State follows an order of selection for services. In addition, because consumer and advocacy groups expressed concern that State agencies were not serving those individuals with the most severe disabilities, the 1992 amendments established a presumption that any individual can benefit from vocational rehabilitation services to reach an employment outcome.

State Rehabilitation Services

Michigan Rehabilitation Services (MRS) is the primary State agency that helps eligible persons with disabilities prepare for, find, and retain employment. MRS is a division of the Michigan Jobs Commission. There are 37 MRS offices throughout the State.

A person with a disability is eligible for MRS services if the disability causes substantial problems in getting or keeping a job. The individual must *need* vocational rehabilitation services in order to work. All applicants for MRS services are presumed able to work. Persons who are legally blind are served by the Michigan Commission for the Blind.

Provision of MRS services is based on the availability of State and Federal funds. Clients with the most severe disabilities are served first when MRS is unable to serve all eligible clients. MRS provides medical and vocational evaluations, counseling, job placement, and followup services free of charge. Other services are coordinated through public and private agencies in the community. If financially able, clients are expected to help pay for part of the services they receive. The core services provided directly by MRS for persons with disabilities include:

- Vocational and personal adjustment counseling
- Coordination of medical services needed to achieve or maintain employment
- Interpretation of medical, psychological, and vocational reports
- Case management (arranging services, finding grants, and other benefits)
- Job seeking/job keeping skills training
- Accommodation services

[5] 29 U.S.C. § 780.

[6] Section 13 of the Rehabilitation Act of 1973, as amended, requires an annual report to the President and the Congress on Federal activities related to the Rehabilitation Act of 1973, as amended. The report is organized following the titles and sections in the act and contains data from various reports required in the act and its regulations.

[7] P.L. 99-506.

[8] 29 U.S.C. § 706(h).

[9] 29 U.S.C. § 701(6).

[10] P.L. 102-569.

MRS also provides services purchased through outside organizations. These may include:

- Job redesign or reengineering services
- Examinations to evaluate medical, psychological, and psychiatric problems; treatment such as therapy, surgery, and pain management
- Personal assistive devices, such as hearing aids, wheelchairs, braces, prosthetics, listening devices, vehicle modifications, driver evaluation/training, and ramps and other home modifications
- Specialized vocational testing
- Skill training, including on-the-job, vocational, college, self-care, and independent living
- Job placement assistance
- Work tools, licenses, and clothing; transportation to employment; relocation to employment
- Interpreter services for initial interview and training period
- Job follow-along services to ensure employer and employee satisfaction

In addition, MRS provides services to businesses either directly, contractually, or by fee for service so as to increase employment opportunities for persons with disabilities. Such programs include:

- Prescreened worker referral
- Return to work services
- Disability management
- Job site accommodations
- Consultation on Americans with Disabilities Act

In fiscal year 1997 the number of persons with disabilities served by MJC–RS was 40,292.[11] The number of persons with disabilities assisted into jobs by MJC–RS was 6,591. The average time for an individual to be in the program was 20 months.[12] The percentage of persons served by MJC–RS by disability category is indicated in table 2.

The annual budget for MJC–RS in fiscal year 1997 was $89,150,744. The agency receives 80 percent of its funding from the Federal Government, either through grants under title I of the Rehabilitation Act of 1973 ($65,834,659), Social Security Administration funds ($1,845,775), or other Federal funding sources ($3,459,699). The State provides only 10 percent of the agency's funding ($9,531,180), and local matching funds, which are almost 9 percent of the agency's budget ($7,726,512), nearly equal the State's contribution.[13] Table 3 shows MJC–RS funding sources.

Table 2
Persons Served by MJC–RS by Disability, FY 1997

Condition	Percent
Orthopedic	17.4
Mental retardation	15.8
Mental illness	15.3
Learning disabilities	12.1
Hearing impairment	11.4
Alcohol and drug dependence	10.8
Other mental/emotional disabilities	3.7
Visual impairments	1.2
Amputation	1.2
Other disabilities	11.2

SOURCE: Michigan Jobs Commission-Rehabilitation Services.

Table 3
MJC–RS Funding Sources

Category	Expenditure	
Federal basic funding support	$65,834,659	(73.8%)
Other Federal support	3,459,699	(3.9%)
Social Security Administration	1,845,775	(2.1%)
State general funds	9,531,180	(10.7%)
Local matching funds	7,726,512	(8.7%)
Fee for service	520,457	(.6%)
Funds from other State depts.	232,462	(.2%)
Total	89,150,744	(100%)

SOURCE: Michigan Jobs Commission-Rehabilitation Services. FY 1997 figures, the most recent available.

[11] Michigan Jobs Commission, Rehabilitation Services, "Program Facts and Figures," 1998. FY 1997 figures are the most recent available.

[12] Ibid.

[13] Ibid.

Federal Monitoring of Rehabilitation Services

The Rehabilitation Services Administration (RSA) was established within the Department of Health, Education, and Welfare by the Rehabilitation Act of 1973. The RSA was delegated the responsibility for administering all rehabilitation programs authorized under the act. The RSA was later transferred to the Department of Education under the terms of the Education Organization Act, where it remains today.[14]

The Rehabilitation Act Amendments of 1992 primarily amended the 1973 rehabilitation statute by focusing on accountability. The amendments contain a new requirement for evaluation standards and performance indicators for State rehabilitation service programs. Section 107 of the act requires the RSA to conduct annual reviews and monitoring of established standards and measures. During fiscal year 1996 and again in fiscal year 1997, the RSA review focused on MJC–RS achievement in three areas:

- Employment outcomes
- Informed choice
- Minority outreach

In addition to the three focus areas, the RSA also reviewed performance of the MJC–RS in the areas of (1) due process, (2) consumer satisfaction, (3) order of selection, (4) budget and financial management, and (5) reporting. The RSA's evaluation of the agency's service to persons with severe disabilities and its service and outreach to the minority community are of particular relevance to this study.

Regarding service by the MJC–RS to persons with severe disabilities, the RSA monitoring report reads:

Persons in Michigan with severe disabilities achieved competitive employment at a percentage rate of 91.4 percent for all rehabilitants in competitive employment. The difference of 1.2 percent was the largest difference between those with severe disabilities and all others who achieved competitive employment. Persons with nonsevere disabilities may require fewer services, achieved within a shorter time, and have a greater degree of independence in seeking employment than those with severe disabilities that may account for the difference.[15]

Regarding outreach by the MJC–RS to minorities and rehabilitation rates for persons from minority backgrounds, the RSA monitoring report reads:

MRS has heeded the recommendation made in the RSA final report on the comprehensive review of MRS, "to continue to improve uniformity of intensive outreach efforts already underway in areas of high minority concentration" by forming a Minority Rehabilitation Issues Task Force. . . .

MRS achieved a rehabilitation rate of 62.1 percent for all severe cases for FY 1995. In comparison, African Americans in the Michigan Rehabilitation program achieved only a rehabilitation rate of 53.32 percent and American Indians achieved a rate of only 49.21 percent. While the African American rate is within 10 percentage points usually identified as acceptable, in Michigan this tends to be a significant number of our customers who are achieving at less than the average rate. The rate for American Indians is considered significant.

In an attempt to respond to the data suggesting service inequities for minority populations in the Rehabilitation Act Amendments of 1992, MRS provides service in ways that will meet the needs of our minority customers. All MRS staff have received training in cultural diversity awareness and MRS developed and implemented a multicultural policy several years ago. MRS convened a multicultural/diversity committee to develop a plan for recruiting candidates from minority backgrounds to staff position. As a result the MRS staff is becoming more diverse. This relates to increased satisfaction of our customers from minority backgrounds if they have a counselor who can speak to them in their own language and relates to their cultural differences. MRS has established a new committee, the Minority Issues Committee, to bridge the successful outcome gap that exists between the minority and majority client populations. This committee will become implementation focused to drive action in resolving the differences in outcomes between minority and nonminority outcomes. MRS has developed a cash match agreement with Hannahville Indian Reservation to provide outreach and ensure this population receives the unique and sufficient services to achieve employment.

[14] P.L. 96-88.

[15] Rehabilitation Services Administration, U.S. Department of Education, *FY 1997 Annual Monitoring Review: Michigan Rehabilitation Services*, September 1997, p. 6.

MRS will continue to develop, expand, and replicate programs aimed at minority outreach and inclusion in all priorities such as transition services through community development, liaisonships and grant resources. . . .

Case service costs vary from one ethnic background to another, from one disability group to another with no one ethnic group maintaining dominance across the table. Asian closures have significantly higher case costs as a total group, resulting primarily from costs associated with orthopedic cases being five times the case costs for American Indians, four and a half times the costs for African Americans and three times the cost for Caucasians. A low number of individuals received extraordinarily high cost services. African Americans had higher case costs for amputations and mental retardation cases and hearing impairment cases than other groups due to various reasons. An increasing number of hearing disabilities in this population with fewer opportunities to seek comparable benefits may be a factor. The high cost of absence of limbs cases may result from fewer opportunities for comparable benefits and a high referral rate from a Detroit rehabilitation hospital of complex high cost cases. The low cost of substance abuse case costs for African Americans may result from an initiative beginning in 1994 to develop closer partnerships with substance abuse agencies. The initiative resulted from a Federal grant to the state to provide Drug Abuse and Alcohol Referral Monitoring.

Training was provided to MRS counselors and the substance abuse staff in their communities and a product of this training was a formalized agreement to work together, develop referral procedures and coordinate services for increased services to this disability group and a cost savings for both agencies. Many of these efforts were focused on the areas of the state with a high African American population. In all areas, American Indian case costs were lower than all or most of the other minority groups or the nonminority group. This will be an area addressed by the Minority Issues Committee to develop the appropriate resolution.[16]

The RSA monitoring report compares the costs of services for cases successfully closed by disabling conditions for minorities with severe disabilities and nonminorities:

The relationship of case costs [for minorities] by disability groups compared with the costs for nonminority cases compares similarly for those with severe disabilities as with all disabilities. There is no significant variance identified according to severity of disability.[17]

Definitions of Disability

Title I of the Rehabilitation Act of 1973, as amended, requires service providers to give priority to clients with the most severe disabilities. The act further requires that in the event that vocational rehabilitation services cannot be provided to all eligible individuals with disabilities in the State who apply for the services, an order of selection for vocational rehabilitation services will be established with individuals with the most significant disabilities being selected first for the provision of vocational rehabilitation services.[18]

Under the act, an "individual with a disability" means any individual who:[19]

(a) has a physical or mental impairment that constitutes or results in a substantial impediment to employment; and
(b) can benefit in terms of an employment outcome from vocational rehabilitation services. . . .[20]

An "individual with a significant disability" means an individual with a disability who:[21]

(i) has a severe physical or mental impairment which seriously limits one or more functional capacities (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of an employment outcome;
(ii) whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time; and
(iii) who has one or more physical or mental disabilities resulting from amputation, arthritis, autism, blindness, burn injury, cancer, cerebral palsy, cystic fibrosis, deafness, head injury, heart disease, hemiplegia, hemophilia, respiratory or pulmonary dysfunction, mental retardation, mental illness, multiple sclerosis, muscular dystrophy, musculo-skeletal disorders, neurological disorders (including stroke and epilepsy), paraplegia, quadriplegia, and other spinal cord conditions, sickle cell anemia, specific learning disability, end-stage renal disease, or another dis-

[16] Ibid., pp. 11–12.

[17] Ibid., p. 13.

[18] Title I, Rehabilitation Act of 1973, as amended, § 105.

[19] 29 U.S.C. § 705(20).

[20] Ibid., § 7.

[21] 29 U.S.C. § 705(11).

ability or combination of disabilities determined on the basis of an assessment for determining eligibility and vocational rehabilitation needs described in subparagraphs (A) and (B) of paragraph (2) to cause comparable substantial functional limitation.[22]

Under the Rehabilitation Act of 1973, as amended, the term "employment outcome" means:

(a) entering or retaining full-time or, if appropriate, part-time competitive employment in the integrated labor market;
(b) satisfying the vocational outcome of supported employment; or
(c) satisfying any other vocational outcome the Secretary determines to be appropriate in a manner consistent with the Act.[23]

[22] Ibid.

[23] Ibid.

Chapter 3

Perspectives on the Provision of Rehabilitation Services

The Advisory Committee held a public meeting and received testimony on employment rehabilitation services in Michigan. Those offering testimony included: Douglas Burleigh, regional commissioner, Rehabilitation Services Administration, U.S. Department of Education; Robert Davis, State director, Michigan Jobs Commission-Rehabilitation Services; Patrick Cannon, State director, Michigan Commission for the Blind; Harry Smith, Michigan Association of Rehabilitation Services Organizations; Elizabeth Bauer and Amy Mays, Michigan Protection and Advocacy; Robert McConnell, Michigan Association of Multicultural Rehabilitation Concerns; Richard Webster, Michigan Rehabilitation Advisory Council; RoAnne Cheney, Michigan Disability Rights Coalition; Patricia Cudahy, Statewide Independent Living Council; Greta Wu, Peckham Industries; June Cronk, Lansing Center for Independent Living; and Duncan Wyeth, Governor's Developmental Disabilities Council.[1]

U.S. Department of Education, Rehabilitation Services Administration

Douglas Burleigh, regional commissioner, U.S. Department of Education, Rehabilitation Services Administration, testified about the Federal-State partnership of rehabilitation services programs, definitions of disability, successful delivery of service, and outreach to minorities. He reported:

Rehabilitation Services . . . is a State and Federal program [with] the Federal Government providing 80 percent of funding of the State vocational rehabilitation programs and the State agencies providing 20 percent. In 1997, $2.1 billion were appropriated by Congress for vocational rehabilitation programs around the United States. Of that amount $66.9 million was allocated to Michigan Rehabilitation Services and $9.1 million was allocated to Michigan Blind. In fiscal year 1998, Federal appropriations for vocational rehabilitation services was $2.2 billion, with $67.3 million allocated to Michigan General and $9.1 million allocated to Michigan Blind.

The State-Federal VR program is an eligibility-based program. It is not an entitlement program such as medicaid or medicare. To receive vocational rehabilitation services, an individual must meet eligibility criteria. Those criteria are (1) an individual has to be a person with a disability . . . that constitutes an impediment to work, (2) the presumption of employability, and (3) the individual requires vocational rehabilitation services in order to become employed.

The presumption of employability is a major change by Congress in the 1992 amendments to the act. Prior to that, State vocational rehabilitation agencies determined whether a person could benefit from vocational rehabilitation services. Congress determined that particular eligibility criterion was weeding out individuals with severe disabilities on the assumption that, in fact, they were too severe to be employable. So in 1992, Congress said State vocational rehabilitation agencies will assume that everybody who has a disability, i.e., an impediment to work, can work.

The vocational rehabilitation program, unlike any other Federal or State jobs program, is highly individualized. Vocational rehabilitation counselors sit down with individuals who are eligible for services and with those individuals determine vocational objectives of their choice.

The Department of Education monitors the State's performance activities against the requirements of the law and regulations and whatever policy that is promulgated to interpret the regulations and the law. Every fiscal year the Department selects between 10 and 12 State vocational rehabilitation agencies for comprehensive reviews. A comprehensive review was conducted in Michigan 3 years ago. During the De-

[1] The public hearing was held on June 25, 1998, in Lansing, Michigan. A complete transcript is available from the U.S. Commission on Civil Rights, Midwestern Regional Office, Chicago, Illinois. Douglas Wyeth testified during the public session of the meeting.

partment reviews, case records [are examined] to ensure that the State agency is delivering services in the way their policies and procedures say they deliver services and which are in compliance with Federal law. In addition, there are public hearings where people from around the State may come and relate their concerns about the State agency and its services they feel are being provided inequitably.

Over the years the Rehabilitation Act has been amended by Congress to give individuals with disabilities more authority and responsibility in determining their vocational objectives and the services they want to receive. Hence, the law and the State plan are replete with the requirements to show evidence that the individual with the disability received information in making an informed choice about the goals and objectives and services on his or her IWRP.

With the several amendments to the Rehabilitation Act of 1973, new requirements on the States are focused on having the States work with individuals with severe disabilities and the most severe disabilities rather than individuals with nonsevere disabilities. An individual with a severe disability is an individual with a disability that seriously limits one or more functional capacities, such as mobility, communication, self-care, interpersonal skills. The regulations list what those disabilities are: stroke, spinal cord injury, paraplegic, quadriplegic, learning disabilities, etc.; however, the list is not considered exclusive. As a result, the person's vocational rehabilitation requires multiple vocational rehabilitation services over an extended period of time. That is how the Federal law and regulations define an individual with a severe disability.

In the State of Michigan and nationally, the preponderance of services and the preponderance of placement employment closures is for individuals with severe disabilities. In Michigan it is around 90 percent. Ninety percent of the people rehabilitated by Michigan General have severe disabilities as I have just defined it. . . . The amount of money spent to rehabilitate individuals with disabilities and place them in employment is more but not necessarily significantly more, but it is more for people with severe disabilities than nonsevere disabilities.

Under the rehabilitation program a success is employment, which is a status 26. There are two other, unsuccessful, ways for an individual to exit the program: (1) the individual can choose not to continue in the program, move out of the State, or become institutionalized before the plan of services starts; or (2) an individual can exit the system while receiving services but before placement in a job. An unsuccessful exit is called a status 28. The rehabilitation success rate, i.e., the proportion of successes to unsuccesses plus successes, is status 30 and is determined by status 28 cases plus status 26 cases divided by status 26 cases. A perfect rate is 100 percent, and an awful rate is zero percent.

In asking about services to people from minority groups, there are many ways to evaluate the adequacy of State vocational rehabilitation agencies. One way is by looking at how much is spent [on the different racial and ethnic groups]. There have been reports that nationally less is spent on individuals from minority groups than is spent on whites. A second way to evaluate services is examining rehabilitation rates for different groups.

In fiscal year 1996 in Michigan General, the average cost of services to people placed in employment was $2,803 for whites, $2,677 for African Americans, $2,550 for American Indians, and $3,355 for Asian Americans. For minority groups who have severe disabilities within the Michigan Rehabilitation Services system, the mean cost was $2,901. For whites with severe disabilities the mean cost was $2,885, for African Americans with severe disabilities the mean cost was $2,967, for American Indians with severe disabilities the mean cost was $2.499, and for Asian Americans with severe disabilities the mean cost was $3,027.

When Congress was reviewing the law to amend it for another 5 years, they received testimony that asserted individuals from diverse cultural backgrounds were being served at a lower level, receiving less services, and in fewer numbers. As a result, Congress in the Rehabilitation Act Amendments of 1992, told agencies to reach out more to individuals from diverse backgrounds. The Department as part of its review of State agencies looks at State agency statistics on services to people from diverse backgrounds, how much is spent, and numbers served and rehabilitated.[2]

Michigan Rehabilitation Services

Robert Davis, State director for Michigan Rehabilitation Services, testified about the agency's rehabilitation services to individuals with disabilities. He first addressed three topics of concern to the Committee: (1) the number of individuals served, (2) order of selection, and (3) re-

[2] Douglas Burleigh, testimony before the Michigan Advisory Committee to the U.S. Commission on Civil Rights, factfinding meeting, Lansing, MI, June 25, 1998, Lansing, Michigan, transcript, pp. 5–44 (hereafter cited as Michigan Transcript).

habilitation services to the most severely disabled.

MRS rehabilitates about 7,000 people in Michigan that have disabilities. There are estimates that in Michigan, 1.7 million individuals may have a disability, but that number would include people beyond retirement age with debilitating illnesses. So it is very difficult to know the exact number of employable-age individuals with a disability. MRS has 26,000 people with disabilities on its open caseload, and 530 staff. In a typical year approximately 40,000 people receive MRS services, 90.2 percent of those coded by Federal definition as severe.

Nationwide the VR program will rehabilitate about a quarter of a million. It is estimated, though, that nationally perhaps 30 to 40 million disabled people potentially want and possibly could work. The overall size of the Federal-State program is obviously not adequate to that challenge, so our strategy in Michigan is to try and make accessible to people mainstream systems. By the mainstream systems I'm talking about the employment and training system and the educational system. And we have strategies in place to do both of those.

MRS does maintain statistics on the number of individuals who apply for services and are deemed ineligible. The agency operates according to a numerical annotation called a status, to everything that happens in the rehabilitation process. A zero to eight closure is a negative closure in the sense of the individual leaving the system before an eligibility decision has been made. Moreover, starting in 1992 there is a presumption across the board for anyone with a personal disability to be employable, so that is no longer a valid reason for being made ineligible.

An order of selection is a process that is very clearly stipulated by Federal regulations that a State must enter into if the State director determines that the State has a significant inability to serve all of those eligible people. In other words, there are not enough funds for people that are eligible for the services, and the State agency has to make a distinction among its clients between most severe and severe. MRS is not an order of selection agency. Ninety percent of the MRS clientele are severe and the agency's feasibility studies indicate that it is a very problematic process to determine who is most severe and [a process] subject to a high degree of subjectivity.

Along this line, the coding of an individual as "disabled," "severely disabled," or "most severely disabled" is not subjective and loose. A good portion of the coding is categorical. For example, 40 percent of MRS clients get either a supplemental social security income check or a social security disability insurance check. To qualify for those benefits, by almost anyone's opinion, one would have to be severely disabled. So those are automatically coded severe, according to the Federal definition. There are some other portions of the code, which by disability, are also categorical. The remaining portion have to establish eligibility according to limitations in different important life functions. That is not as loose as sometimes characterized, and 90.2 percent of the MRS population are coded as severe. Further, approximately 88.4 percent of our successful rehabilitations, i.e., people who at the end of the rehabilitation process have successfully worked and their work is verified for a 90-day period, are coded severe.

In years past the agency did "cream" because counselors had to do a certain number of successful rehabilitations a year. That was identified as a problem by the rehabilitation community and by Congress. Today, there are no hard and fast placement goals. We allow counselors to assess the difficulty level and the severity level of their own caseloads and establish their own numerical goals. We do not punish them for not meeting those goals, but the numbers are looked at as they pose questions about problems that may occur in the management of a caseload, extra resources that might be needed. It is understood that these are more difficult assignments, and the expectations are correspondingly geared down.

To ensure that "typecasting" on the basis of disability does not happen, it is an item specifically defined and examined in case reviews, i.e., looking for stereotyping, identifying it, and taking actions to move away from it. In addition, when employers and workshop groups act in this manner, the agency pulls its business from those employers and workshops until those organizations provide more choices and more job variety for the MRS clientele.[3]

Davis followed those comments with testimony specific to efforts by the MRS to serve the minority community. The Committee asked Davis to comment on the issue of using local money as part of the State's matching funds. The concern about this practice was grounded in the presumption that communities able to provide local funding are in all likelihood wealthier communities and disproportionately nonminority. Davis responded:

[3] Testimony of Robert Davis, Michigan Transcript, pp. 124–43.

It takes about $17 million of [State] matching funds to receive all available Federal funding. Ten million of that 17 million for Michigan Rehabilitation Services comes from general funds that are appropriated by the State legislature. About $5 million of it comes from local cash match agreements, and these are the 147 local agreements predominantly with local school systems, intermediate school districts, and community mental health centers. Those are the two most frequent partners in the local level. There is an additional million to $2 million in what we called loaned staff, loaned assets, and those are, again, community partners that have given us staff, for example, a community mental health center that's given us two or three staff in the Detroit area to do with as we want, to provide services to our mutual clientele.

We use that money to provide services through 34 offices scattered throughout the State. We try to distribute our resources on the basis of where the population density is. We also try to distribute our staff and our case services accordingly.

MRS is extremely aware of the equity problem coincident with the local cash match part of its budget, which is $5 million and $2 million. What the agency has done is take some discretionary funds earned from successfully rehabilitating social security recipients and put those into communities most disadvantaged by having less opportunity for cash match. The agency specifically targeted funds this year for the Detroit area with the idea that Detroit could perhaps over a 3- or 5-year period develop the same level of partnership agreements and develop a cash match to the degree that the rest of the State could.

The other offsetting governor on match inequity is the existence of a limiter on the amount of cash match that can be made by richer communities. [Such communities] may not go over a certain percentage of their percentage of the population, and that limits the amount of local cash match partnership money they can develop. . . . The agency is trying to maintain an equitable balance in the face of a situation, where, if environmental pressures have their way, resources would be skewed [to the wealthier communities].[4]

Finally, with respect to services provided minorities within the system and outreach to the minority community, Davis told the Committee:

In terms of our clientele and minority representation, in the last population census for African Americans, 13.9 percent of the State's population was African American and 2.2 percent were Hispanic. Currently 25.2 percent of the MRS caseload is African American and 2.6 is Hispanic.

In addition, the agency has tried to hire staff that represent the community. Outreach must really be done with an understanding of cultural values. For example, in the Hispanic community, sometimes Hispanic individuals will not self-identify themselves to the government agencies, so agency workers have to go into the community and be a part of the community and be a trusted individual. Obviously, if you don't speak Spanish that makes the task that much more difficult. So we try our best to hire people with those kinds of skills.[5]

Michigan Commission for the Blind

Patrick Cannon, State director for the Michigan Commission for the Blind, testified about the agency's work with individuals who are blind. Cannon told the Committee that (1) everyone served by the Michigan Commission for the Blind is by definition severely disabled; (2) the agency operates under the philosophy that its clients need to set their own rehabilitation and employment direction; (3) the greatest barrier facing people with disabilities is the biases, fears, myths, and stereotypes on the part of the general public and employers; and (4) for cultural reasons, such biases and stereotypes affect more people with disabilities who are minorities. In addition, Cannon emphasized that the provision of accessible and affordable transportation by a community is a critical component of effective rehabilitation services.

The Michigan Commission for the Blind is an agency with nine offices and a staff of 109 employees, and of those staff members 18 are minorities. As to serving people with severe disabilities, all of the clients served by the Michigan Commission for the Blind would fit the definition of severe disabilities. One of the agency's components is the Blind Training Center in Kalamazoo, a residential training facility where clients learn the skills of blindness on orientation, mobility and travel skills, exposure to Braille, adaptation skills, industrial arts, and many other things that will assist those individuals coming to terms with their blindness and acquiring the skills that will enable them to access additional services, technologies, and opportunities that will pave their pathway toward independence and productivity.

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[4] Ibid.

[5] Ibid.

The Michigan Commission for the Blind believes very strongly that its clients need to set their own direction. Blind persons, if given the right opportunities and the right training and supports and technologies, can do just about anything that anyone else can do. The commission's VR counseling staff talks about that to clients to help them set their meaningful goals so the individual who is blind can reach out and achieve his or her full potential.

Today, the greatest barrier facing blind people and people with disabilities is the lack of understanding on the part of the general public and employers. Blindness is not the big deal. It is the biases, fears, myths, and stereotypes of those misunderstandings and assumptions of the disability that really create barriers to independent living and productivity. So the efforts on the part of Rehabilitation [Services] and other disability advocacy agencies to try and create a clearer picture of what blindness is and what it is not is a critical component towards effective rehabilitation. Along with that there is a notion of typecasting or stereotyping. There was a time when it was thought that blind persons could only tune pianos and weave baskets. That was, fortunately, a long time ago, but there are still people who will try and draw connections between a specific disability and a particular job function. Many people think that if a person has a disability, he or she cannot work, cannot be independent, and cannot be productive.

I believe that that same kind of thinking, in some instances for cultural reasons, is more prevalent among people with disabilities who are minorities. That is one of the reasons outreach is essential, and the Commission for the Blind does such outreach in different ways. Outreach and awareness are important components of the agency's service.

A specific barrier that is significant to the clients that the commission serves, as with other people with disabilities, is the lack of accessible and affordable transportation. Transportation to people who are blind is, at times, the most significant provided service because the blind are nondrivers, and as nondrivers have to rely on public transportation. In communities where public transportation is not existent or inadequate, that is a significant barrier to employment and independent living.

Finally, reliable data is inadequate on the extent of the population with disabilities who have functional limitations that are barriers to employment. The Commission on Disability and the National Association of Governors Committee have strongly advocated for a more effective way of counting people with disabilities in the 2000 census. In the next national census, we think we will have more accurate data as to the people with disabilities.[6]

Service Delivery to the Most Severely Disabled

Harry Smith, Michigan Association of Rehabilitation Services Organizations, told the Committee that the definitions of disability were imprecise and vague. As a consequence, the implementation of any order of selection would be flawed. Smith also asserted there is an absence of credible data on the number of persons with functional limitations, which thwarts a rational planning process.

As I see it, you have in the Federal [rehabilitation services program] an unworkable definition. The issues that you are discussing today emanate essentially from an inherent flaw in the Rehabilitation Act in that it assigns to the State rehabilitation agency the responsibility to deliver services to a population which is defined in very loose terms.

The definition [of disability] includes not only a set of functional limitation statements, but also a list of diagnostic categories that allow for eligibility for a program. It is within those diagnostic categories that one begins to have [an idea] of what is wrong with the way this program is structured. For example, the term cerebral palsy is an example of an individual who would be eligible for the program. But the term itself masks a great deal of information and assumes that all cerebral palsy is equal in terms of its functional implications for the individual, as does the term blindness, or any other of the diagnostic labels that are included in this list. Congress assigned responsibility to the States as to what most severely disabled means. As a consequence, within this country there are some 80 jurisdictions required by the Federal Government to define the term most severely disabled. That's an abject failure.

A second problem, in my opinion, is the whole issue of the order of selection provision. There are, by any rational look at the numbers, a pool of individuals who are eligible for services who far outstrip the capability of the State rehabilitation agency to deliver services to them on an annual basis. . . . The order of selection, as you can appreciate, gets more complicated if you have a loose definition given to you by the United States Congress. Who gets what? It is really an inequity issue.

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[6] Testimony of Patrick Cannon, Michigan Transcript, pp. 144–55.

Another major problem is the total absence of useful data that would guide the States in terms of what is a disability. If you look at the catalog of the Federal domestic assistance programs, I think you'll find an excess of 100 different programs that are targeted towards disability, and you will find a plethora of definitions about what constitutes a disability and the programs that are financed and/or operated by the Federal Government. In the last census, there was an attempt to provide input to the Census Bureau so that it could provide a national database of persons with functional limitations that made sense and that would provide a more rational planning process. It does not exist today.[7]

Elizabeth Bauer, executive director of Michigan Protection and Advocacy, and Amy Mays, director of the client assistance program at Michigan Protection and Advocacy, spoke to the Committee about rehabilitation service delivery. Michigan Protection and Advocacy is a private, nonprofit organization established for the purpose of advocating for the federally mandated rights of individuals with disabilities. The representatives from Protection and Advocacy stated calls to their office were largely of three types: (1) calls from service providers who are out of funds, (2) calls from clients who do not understand their rights, and (3) calls from clients wanting more and/or different services than those being provided by MRS.

The purpose of Michigan Protection and Advocacy is to provide services to individual folks who are either interested in receiving vocational rehabilitation services, are current applicants or clients of vocational rehabilitation services, or may have had a former client appropriate our services. On any given day our organization will receive 10 to 15 calls.

Most issues play into the rationing effect. People are generally reacting to the funding levels available in each district office, since whether or not they receive services is connected to the funding level available. As the year goes on the funding level goes down, and that prompts calls to our office from [service providers] saying, "We don't have any money. What do we do about that now?" In those instances we remind them of their Federal mandates, and tell them to remind their staff that they still need to approach each case individually and make decisions based upon informed choice.

Protection and Advocacy also receives numerous calls dealing with communication problems. Rehabilitation counselors . . . have anywhere from 150 to 200 cases. As a result, we get a lot of clients who either have not heard from their counselor in a while or they have not touched base with them themselves. Many people find that they are unable to advocate for themselves as effectively as they would like, and many times people do not understand what their rights are.

The client assistance program with the Michigan Protection Advocacy Service has served about 1,500 people. A large percentage of calls to MPA are from individuals who feel they are not getting the services that they want. I will also add that sometimes individuals want to have a lot more than what can realistically happen. Most complaints about service provision are [general in nature] as people are not calling and saying, "I think I need these services." They are not identifying those.[8]

Roanne Chaney, Michigan Disability Rights Coalition, told the Committee that vocational rehabilitation counselors often do not recognize the effectiveness of providing independent living and working services to clients.

Many [VR counselors] do not recognize the interaction between independent living [IL] issues and rehabilitation services. An upcoming study funded through a Developmental Disabilities Council grant has done a cost effectiveness study of [IL services].

The study shows a cost effectiveness for investing in personal assisted services for people who work, i.e., the dollars put in compared to the dollars returned in taxes are the greatest for people provided IL service. There is also the category of cost avoidance, what is not paid out in terms of . . . government subsidies that are avoided by a person staying employed.

In addition, the study reports on the [cost effectiveness] of IL home-based employment [and] secondary education. It is sometimes difficult to get funding through rehabilitation services [for these types of programs].[9]

Greta Wu is the service director at Peckham Vocational Industries, a community rehabilitation organization in the Lansing area. Peckham Industries provides rehabilitation services, in-

[7] Testimony of Harry Smith, Michigan Transcript, pp. 45–64.

[8] Testimony of Amy Mays, Michigan Transcript, pp. 79–83.

[9] Testimony of RoAnne Chaney, Michigan Transcript, pp. 109–17.

cluding career assessment, job training, supported work experience, job placement, education, and job coaching services. Wu talked about Peckham's relationship with MRS.

The Michigan Rehab Services refer a lot of people to Peckham. They do vocational assessment. Typically they do not make commitments on how many clients will be referred, they just refer clients to us for services. If the referred person does not have a vocational goal, we help them to determine that.

Although Peckham does not have specific performance requirements from MRS, it is required to report outcomes. MRS evaluates each service provided by Peckham to its referrals. MRS also evaluates how successful the placement rates are and evaluates Peckham on its inclusion of consumer input into services.[10]

June Cronk has been affiliated with the Lansing Center for Independent Living for 18 years. She is currently chairperson of the board for the center. Cronk talked about the center's association with Michigan Rehabilitation Services.

The Lansing Center for Independent Living receives a lot of referrals from the Lansing district office of MRS for many reasons: people who need help with housing, people who need help with transportation, people who need help with the Family Independence Agency . . . For just our regular services, they just refer them over there and we do what we can do, and that's not an issue at that point.

To this end, our agency has contracts with the local district office of MRS that have expected outcomes and numbers at the end of the fiscal year. We report all those things to MRS, and I expect if they are not satisfactory, then MRS will not renew the contract.

One major flaw in the current program is that if a person goes to work, he loses his social security after 12 months if he earns over $500 a month. He can also lose medicare after a certain amount of time, and if on medicaid and have subsidized housing, lose that too. . . . There is a whole system of disincentives in place for people with disabilities if they want to go with work.[11]

Duncan Wyeth, a specialist in customer relations with Michigan Rehabilitation Services and a member of the Michigan Developmental Disabilities Council, addressed the issues of "severe" disability and the number of individuals needing services.

The discussion of severity is amusing in that it is similar to the futile Medieval discussions about the number of angels that can dance on the head of a pin. I have cerebral palsy. It affects my balance, my walking, my fine motor control. In my work environment as an advocate for persons with disabilities, I would suggest to you that my cerebral palsy is a significant advantage. Severity is a very relative term. There are no absolutes in terms of severity. The issue is whether or not the specific social and physical environment that an individual is in causes that characteristic to interact with that environment in such a way as to present a disadvantage.

The number of people needing services and the number of people actually being served by the rehab system is an important issue. Historically in this country . . . people with disabilities were either underserved or unserved. So developed a series of specialized programs to specifically remedy that underservice or nonservice. Those specialized programs have themselves, at times, become a barrier to further progress insofar as when a person with a disability contacts the employment service and identifies himself as having a disability, that employment service automatically says, "Oh, you need to go to rehabilitation or vocational rehabilitation." There needs to be a total integration of persons with disabilities so that the State agency, rather than becoming the first service delivery system for persons with disabilities might be just one component of employment services.[12]

Service Delivery to Minorities

Harry Smith, Michigan Association of Rehabilitation Services Organizations, has 30 years of experience in rehabilitation services in Michigan. He told the Committee that over that period there has been a fundamental change in funding. Years ago there was no reliance on local third-party dollars; today there are more than 100 local entities in the State providing part of the State's matching grant money. This devel-

[10] Testimony of Greta Wu, Michigan Transcript, pp. 197–207.

[11] Testimony of June Cronk, Michigan Transcript, pp. 207–12. In December 1999 President Clinton signed the Work Incentives Improvement Act, which removes income limits and allows disabled workers to retain health insurance coverage through medicaid or medicare.

[12] Testimony of Duncan Wyeth, Michigan Transcript, pp. 227–36.

opment could have a severe impact on the equitable delivery of rehabilitation services to the poorer communities.

In Michigan we have gone from a situation where there was no reliance on dollars originating from the third-party sources, to a situation where there are now 140 plus agreements that are entered into between the State rehabilitation agency and local entities to generate the local dollars that can then be used by the State of Michigan to claim the Federal match that is necessary to drive the program.

What is the consequence of using that local match? [First], in some instances a consequence is that dollars are targeted towards populations that may or may not be consistent with the intent of the Congress. [Second], the targeted dollars may be consistent with [the intent of Congress] in the broad definitional sense provided to the State rehabilitation agency, but nevertheless directs resources to populations when there are equally valid claims from other disability groups that do not have those kind of contacts in local communities where they can have dollars put up and targeted to meet their needs.

[So service provision] becomes a function of where you reside within the State of Michigan. As one would expect, the richer communities of the State of Michigan are in better positions to make contributions to provide for an expansion of rehabilitation service capacity than the poorer communities are within the State of Michigan. So you end up with a dollar skewing. And I recognize that the State rehabilitation agency has taken efforts to minimize the impact of that. The question I have in my mind is, Can they eliminate it? And I would suggest that would be very difficult for them to do. This problem with the local money is not a recent phenomenon that's just occurred with this particular administration.[13]

Robert McConnell, Michigan Association of Multicultural Rehabilitation Concerns, discussed rehabilitation services relevant to minority persons with disabilities.

The Rehabilitation Act Amendments in 1992 had a special section, section 21, that addresses issues that affect minority persons with disabilities and rehabilitation service delivery systems. There is a significant difference in the incidence of disability between the minority and nonminority populations. Depending upon the racial or ethnic [minority] group, minorities are from 1½ to 2½ times as likely to have a disability.

Employment and rehabilitation programs seem to be less effective for minorities than nonminorities. In general, earning levels, type of employment, ability to acquire employment, and ability to maintain employment are all issues that are more pronounced with minority populations of persons with disabilities than nonminorities.

Data also indicates that persons with disabilities from minority backgrounds have lower income levels than nonminorities with disabilities. Education levels of minorities are behind those of the majority population, and health care and treatment is an issue that is particularly pronounced for minority persons with disabilities.[14]

The effectiveness of the Americans with Disabilities Act (ADA) depends on awareness about the law among those affected, and the adequacy of enforcement. In both areas, minority populations appear to be disadvantaged. . . . Two factors appear to mitigate against timely resolution: (1) inadequate staffing, and (2) cumbersome complaint resolution process . . .

It is recommended that annual followup and monitoring and quarterly reporting occur by the Rehabilitation Services Administration. This monitoring should occur on two levels: (1) performance as described in the State Plan . . . and (2) maintenance of data on equity performance indicators [including] outreach/penetration, outcome indicators, and service equity.[15]

Greta Wu identified cultural barriers that interfere with rehabilitation service delivery to minority communities.

From the experiences at Peckham Industries, we notice that with the refugee population often we encounter a lot of resistance. The [refugee] family does not want to recognize the disability and do not want to seek help. It is almost a kind of issue that they do not want even to discuss, so when we offer to help they say, "No, we can take care of that." Particularly with mental health, there is a very big stigma.[16]

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13 Testimony of Harry Smith, Michigan Transcript, pp. 45–64.

14 Testimony of Robert McConnell, Michigan Transcript, pp. 70–75.

15 L. Robert McConnell, letter to Michigan Advisory Committee, U.S. Commission on Civil Rights, July 13, 1998, Midwestern Regional Office files.

16 Testimony of Greta Wu, Michigan Transcript, p. 206.

Surveys on Rehabilitation Services

Michigan Rehabilitation Advisory Council Report

Richard Webster, director of the Michigan Rehabilitation Advisory Council, submitted the council's most recent annual report on the status and quality of vocational programs operated within the State. The Michigan Rehabilitation Advisory Council is a federally mandated council to advise Michigan Rehabilitation Services (MRS) on all programs and policies related to title I and title VII–C of the Rehabilitation Act. Pertaining to the FY 1997 performance of MRS, the council reported:

- Total of 9,800 individuals placed into employment, with 6,488 rehabilitated (90 days of suitable work), compared with a goal of 6,700. 41,000 customers served with case service/grants budget exceeding $37M. All goals surpassed with the exception of successful rehabilitations; 3% gap was due to early retirement of 38 counselors and change of federal policy requiring 90 days follow up for successful rehabilitation.
- Service delivery redesign pilot project completed; implementation in all offices underway. Three-year comparison shows significant reduction in cycle time for critical stages of rehabilitation model (79 to 36 days for eligibility; 125 to 92 days for rehabilitation plan).
- Increases in all categories in number of under served people with disabilities served. Increase of 1,150 school age youth and 1,100 African Americans.
- Full funding achieved as result of expanding cash match to $4.5M in 1997 and $5.0M in 1998. 140 agreements show balance between community mental health (40%), schools (37%), and other sources (22%).[17]

Survey of Needs for Rehabilitation Services

An internal study by the Michigan Rehabilitation Services in 1988 found that existing information about needs for rehabilitation services was inadequate. The information was either national in scope or dealt with disability rather than need for services. As a result, MRS engaged in a statewide survey to learn the number of people in Michigan limited in their ability to function in employment and independent living because of physical, mental, or emotional condition and the severity of the limitation.[18]

Surveys of the general population provide notoriously variable estimates of the number of people who have disabilities.[19] Surveys of the general population require that individuals who have disabilities identify themselves, and the results may vary widely when different methods of inquiry are used. Some individuals do not consider themselves disabled or functionally impaired even when they have conditions that might be regarded as a physical or mental impairment that constitutes or results in a substantial impediment to employment by others. The same individuals may view their situation differently when they are successfully working than when they are out of work and seeking employment.

The content of the MRS survey was developed after reviewing other studies by Federal and State agencies and consumer groups. The study's overall design was based on the survey, "The ICD Survey of Disabled Americans: Bringing Disabled Americans into the Mainstream," conducted in 1986 by Louis S. Harris and Associates for the International Center for the Disabled in cooperation with the National Council for the Handicapped.

The MRS design employs "screening" techniques to locate respondents for the study. Screening questions leading to indepth interviews generally do not provide the same estimates as studies designed solely to establish prevalence rates. Table 4 shows the MRS survey resulted in an estimate that 5.4 percent of the persons in Michigan aged 16–74, or 356,900 individuals, have a disability or health condition that limits their ability to work or conduct other major life activities. The estimated prevalence of disability resulting from this survey is lower than the rate obtained by other methods.

The 1990 U.S. census found the number of people in Michigan aged 16 to 64 who were limited in their ability to work at a job to be 9.3 per-

[17] The Michigan Rehabilitation Advisory Council, "MRAC Annual Report 1996–97."

[18] Michigan Rehabilitation Services, "The MRS Survey of Needs for Rehabilitation Services in Michigan," conducted by Project Outreach of the Michigan Board of Education, Robert D. Struthers, Ph.D., project coordinator, July 18–Aug. 3, 1988 (hereafter cited as MRS Survey).

[19] *See* L.D. Haber, "Trends and Demographic Studies on Programs for Disabled Persons," in *Social Influences in Rehabilitation Planning: Blueprint for the 21st Century* (Alexandria, VA: National Rehabilitation Association, 1984).

cent, or 550,000. Other estimates based on national studies are also generally higher.[20]

The MRS study provides evidence that the number Michigan residents with a physical or mental impairment causing a substantial impediment to employment is large—some 356,900 adults aged 16–74. Moreover, according to the MRS survey, 91 percent of those responding they had a disability had a severe disability by Federal definition. Assuming the rate of disability to be constant and given the increase in population in the last 10 years, the number of individuals aged 16–74 with a disability that is a substantial impediment to employment is 400,000, and 364,000 of those individuals have a disability that by Federal definition is severe.[21] According to the testimony of Robert Davis, State director of Michigan Rehabilitation Services, MRS rehabilitates 7,000 people on an annual basis. In a typical year approximately 40,000 people receive MRS services.[22]

Table 4
Calculation of the Number of People with Disabilities in Michigan, Ages 16–74

Households in Michigan (1987)	3,385,000
Total population (1987)	9,200,000
Population aged 16–74 (total pop. x .721)	6,633,200
Households screened	13,551
Mean residents in screened households	2.8
Individuals screened	37,536
Number aged 16–74 (37,536 x .721)	27,059
Survey identified 16–74 persons w/disability	1,456
As percent of households screened	10.8%
As percent of individuals screened	5.4%
Percent times total population 16–74 (5.4 x 6,633,200)	356,900

SOURCE: Michigan Rehabilitation Services, "1998 MRS Needs Survey."

Statewide Independent Living Council Survey

Patricia Cudahy from the Statewide Independent Living Council (SILC) testified on its survey of rehabilitation services delivery. SILC, a Governor-appointed council made up of 18 individuals, more than half of whom have disabilities, advises the Governor and the State departments on issues affecting the lives of people with disabilities. In the 3-year period 1995–97 at a series of town hall meetings, SILC undertook to collect input from individuals with disabilities, their families, advocates, and professionals on the concerns and shortcomings in the delivery of rehabilitation services. Cudahy told the Committee:

> When we did the town hall meetings, SILC had five different disability issues: employment, transportation, assisted technology, personal and family supports, and independent living services. Out of the 275 people surveyed, [all] 275 thought that people with disabilities in their area needed help in finding available jobs . . . and they needed transportation to get to work.
>
> Several themes emerged regarding employment. One of these is transition programs. While transition services for youth is a major and important emphasis [of MRS], other life transitions should be considered. For people with significant disabilities the aging process poses many challenges. The person with a significant disability is now living longer and is faced with an added stress of a body going through the aging process along with the disability. [Rehabilitation Services delivery programs] also need to consider job longevity expectations. There needs it be an increased awareness of the impact of adding employment to the life of a person with a significant disability.
>
> Transportation continues to be a high concern of people with disabilities. . . . There need to be more people employed in the [rehabilitation] system who have disabilities themselves in order to affect the systems change we need. . . . Independent living is a key component of employment; a person who has a significant disability has to understand in his own mind that he has value and worth and that he can go to work and amount to something. And that is where independent living starts.[23]

[20] MRS Survey.

[21] Ibid.

[22] *See* chap. 3, testimony of Robert Davis.

[23] Testimony of Patricia Cudahy, Michigan Transcript, pp. 139–47.

Chapter 4

Data Analysis on the Provision of Rehabilitation Services

The Research and Training Center for Access to Rehabilitation and Economic Opportunity, Howard University, in 1995 studied the variables related to the provision of rehabilitation services.[1] The study was supported by a grant from the U.S. Department of Education, National Institute on Disability and Rehabilitation Research, and the Rehabilitation Services Administration.

The study addressed several topics pertinent to the Michigan Advisory Committee study on the provision of rehabilitation services. Specific research topics included: (1) how much of the variance in cost of service is a result of severity and type of disability, age, sex, and race, across States and within each State, and (2) what services show variation in delivery according to race/ethnicity.[2]

Following the study by Howard University, the Michigan Advisory Committee analyzed the data of rehabilitation service delivery to individuals in Michigan's tricounty area: Clinton, Eaton, and Ingham.[3] The Michigan Jobs Commission, Rehabilitation Services, has 25 service delivery areas; the Lansing office serves residents living in Clinton, Eaton, and Ingham Counties. Of interest to the Advisory Committee were (1) the delivery of services on the basis of severity of disability, and (2) the delivery of rehabilitation services on the basis of minority/ethnic status.

[1] Sylvia Walker, Charles Asbury, Armon Rodgriguez, and R.C. Saravanbhavan, Howard University Research and Training Center for Access to Rehabilitation and Economic Opportunity, "An Examination of Variables Related to the Cost of Purchased Rehabilitation Services Relative to the Needs of Persons with Disabilities from Diverse Ethnic Backgrounds," 1995 (hereafter cited as Howard Study).

[2] Howard Study, pp. 26–27.

[3] Data analysis was conducted by Commission staff in the Midwestern Regional Office, U.S. Commission on Civil Rights.

Howard University Study

The Howard University Research and Training Center examined the factors that influenced variations in the cost of purchased services in the delivery of rehabilitation services to racial/ethnic groups. Data analyses confirmed significant variations in services and costs within regions among racial/ethnic groups.

Two variables, "time spent in VR program" and "the number of services," accounted for 19 percent of the variance in the cost of purchased services. Further analyses indicated a cluster of 15 other factors, including the client's race/ethnicity, which accounted for an additional 2 percent of the variance in the cost of purchased services. In general, individuals from African American, Hispanic American, and American Indian groups do not have as much money spent on their services as do persons from white or Asian groups.

The study further indicated that the individual's educational level and economic independence upon entrance into the program were the two major influences on the individual's earnings at closure. The inferences from this finding are (1) consumers from racial/ethnic minority groups, especially African Americans, American Indians, and Hispanic Americans, enter vocational rehabilitation programs with relatively less education; (2) since education is closely linked to economic status, these consumers are likely to be economically worseoff; and (3) it is possible that these minority consumers may not be fully aware of their rights to request services, where such services are available, and how to access such services.[4]

If funding is proportionate among groups, then the percentage of funds spent on one particular subgroup should be the same as its percentage representation in the total group. How-

[4] Howard Study, pp. 98–99.

ever, the specific examination of the data shows that for the category of purchased services costing *$2000 or less*, African Americans were overrepresented (19.2 percent) relative to their percentage in the total population (17.4 percent). The proportion of white Americans was lower (70.5 percent) relative to their representation in the population (72.4 percent).

For the category of services costing *more than $5,000*, the relative percentages are reversed, with whites being disproportionately overrepresented (74.7 percent) compared with their total population (72.4 percent), and blacks (14.9 percent) being underrepresented compared with their representation (17.4 percent) in the population. A similar pattern was noted for American Indians and for Hispanic Americans, but to a much lesser extent. The representation of Asian Americans was more comparable to their population proportions.

An examination of the remaining cost of services for the category of service costing *between $5,000 and $8,000* shows a similar pattern as noted for the *above-$5,000* category. White clients were always represented relative to their population representation; in general the other groups were underrepresented relative to their population.[5]

A "saturated" model was employed to identify significant variables that account for variance in the cost of services. The dependent variable was the amount of money spent for purchased services. The list of independent variables included demographic characteristics, major and secondary disabilities, and other considered variables. The total number of variables reaching significance for the saturated model was in order of influence as follows:

1. Time in VR
2. Number of purchased services
3. Orthopedic, limbs
4. Blindness
5. Educational facility
6. Major disability
7. Rehabilitation facility
8. Psychotic conditions
9. Hearing impairment
10. White
11. Orthopedic, absence one upper, one lower
12. Drug abuse
13. Deafness
14. Orthopedic, lower[6]

Analysis of Rehabilitation Service Delivery in the Tricounty Area

The Michigan Advisory Committee undertook its own independent study to determine if, in Michigan, severity of disability and/or race were associated with the provision of rehabilitation services. The Advisory Committee analysis was limited to the tricounty area of Clinton, Eaton, and Ingham Counties, served by the Michigan Jobs Commission Lansing Rehabilitation Services (RS) office. This area was selected as a representative area because of its central location, relatively sizable population that is racially and ethnically diverse, and the area's diversity of rural and urban populations. Services provided by the Michigan Commission for the Blind were not analyzed as part of this study.

The population of Clinton, Eaton, and Ingham Counties is estimated in 1997 by the U.S. Census Bureau to be 371,275 (86.4 percent) white; 30,021 (7 percent) African American; 17,037 (4 percent) Hispanic; 8,254 (1.9 percent) Asian; and 2,912 (0.7 percent) American Indian.

Three sets of analyses were intended. The first analysis was to be a study of the relationship between severity of disability and successful rehabilitation. A multivariate logistic analysis was planned with successful rehabilitation the dependent variable and severity of disability, i.e., *most severe, severe, or not severe*; cost of services; race and ethnicity; education; age; and months of rehabilitation separately and interactively the independent variables.

Michigan Rehabilitation Services codes severity of disability under seven codes: "0" not reported, "1" severe—SSDI eligible, "2" severe—SSI eligible, "3" severe—disability, "4" severe—disability plus qualifying condition, "5" severe—functional limitation, and "6" not severe. Among all clients in the Lansing RS office, 37 had code 0 and 48 had code 6. The other 1,849 cases were designated with a "severe" disability code, i.e., codes 1, 2, 3, 4, or 5.

It is evident that the current format of the data does not allow for an analysis of service on the basis of severity of disability because (1)

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[5] Ibid., pp. 36–38.

[6] Ibid., p. 40.

there is no clear delineation between "severe" and "most severe" in the data set, and (2) the number of "not severe" is too small for a valid statistical procedure.

Two other sets of analyses were undertaken to examine the impact of race and ethnicity on rehabilitation services. First, the case status, e.g., "closed—rehabed" and "closed—not rehabed," for the major racial and ethnic groups was analyzed to determine if the case status was independent of race and ethnicity. That is, the analysis examined whether a relationship existed between race and ethnicity and the status of a case. In concert with this analysis, the rate of successfully closed cases, i.e., employment, was analyzed for differences along racial and ethnic lines.

Second, the types of services provided to the different racial and ethnic groups were analyzed to determine if the type of service provided was independent of race and ethnicity. That is, the study examined whether a relationship existed between an individual's race and/or ethnicity and the type of rehabilitation service he or she received.

Data

Information on clients served by the Lansing RS office during 1998 was obtained by the Committee. The relevant variables obtained for each client included: (1) race/ethnicity, (2) case status, (3) primary disability, (4) secondary disability, (5) severity of disability, (6) beginning service date, (7) case cost, (8) reason case not successfully closed, (9) work status, (10) age, (11) education, and (12) types of services provided. The race and ethnicity groups are white, black, Hispanic, Asian, and American Indian. Case status refers to cases opened and closed and the reasons for case closure.

Thirteen types of services can be provided to clients and information on these services was also obtained for each client. These services can include: diagnostic services, restoration, on-the-job training, placement, college, business/vocational training, maintenance, counseling, adjustment, job referral, miscellaneous, and other.

Racial/Ethnic Overview

In 1998 the Lansing RS office had 1,934 active clients. The racial and ethnic breakdown was 1,503 (77.7 percent) white; 333 (17.2 percent) African American; 62 (3.2 percent) Hispanic; 23 (1.2 percent) Asian; and 13 (0.7) American Indian. Minorities, as a group, are receiving rehabilitation services at a higher rate than their proportion of the population. The minority population percentage in the tricounty area is estimated to be 13.6 percent of the population; yet minorities are 22.2 percent of the Lansing RS office clientele. However, African Americans are the only racial/ethnic minority group to receive a disproportionate level of services relative to their proportion of the population. African Americans are 7 percent of the area population, and 17.2 percent of the Lansing RS office clientele (see table 5).

Table 5
Comparison of Tricounty Population to Rehabilitation Services Clientele by Race/Ethnicity

Race/Ethnicity	Percent of population	Percent of RS clients
White	86.4	77.7
Black	7.0	17.2
Hispanic	4.0	3.2
Asian	1.9	1.2
American Indian	0.7	0.7

SOURCE: Data from Michigan Rehabilitation Services, tabulated by the U.S. Commission on Civil Rights, Midwestern Regional Office.

Table 6
Mean Age and Education Level for Rehabilitation Services Clientele by Race/Ethnicity

Race/Ethnicity	Average age	Average education
White	35	10.8
Black	35	11.4
Hispanic	31	10.6
Asian	26	11.3
American Indian	35	12.5

SOURCE: Data from Michigan Rehabilitation Services, tabulated by the U.S. Commission on Civil Rights, Midwestern Regional Office.

Ages of clients receiving rehabilitation services at the Lansing RS office are similar along racial and ethnic groups. Among white, African American, and American Indian clients, the av-

erage age is 35. The Asian clientele has the lowest average age, 26, and Hispanics have the second lowest average age, 31.

Similar to age, there is no significant difference among the racial and ethnic groups in the mean education level of the clientele receiving rehabilitation services at the Lansing RS office. American Indians have the highest average level of education, 12.5 years. Asians and African Americans average 11.3 years of schooling. The average level of education for whites is 10.8 years, and for Hispanics it is 10.6 years.

Table 7
Case Status by Race/Ethnicity

	White	Black	Hispanic	Asian	American Indian
Extended evaluation	23	9	0	1	0
Closed during processing	135	41	10	1	3
Eligibility development	172	34	5	5	2
Physical and mental restoration	46	11	4	0	0
Training	263	48	8	7	3
Ready for employment	67	20	2	1	1
In employment	159	22	5	1	0
Services interrupted	24	7	3	0	0
Closed—rehabed	233	44	10	4	0
Closed—not rehabed	263	67	11	1	3

SOURCE: Data from Michigan Rehabilitation Services, tabulated by the U.S. Commission on Civil Rights, Midwestern Regional Office.

Analysis of Case Status

The case status indicates the progress of a client toward employment. There are 19 different status codes that may be assigned to a case. The Advisory Committee analysis considered 11 codes to test for independence from race and ethnicity: (1) extended evaluation, (2) closed during processing, (3) eligibility development, (4) physical and mental restoration, (5) training, (6) readiness for employment, (7) in employment, (8) services interrupted, (9) closed—rehabed, (10) closed—not rehabed after 12 months, and (11) closed—not rehabed after 10 months. For the analysis, variables (10) and (11) were combined.

Six of the seven excluded codes had no activity: referral, preservice, counseling and guidance, post-employment service, closed from preservice, and closed due to no application. The other code excluded from the analysis was applicant. The number of clients by race and ethnicity for the 10 included status variables are in table 7.

A chi-square test procedure was employed to analyze the frequency of occurrence of observations in the observed sample of services provided and the expected frequencies of such services obtained from an hypothesized distribution. Comparing observed frequencies with corresponding expected frequencies demonstrates whether differences in case status are associated with race and ethnicity. The employed procedure, a "goodness-of-fit" test, is based on the quantity:

$$X^2 = \sum_{i=1} \{(o_i - e_i)^2 / e_i\}$$
(eq. 4.1)

where X^2 is a value of the random variable X^2 whose sampling distribution is approximated very closely by the chi-square distribution. The symbols "o" and "e" represent the observed and expected frequencies for the *ith* cell.[7]

Computing equation 4.1, $X^2 = 39.2$, while X^2 ($\alpha = 0.05$) with 36 degrees of freedom equals 43.7. Since X^2 (39.2) $<$ X^2 (43.7), the null hy-

[7] Note, if $X^2 > X^2$ ($\alpha = 0.05$), the null hypothesis of independence is rejected at the α level of significance; otherwise, the null hypothesis is accepted. The degrees of freedom, v, is (r-1)(c-1).

pothesis is rejected at the 0.05 level of significance, and race and/or ethnicity and the status of a case are not related. In other words, the race and ethnicity of clients are independent of the particular status of a case, everything else held constant.

A subsequent analysis was undertaken to examine specifically whether the proportion of minorities in the rehabilitation services program obtaining employment was significantly different from the proportion of nonminorities in the program obtaining employment. Examining table 7, 28.3 percent of whites have obtained employment, i.e., status of "in employment" or "closed—rehabed," while only 21.8 percent of minorities have obtained employment.

To control for the outlier effect of extraneous case status and condensed timeframes, only four case status variables were considered: (variable 7) in employment; (variable 8) services interrupted; (variable 9) closed—rehabed; and (variables 10 and 11) closed—not rehabed. By racial/ethnic group, these case status variables affected 679 whites, 140 African Americans, 29 Hispanics, 6 Asians, and 3 American Indians.

The first two variables, "closed—rehabed" and "in employment," were combined into a "successful rehab" variable, while the two variables "closed—not rehabed" and "services interrupted" were combined into one "unsuccessful rehab" variable. From table 7, 392 whites had a successful rehab, 66 African Americans had a successful rehab, 15 Hispanics had a successful rehab, 5 Asians had a successful rehab, and no American Indians had a successful rehab.

Combining the four minority groups, in the Lansing RS office white clients have a "successful rehab" rate of 57.7 percent. Minorities have a lower "successful rehab" rate of 48.3 percent. Using a point estimation technique of the observed proportion in a binomial distribution, a confidence interval can be established for p to determine if the observed "successful rehab" rates for minorities is significantly different than expected. The point estimator of the observed proportion, π, is determined by:

$$\pi - z_{\alpha/2} \cdot \{(\pi \cdot q)/n\}^{1/2} < p < \pi + z_{\alpha/2} \cdot \{(\pi \cdot q)/n\}^{1/2}$$
(eq. 4.2)

Computing equation 4.2, the confidence interval for p is:

$$52.7\% < p < 55.8\%$$
(eq. 4.2a)

where $\alpha = 0.05$. This means, other things constant, with 95 percent probability the observed percentage of minorities with a "successful rehab" should be between 52.7 percent and 55.8 percent. However, the observed proportion of minorities is 48.3 percent, a rate significantly lower than what would be expected absent unusual circumstances.

A possible explanatory variable is that the unemployment rate for minorities in the Lansing RS area is significantly higher than the unemployment rate of whites. If minorities, independently of rehabilitation services, are less likely to be employed than nonminorities, then the results observed in equation 4.2a are not unexpected.

Analysis of Types of Services Provided

The number of types of services provided to clients was evaluated for independence from race and ethnicity. The 13 types of services provided: (1) diagnostic services, (2) restoration, (3) on-the-job training, (4) placement, (5) financial aid for college, (6) business/vocational training, (7) transportation, (8) maintenance, (9) counseling, (10) adjustment, (11) job referral, (12) miscellaneous, and (13) other, by race and ethnicity are shown in table 8.

A chi-square test procedure was employed to analyze the frequency of occurrence of observations in the observed sample of services provided and the expected frequencies of such services obtained from an hypothesized distribution. By comparing the observed frequencies with the corresponding expected frequencies, it can be determined whether differences in services among racial and ethnic groups are a result of sampling chance or the result of a nonuniform distribution.

The procedure, a "goodness-of-fit" test, is based on the quantity:

$$X^2 = \sum_{i=1} \{(o_i - e_i)^2 / e_i\}$$
(eq. 4.3)

where X^2 is a value of the random variable X^2 whose sampling distribution is approximated very closely by the chi-square distribution. The

Table 8
Numbers of Types of Services Provided by Race/Ethnicity

	White	Black	Hispanic	Asian	American Indian
Diagnostic	1,825	436	71	11	22
Restoration	342	114	12	4	0
On-the-job placement	41	8	0	0	0
Placement	381	50	12	0	0
College	156	22	1	0	1
Business/Vocational training	70	10	1	0	0
Transportation	157	35	10	3	2
Maintenance	104	36	7	1	0
Other	242	45	13	1	1
Miscellaneous	116	18	5	4	0
Counseling	817	152	32	8	0
Adjustment	133	30	5	1	1
Job referral	405	48	13	3	0
Total	4,789	1,004	182	36	27

SOURCE: Data from Michigan Rehabilitation Services, tabulated by the U.S. Commission on Civil Rights, Midwestern Regional Office.

symbols "o" and "e" represent the observed and expected frequencies for the *ith* cell.[8]

Computing equation 4.3, $X^2 = 47.4$, while X^2 ($\alpha = 0.05$) with 48 degrees of freedom equals 43.7. Since X^2 (47.4) > X^2 (43.7), the null hypothesis is rejected at the .05 level of significance. Race and ethnicity and the types of services provided are not independent. That is, the above establishes a statistically significant relationship between an individual's race and/or ethnicity and the receipt of specific rehabilitation services.

Equity of Resource Distribution

For several years appropriations of general funds by the Michigan State Legislature have been insufficient to capture all Federal dollars available for vocational rehabilitation. The Rehabilitation Services Administration requires match by the State or local public entities at a ratio of 21.3 percent State or local to 78.7 percent Federal dollars.[9]

MRS attempted to make up the shortfall in general funds by approaching public community partners. Most of the partners with available funds were community mental health agencies or local school districts. These entities and others have contributed a total of more than $5 million that supports a total of about $18.3 million. These funds represent about 20 percent of the total budget.[10]

The remaining 80 percent of the MRS budget goes to support the Michigan Career and Technical Institute ($7.7 million); operations, including staff, travel, supplies, rent, etc. ($40.3 million); title I grants ($6.3 million), non-title I grants ($3.6 million), and case service dollars for the general disabled population. Most of this 80 percent is distributed equitably based on the 1990 census data for the disabled working-age population. Grants are awarded on a variety of bases, some competitive, some by population formula.[11]

The 20 percent, or $18.3 million, is what MRS calls the cash match portion of its case service budget. This is where the equity problem presents itself in that opportunities for cash match contributions vary from area to area around the State. Historically, communities on the west side of Michigan have been more able or willing to put forth local match dollars than those on the

[8] Note, if $X^2 > X^2$ (α=0.05), the null hypothesis of independence is rejected at the α level of significance; otherwise, the null hypothesis is accepted. The degrees of freedom, v, is $(r-1)(c-1)$.

[9] Robert E. Davis, letter to Peter Minarik, Midwestern Regional Office, U.S. Commission on Civil Rights, May 24, 1999, Midwestern Regional Office files.

[10] Ibid.

[11] Ibid.

eastern side—especially the southeast Michigan area.[12]

MRS senior managers recognized this as a growing problem several years ago and instituted a system to mitigate this trend and achieve greater equity over time. The process of managing this 20 percent of the budget toward equity is as follows:

1. A determination is made before the fiscal year as to how much local match is necessary and how much Federal funding that match would capture.
2. Population-based targets are established for each district office. MRS district offices cover specific counties. U.S. census population data for disabled working-age persons are used. Managers are instructed to manage their local cash match agreements toward their population-based portion of the potential cash match case service funds.
3. This equity target is compared with the actual and potential value of cash match agreements. The ratio of actual and potential agreement value to the population-based proportion of the cash match total is computed. "Equity" is the percentage of the population-based figure represented by the actual and potential value. For example, Oakland County's figure is 99 percent. This means that its actual and potential agreements are 99 percent of what they would be entitled to if the total cash match was distributed entirely on a disability population-based basis.
4. Managers are instructed they should work toward having their equity ratios between 80 and 120 percent. One hundred percent would represent perfect population-based equity. Offices over 120 percent are not allowed to commit to any agreements over the 120 mark. Offices less than 80 percent are given a period of time to garner more resources in their current agreements or establish new agreements to bring their figure up. A deadline is established.
5. Once the deadline has been reached, the total value of agreements is completed. If it falls short of capturing all Federal dollars available, those offices at more than 120 percent are given the green light to pursue more resources. The overall objective is to have a movement toward 100 percent, but there is acknowledgment that a gradual process is needed to avoid disruption to services in the communities involved.
6. An additional measure MRS undertook to achieve greater equity was to provide the offices with *the lowest amount of cash match* (those in Wayne and Macomb Counties) with *supplemental funds to help balance* their needs. For example, in 1998, an extra amount of money (approximately $1.1 million) was given to Wayne and Macomb counties. The plan was for this supplemental amount to be reduced on a regularly scheduled basis as Wayne and Macomb garnered more cash match. (The equity figures listed for those two counties do not include that supplement. Inclusion would bring them closer to equity.)[13]

Table 9 shows the change in equity figures for each of the MRS district offices over the years 1997, 1998, and 1999. MRS states that its goal was to see movement toward the 100 percent number. An examination of table 9 shows there has essentially been no change in Flint, Port Huron has come closer to equity, Oakland has increased and is now close to perfect equity, and Macomb has increased. Overall, progress has been made in the majority of communities. A few offices have moved away from equity, but they are the exception. MRS has measures being instituted to change that trend.[14]

[12] Ibid.

[13] Ibid.

[14] Ibid.

Table 9
Michigan Rehabilitation Services Cash Match Comparison, FY 1997, 1998, and 1999

Office	1997 budget	% equity	1998 budget	% equity	1999 budget	% equity
Flint	$1,388,897	122	$1,388,889	122	$1,488,889	122
Port Huron	953,280	132	953,256	133	901,670	116
Oakland	1,054,658	63	1,596,970	95	1,793,541	99
Macomb	573,485	46	819,649*	65	919,270**	68
W. Central	1,050,506	82	1,207,378	94	1,244,730	89
N. Michigan	1,160,466	125	1,160,467	125	1,326,252	133
Grand Rapids	1,625,928	177	1,625,804	177	1,187,593	119
Marquette	1,007,217	160	999,715	159	1,000,100	147
Mid. Michigan	1,673,506	151	1,617,778	146	1,567,455	131
Lansing	1,162,126	158	962,219	131	982,504	123
S.W. Michigan	2,273,451	143	2,254,230	142	2,032,193	118
Ann Arbor	1,032,984	88	963,907	82	1,257,615	100
Wayne	1,853,326	35	2,259,242*	47	2,658,130**	50

* plus $848,124 for Wayne, and $222,884 for Macomb
** plus $575,026 for Wayne, and $70,336 for Macomb

SOURCE: Michigan Rehabilitation Services.

Findings and Recommendations

Each year this Nation spends billions of dollars to rehabilitate persons with disabilities. In Michigan these efforts are directed by two agencies: the Michigan Jobs Commission, Rehabilitation Services (MJC–RS), and the Michigan Commission for the Blind (MCB). The objective of these services is employment. To be eligible for MJC–RS or MCB services, a client must need vocational rehabilitation services in order to be employable.

This study by the Michigan Advisory Committee to the U.S. Commission on Civil Rights examined whether persons with disabilities who wished to receive rehabilitation services faced limiting factors on the availability and quality of services as a result of severity of disability, race, or ethnicity. In this chapter the Advisory Committee sets out its findings and recommendations. The findings and recommendations are collected in four parts: (1) rehabilitation services on the basis of disability, (2) rehabilitation services to racial and ethnic minorities, (3) funding, and (4) Federal Government impediments.

1. Rehabilitation Services on the Basis of Disability

Finding 1.1. Multivariate Analysis of the Equal Provision of Service Regardless of the Severity of Disability. MJC–RS codes severity of disability under seven codes; one code is for undiagnosed severity, one code is for "not severe," and the other five codes are different codes for "severe." Within the records examined by the Advisory Committee, 97.5 percent of the coded records listed the client's disability as "severe."

To confirm that the MJC–RS provides equal service regardless of the severity of disability, multivariate analyses were planned with competitive employment and salary the dependent variables. The severity of disability, cost of services, race, age, ethnicity, education, months of rehabilitation, and types of services provided were planned to separately and interactively be the explanatory, or independent, variables.

As no clear delineation is made by the MJC–RS between "most severe" and "severe," and the number of clients classified as "not severe" is too small for valid statistical analysis, the current format of the MJC–RS data set does not allow for an analysis of service on the basis of severity of disability. Further, an examination of recent RSA audits of the MJC–RS reveals that analyses of the equal provision of service on the basis of severity of disability are not routinely done by Federal monitors.

Recommendation 1.1. The Rehabilitation Services Administration of the U.S. Department of Education should request that the MJC–RS amend its coding system in order to classify clients as "most severe," "severe," and "not severe." Doing so will allow for enhanced internal and external independent evaluation of compliance with the Rehabilitation Act Amendments of 1992, which mandate that priority in service be provided to individuals with the most severe disabilities.

The Committee further recommends that the Rehabilitation Services Administration of the U.S. Department of Education conduct a multivariate analysis to determine whether MJC–RS and other State agencies provide service regardless of the severity of disability.

Finding 1.2. Service Rationing. The Rehabilitation Act Amendments of 1992 mandate that services be provided first to those individuals with the most severe disabilities, then (as resources allow) to those less severely disabled. This is referred to as "an order of selection." To implement the act, States are obligated to determine what disabilities meet the standard of "most severe."

The MJC–RS does not use an order of selection. All individuals who wish to receive rehabilitation services in order to obtain employment are given services by the MJC–RS. Based upon the information presented to the Advisory Committee, individuals with the most severe disabilities are not being excluded from rehabilitation

services to the benefit of individuals with less severe disabilities.

However, because no clear delineation is made by the MJC–RS between "most severe" and "severe," and the number of clients classified as "not severe" is too small for valid statistical analysis, the current format of the MJC–RS data set does not allow for an analysis of service rationing on the basis of severity of disability.

Recommendation 1.2. As in recommendation 1.1, the Rehabilitation Services Administration of the U.S. Department of Education should examine the MJC–RS coding system under which virtually every client is classified as "severe," and determine if the coding system used by the MJC–RS is in compliance with Federal law. The enforcement of a coding system that distinguishes clients as "most severe," "severe," and "not severe" will allow for enhanced internal and external independent evaluation of compliance with the Rehabilitation Act Amendments of 1992, which mandate that priority in service be provided to individuals with the most severe disabilities.

Finding 1.3. Employment Outcome and Severity of Disability. In terms of service provided, the Rehabilitation Services Administration of the U.S. Department of Education reports that individuals in Michigan with severe disabilities achieved competitive employment through the MJC–RS at a rate of 91.4 percent compared with the proportion of all rehabilitants in the MJC–RS system who obtained employment. Since individuals with less severe disabilities may require fewer services and have a greater degree of independence in seeking employment than those with severe disabilities, this suggests that the MJC–RS does provide the necessary services required to reach an employment outcome regardless of the severity of disability.

Recommendation 1.3. As in recommendations 1.1 and 1.2, the Rehabilitation Services Administration of the U.S. Department of Education should examine the MJC–RS coding system under which virtually every client is classified as "severe," and determine if the coding system used by the MJC–RS is in compliance with Federal law. The enforcement of a coding system that distinguishes clients as "most severe," "severe," and "not severe" will allow for enhanced internal and external independent evaluation of compliance with the Rehabilitation Act Amendments of 1992, which mandates that priority in service be provided to individuals with the most severe disabilities.

Finding 1.4. Determination of Client Universe. The last study conducted by the MJC–RS to determine the number of individuals needing rehabilitation services was completed in the 1980s. That study mirrored a previous study by the University of Michigan, and indicated that 600,000 to 660,000 individuals in the State met the test of the requirements of the act and that of those, 175,000 individuals not only met the test but were interested in receiving services from the State rehabilitation agency. The number, 175,000, is a fixed point estimate. This means those studies assert that, although on a rotating basis different individuals are entering and leaving the MJC–RS system, the set of people in the State requiring rehabilitation services remains at 175,000.

In fiscal year 1997 the number of persons with disabilities served by MJC–RS was 40,292, and it is estimated the annual maximum number of individuals that can be served by the MJC–RS is 50,000. The difference between 175,000 persons needing services and the 50,000 who can receive services is 125,000 persons. These studies suggest a significant gap between those receiving rehabilitation services and those needing such services.

Recommendation 1.4. The Advisory Committee recommends that the MJC–RS undertake a new study to determine the number of individuals needing rehabilitation services. If a new study confirms a significant gap between the number needing rehabilitation services and the number receiving services, then that information needs to be plainly set before the public and State officials so that those responsible for funding priorities are accountable for their decisions and a covert system of service rationing does not infect the MJC–RS service delivery system because of inadequate funding.

If the dollars are not adequate to meet the need, State officials need to acknowledge the public policy principles to be used to guide how the dollars are distributed and to whom those dollars are directed.

Finding 1.5. Typecasting. The Advisory Committee did not learn of any information supporting an allegation that MJC–RS placement counselors engaged in typecasting, i.e., predetermin-

ing that individuals with certain disabilities were limited to perform only certain kinds of work.

Recommendation 1.5. Again, as in recommendations 1.1, 1.2, and 1.3, the Rehabilitation Services Administration of the U.S. Department of Education should examine the MJC–RS coding system under which virtually every client is classified as "severe," and determine if the coding system used by the MJC–RS is in compliance with Federal law. The enforcement of a coding system that distinguishes clients as "most severe," "severe," and "not severe" will allow for internal and external independent evaluation of whether clients are being typecasted.

2. Rehabilitation Services to Racial and Ethnic Minorities

Finding 2.1. National Estimates of Minorities Requiring Rehabilitation Services. Of the estimated 13,420,000 working-age Americans with disabilities, African Americans account for 22 percent and Hispanics for 7.5 percent, while Asian Americans and American Indians are 2.5 percent of rehabilitation service clients. The incidence of disability disproportionately affects the minority population.

Finding 2.2. Service Outcome and Minorities. According to the most recent audit of the MJC–RS by the Rehabilitation Service Administration of the U.S. Department of Education, the MJC–RS had a rehabilitation rate of 62.1 percent for all cases identified as "severe" in fiscal year 1995. By comparison, African Americans with a "severe" disability achieved a rehabilitation rate of only 53.3 percent, and Native Americans with a "severe" disability had a rehabilitation rate of only 49.2 percent.

According to the U.S. Department of Education, since the difference of the African American rate from the mean rehabilitation rate is within 10 percentage points, the difference is considered "acceptable," though the Department acknowledged that the difference still represented "a significant number of customers who are achieving at less than the average rate." The differential rate of service outcome for Native Americans was considered significant by the U.S. Department of Education.

Recommendation 2.2. The Rehabilitation Services Administration of the U.S. Department of Education should revise its methodology for determining whether a particular minority group receives a lower service outcome. Instead of using a fixed percentage differential for determining acceptability ranges, the Committee recommends the implementation of a scientifically based statistical test.

Finding 2.3. Test for a Relationship between Race/Ethnicity and Case Status. The Advisory Committee tested for a relationship between MJC–RS clients' race and ethnic minority status and the case status of the client, e.g., closed—rehabilitated, closed—not rehabilitated, services interrupted, etc. It was found that race and ethnicity and the status of a case were not related. That is, the race and/or ethnicity of a client is independent of the particular status of a case. The analysis suggests that the ultimate delivery of service by the MJC–RS is statistically proportionate along racial and ethnic lines.

Finding 2.4. Types of Services Provided and Minorities. The Advisory Committee tested for a relationship between the race and ethnicity of a MJC–RS client and the types of services provided to the client, e.g., diagnostics, college financial aid, transportation, etc. It was found that race and ethnicity and the types of services provided were not independent. That is, there is a statistically significant relationship between an individual's race and/or ethnicity and the receipt of specific rehabilitation services.

Recommendation 2.4. The Advisory Committee recommends that the U.S. Department of Education and/or the MJC–RS undertake an internal study to determine whether the observed disparity in services offered to minorities is racially and ethnically biased or based upon other factors.

Finding 2.5. Outreach to Minorities. The U.S. Congress, through its authorizing legislation, has recognized that minorities historically did not have the same access to rehabilitation services as did the majority population, and has required specific outreach efforts to the minority community. There is a need for most service organizations to become more culturally competent with respect to the delivery of services to minority communities.

Service delivery systems, to be effective, must be delivered in a way that considers and is responsive to the populations they serve. Issues of staffing awareness, training and development, outreach, and policy development all relate to making institutional systems more culturally

competent with the clear intent of providing equitable services to minority populations. To this end all MJC–RS staff have received training in cultural diversity awareness, MJC–RS has developed and implemented a multicultural policy, and the agency has undertaken deliberate efforts to increase its numbers of minority employees.

In addition, the MJC–RS has established a Minority Issues Committee to bridge the successful outcome gap that exists between the minority and majority client populations. No evidence was presented to the Committee, however, demonstrating that outcomes and equal access to rehabilitation services along racial and ethnic lines were being quantitatively evaluated by the Minority Issues Committee.

Recommendation 2.5. In order to ensure that minority individuals receive services in an equitable manner, outcomes and access to services need specific attention and monitoring. If programs are not monitored for equity in terms of outcomes, equity in both access to service and in receipt of service cannot become a reality.

The Committee recommends that some internal ombudsman within the MJC–RS be given responsibility for monitoring outcomes and services with respect to equity along racial and ethnic lines. We further recommend that this ombudsman and/or the MJC–RS Minority Issues Committee employ monitoring procedures that incorporate scientifically based statistical tests to routinely analyze whether there is a relationship between the estimated minority community requiring rehabilitation services and the actual services provided by the MJC–RS to the minority community.

3. Funding

Finding 3.1. The Use of Local Funding for the State Match. The Rehabilitation Act of 1973, as amended, authorizes more than $2 billion in Federal support for the training and placement of persons with mental and physical disabilities into full-time, part-time, and supported employment. The program is a joint State and Federal effort, with the Federal Government providing 80 percent of the funding to State vocational rehabilitation programs, and States providing the remaining 20 percent.

The annual budget for MJC–RS in fiscal year 1997 was $89,150,744. The State agency receives 80 percent of its funding from the Federal Government, through grants under title I of the Rehabilitation Act of 1973 ($65,834,659), Social Security Administration funds ($1,845,775), or other Federal funding sources ($3,459,699). The State provides only 10 percent of the agency's funding ($9,531,180), with local funding accounting for the additional matching funds.

Since the MJC–RS, out of its general fund of appropriated dollars from the State legislature, is unable to earn the full Federal matching allotment reserved for Michigan under the formula that distributes the dollars among the States, the agency has increasingly been required to find community partners capable of putting up local dollars and substitute for dollars that up to a decade and a half ago were matched fully by the Michigan Legislature.

The MJC–RS has released to the public the office area recipients of all rehabilitation funding within the State. That data indicate the agency is moving in a direction of funding equity among all geographic areas in the provision of rehabilitation services.

Recommendation 3.1. The use of local matching money to substitute for funds formerly appropriated statewide by the State legislature needs serious scrutiny. Clearly, less affluent communities are less able to provide matching funds for rehabilitation services. Hence, less affluent communities in the State are at risk for a disproportionately lower share of rehabilitation service resources. Where these areas are also communities of color, then the funding becomes disproportionate not only along wealth and class lines, but also along racial and ethnic lines.

The Rehabilitation Services Administration of the U.S. Department of Education needs to attend to this issue. In particular, insofar as the Rehabilitation Act Amendments of 1992 specifically addresses the issue of minority outreach, it is incumbent upon the RSA as part of its monitoring process of the MJC–RS to ensure that the use of matching funds does not result in disparities of service along racial and ethnic lines.

4. Federal Government Impediments

Finding 4.1. Definition of Disability. The Rehabilitation Act of 1986 amended the definition of a "severe handicap" to include functional as well as categorical criteria. In addition, a definition of "employability" was inserted in the act for the first time, to clarify that part-time work is a

viable outcome of rehabilitation services. Under the act, an "individual with a disability" means any individual who:

(a) has a physical or mental impairment that constitutes or results in a substantial impediment to employment; and
(b) can benefit in terms of an employment outcome from vocational rehabilitation services. . . .[1]

An "individual with a significant disability" means an individual with a disability who:

(i) has a severe physical or mental impairment which seriously limits one or more functional capacities (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of an employment outcome;
(ii) whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time; and
(iii) who has one or more physical or mental disabilities resulting from amputation, arthritis, autism, blindness, burn injury, cancer, cerebral palsy, cystic fibrosis, deafness, head injury, heart disease, hemiplegia, hemophilia, respiratory or pulmonary dysfunction, mental retardation, mental illness, multiple sclerosis, muscular dystrophy, musculo-skeletal disorders, neurological disorders (including stroke and epilepsy), paraplegia, quadriplegia, and other spinal cord conditions, sickle cell anemia, specific learning disability, end-stage renal disease, or another disability or combination of disabilities determined on the basis of an assessment for determining eligibility and vocational rehabilitation needs described in subparagraphs (A) and (B) of paragraph (2) to cause comparable substantial functional limitation.[2]

The Federal statute defining severely disabled individuals is nebulous, resulting in inconsistent and different interpretations of severity depending upon the particular State, agency, and counselor, with the result that different States will have different definitions of disability.

The fact that within the records examined by the Advisory Committee 97.5 percent of the coded records listed the client's disability as "severe" is evidence that current Federal rules and guidelines do not provide precision, clarity, and uniformity in defining disability.

Recommendation 4.1. The Committee recommends that the Rehabilitation Services Administration of the U.S. Department of Education reexamine and reclassify the disability definitions and distinctions, and provide clear guidance on the interpretation of the definition of disability. The absence of clear and precise disability definitions and distinctions precludes a valid and reliable foundation for examining services to those needing rehabilitation services under the priority of service mandated by the Rehabilitation Act Amendments of 1992. In addition, the absence of clear and precise disability definitions and distinctions at the Federal level may impede and/or prevent full-service delivery to individuals requiring rehabilitation services who move from one State to another State.

Finding 4.2. Social Security and Medicare Barriers to Employment. Individuals who earn more than $500 a month ($1,050 if blind) lose social security disability benefit payments and government health care. This Federal rule has a severe impact on employment opportunities for individuals with disabilities.

Recommendation 4.2. The wooden requirement of eliminating income maintenance payments to individuals with disabilities who earn more than $1,050 a month discourages the individual from seeking productive full-time employment. Federal rules should be amended to provide for graduated benefit reductions, similar to that provided social security recipients. That would allow individuals to obtain Social Security Insurance while holding certain minimal levels of employment and to stay on medicare if they so desire, particularly for items such as prescription drugs and medically related supportive services.

Legislation has been proposed in the U.S. Congress to remedy this problem: (1) S. 331 in the U.S. Senate and (2) H.R. 1180 in the U.S. House of Representatives. The Michigan Advisory Committee supports both pieces of legislation.[3]

[1] Ibid., section 7.

[2] Ibid.

[3] In December 1999, after this report had been written, President Clinton signed the Work Incentives Improvement Act, which among other things, allows States to opt to permit people with disabilities to return to work without losing their medicare or medicaid health insurance benefits.

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