

A GUIDE TO IMPLEMENTING AND EVALUATING A
VOCATIONAL REHABILITATION COUNSELLING PROGRAM
FOR INDIVIDUALS INJURED IN MOTOR VEHICLE
ACCIDENTS IN NEWFOUNDLAND AND LABRADOR

CENTRE FOR NEWFOUNDLAND STUDIES

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ABSTRACT

The purpose of this project was to develop a guide to implementing and evaluating a vocational rehabilitation counselling program. It was designed to assist clients who have been injured as a result of motor vehicle accidents and who are having difficulty returning to active employment.

The majority of injuries sustained in motor vehicle accidents are known as whiplash associated disorders. The client focus of this vocational rehabilitation counselling program includes clients who have experienced difficulty adjusting to, and coping with, their injury and disability as a result of their whiplash associated disorder.

This Vocational Rehabilitation Counselling Program follows five phases - pre-evaluation, evaluation, planning, treatment, and job placement. A guide for implementing these phases and a guide for evaluating the program has been developed.

Various conclusions, based on developing a guide to implementing and evaluating a comprehensive vocational rehabilitation counselling program, have been discussed. In addition, recommendations for further research, based on the project limitations, have been proposed.

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CHAPTER I - INTRODUCTION

While the field of vocational rehabilitation has a long-standing history in the United States, it is relatively new in Canada (Wallace & Nordin, 1991). The United States has over ninety Masters and twenty Doctoral accredited degree programs in the area of rehabilitation. Canadian universities, however, are just beginning to offer graduate programs in the rehabilitation field. Rehabilitation professionals in Canada formed a national governing body in 1970 called the Canadian Association of Rehabilitation Professionals (CARP), which is still in the process of developing a professional code of ethics. The field of vocational rehabilitation in Canada is still at its beginning stages, especially with offering vocational rehabilitation counselling to individuals injured in motor vehicle accidents.

Recently, there have been revisions made to the insurance laws in Newfoundland and Labrador which allow up to \$25,000 to be allocated, per injured individual, for medical and rehabilitation expenses as a result of an automobile accident injury (Government of Newfoundland and Labrador, 1994). If a client has this type of medical coverage, known as "accident benefits" or "Section B", he/she may receive loss of income benefits (maximum \$140.00/week) up to the age of 65 years if deemed permanently disabled from any type of employment due to an injury from a motor vehicle accident; may receive loss of income benefits until deemed able to return to the job held at

the time of the motor vehicle accident; and, may be entitled to having reasonable treatments (physiotherapy, occupational therapy, chiropractic treatments, acupuncture, aquatic therapy, and massage therapy) medications, and orthotic aids paid for by the insurance company.

In addition to expenses that may potentially be paid out under accident benefits, an increasing number of injured individuals are suing the insurance company deemed “at fault” for the accident, for a large number of dollars. Liability insurance, presently, can go as high as \$1,000,000 and if an individual was injured by a person who has this amount of insurance, the individual could potentially sue the insurance company, of the person “at fault”, for this amount of money. Because of the substantial amount of money that insurance companies may potentially pay clients who have sustained a bodily injury, there has been an increased desire among the insurance industry for rehabilitation services that assist clients' return to pre-injury status, including employment, in a manner which has high quality and cost-efficiency.

Murta (1991) states that components of a cost-containment strategy in managing insurance claims include rehabilitation efforts that minimize the duration and recurrence of claims, facilitates the employee's return to work, ensures clients are fit to return to work, and reviews the progress of the clients once returned. Merritt and Goldman (1991) believe that vocational rehabilitation can also assist clients who cannot return to pre-injury

employment, but are in need of vocational (re)training. According to the Insurance Bureau of Canada (cited in Johnston, 1994) "Canadian insurers must provide a non-adversarial environment that educates and encourages claims personnel to support rehabilitation services that accelerate the recovery of injured individuals and returns or maximizes the potential for full recovery" (p.28).

Society, overall, and clients, in particular, benefit when quality rehabilitation is available to injured claimants. Roessler (1988) believes that society loses some of its most experienced and knowledgeable workers when people who have experienced mid-career disabilities never return to work. Without vocational rehabilitation counselling, long-term unemployed status often results in increases in depression, tension, self-imposed handicaps, and decreases in self-esteem, health status, and psychological well-being (Roessler, 1988).

Purpose and Scope of the Project

The purpose of this project was to develop a vocational rehabilitation counselling program. The program is designed to assist individuals who have been injured as a result of motor vehicle accidents and who are having difficulty returning to active employment. Based on a comprehensive review of the literature, a guide for implementing the program is outlined, including philosophy, objectives, and the specific program components. A

guide for evaluating the vocational rehabilitation counselling program has also been developed.

The program is designed to meet the vocational rehabilitation counselling needs of injured clients, with the social, biological, and psychological factors considered as they relate to a person's vocational rehabilitation potential. This project did not involve field testing by the researcher, however, recommendations for further research are made in this regard.

The goal of the vocational rehabilitation counselling program is to return clients to a vocational life most similar to that enjoyed before injury. Inherent in this program is the premise that in order to positively affect a person's vocational rehabilitation, other personal and environmental factors must also be considered.

Definitions

Matkin (1985) purports that rehabilitation is a largely ambiguous term. When reviewing the literature surrounding rehabilitation, it is evident that various definitions of the term exist. Today, there are a number of different types of rehabilitation, e.g. vocational, medical, social, psychological, and so forth.

The United Nations World Programme of Action Concerning Disabled Persons (cited in Robertson & Brown, 1992), defines general rehabilitation as "a goal-directed and time-limited process aimed at enabling an impaired person to reach optimum mental, physical and/or social functional level, thus providing her or him with the tools to change her or his own life" (p.2).

According to Johnston, Nickerson, and Magnusson (1991), the World Health Organization defines medical rehabilitation as, "the restoration of an individual disabled by disease, injury, or congenital abnormality to an optimal state of medical, social, psychological, and vocational functioning" (p.170). The writers also say that the insurance industry narrows this broad definition and focuses on the vocational aspect of rehabilitation.

Hershenson's (1990) principal premise is "...that rehabilitation counselling is ultimately concerned with the vocational sphere of functioning and with other areas of life functioning, as they impinge on vocational functioning..."(p.272). This quotation reflects the definition of vocational rehabilitation used in the development of this program. While a counsellor is involved in a client's vocational rehabilitation, other areas of the client's life impact on the entire rehabilitation process. Hershenson (1990) purports that a person's disabling condition impacts on that person's self-image, assets/skills, and goals, as well as environment. Rioux (1996) states there is a recent trend towards "classifying" disability

which does not take into account various socio-environmental and psychological factors. The rehabilitation counsellor must affect these factors in order to facilitate coping with the disability. In particular, Kennett (1992) states that rehabilitation counselling must use a broad range of helping strategies, including behavioural, educational, and social approaches aimed at helping individuals overcome obstacles.

Limitations of the Project

This project was limited in that its scope involved designing a guide for implementation and evaluation of a vocational rehabilitation counselling program versus the actual field implementation and field evaluation of the program. For purposes of this project, the researcher thoroughly reviewed the literature on vocational rehabilitation counselling in an effort to design a program which may, in the future, be readily implemented and tested.

It is also important to note that this rehabilitation counselling program will focus on vocational rehabilitation, rather than medical, psychological, or social rehabilitation. However, medical, psychological, and social factors will be considered as they affect vocational rehabilitation potential.

Another limitation of this project is that it is designed for clients who have

experienced mid-career disabilities due to automobile accidents, rather than for all disabled people. Yet, similar rehabilitation principles could apply to all disabled populations.

CHAPTER II- REVIEW OF THE LITERATURE

The rehabilitation counsellor has an ethical obligation to provide clients with varying views on topics that have been researched and well founded, as well as an obligation to provide services that are based on available research findings (Canadian Guidance and Counselling Association, 1989) . In conducting a literature review on rehabilitation, a number of research findings have emerged that are worthy of noting for purposes of this Vocational Rehabilitation Counselling Program. The following pages provide a summary of the relevant literature on rehabilitation counselling.

History of Vocational Rehabilitation

"The history of rehabilitation of people with disabilities focuses on the treatment of individuals who deviate negatively from the majority of society in regard to one or more of the following: physical appearance, physical functioning, intellectual functioning, and behaviour" (Rubin & Roessler, 1983, p.1).

Rubin and Roessler (1983) reported that early attitudes toward the physically handicapped were not compassionate. Early Greeks believed that a physical scar or disability reflected a blemish on the person's soul. During the Greek and Roman eras no organized efforts to provide training and rehabilitation to disabled people existed. It was

in the fifteenth century that the first attempts at rehabilitating a disabled person, a deaf pupil, were recorded. Advances in nineteenth century America stemmed from a humanitarian background that stressed the importance of the successful helping of those less fortunate. During the latter part of the nineteenth century, educational developments laid the foundation for the advent of vocational rehabilitation programs (Rubin & Roessler, 1983).

According to Berkowitz and Berkowitz (1991), rehabilitation has been an integral part of workers' compensation programs since 1911. The focus of rehabilitation has been "to restore the worker, as closely as possible, to the position enjoyed prior to the injury" (Berkowitz & Berkowitz, 1991, p.184).

Johnston et al. (1991) describe the first rehabilitation consultants with insurance companies as people who would visit claimants acting as good will ambassadors between clients and the companies. During each visit, the consultant often collected information related to claims management. Medical histories, physical limitations, employment history, and work related skills were often discussed. Gradually, information gathered on physical tolerances, transferable skills, interests, and education began to be used to assist clients' return to employment. "In the early 1980's, the growing incidence of disability claims, escalating costs, and increased consumer awareness gave impetus to improving claim management, with increased emphasis on rehabilitation" (Johnston et al., 1991, p.

170).

Vocational Development and Disability

Theory and research regarding vocational development and disability is relevant to vocational rehabilitation counselling practice because all is not known regarding the rehabilitation counselling process.

According to Thomas and Parker (1992) there are two theories that are particularly relevant to vocational rehabilitation counselling and vocational development. The first theory, Minnesota Theory of Work Adjustment, is based on a trait and factor perspective. It considers the degree to which an individual "fulfils the requirements of the work environment as well as the degree to which the work environment fulfils the requirements of the individual" (Thomas & Parker, 1992, p.68). The second theory, McMahon's Model of Vocational Redevelopment, proposes that work adjustment is how well worker dimensions and job dimensions fit together. Thomas and Parker (1992) state that McMahon was interested in the factors involved in vocational redevelopment of people who have physical disabilities and are in the middle of their careers. While this theory has been praised for identifying factors in the return to work process, it does not explain the process of vocational redevelopment (Thomas & Parker, 1992).

Richard T. Goldberg, a rehabilitation psychologist in Boston, Massachusetts, has been studying vocational development in injured/disabled clients for a number of years. Based on the content analysis of 200 interviews with disabled clients, he developed the Goldberg Scale to measure a person's potential for successful completion of a rehabilitation program. The total score gives an indication of motivation to work and rehabilitation outlook of candidates for vocational rehabilitation. Thus far, the scale has been used to evaluate 107 rehabilitation clients in vocational rehabilitation programs in the United States (Goldberg, 1992).

The Goldberg Scale is based on six assumptions. It is multidimensional, including components such as motivation to work, realism, and rehabilitation outlook. It can be ordered on a continuum in terms of maturity, irrespective of gender, race or disability. It should be administered in a face-to-face interview. It may be related to age, grade, or any other developmental variable. It predicts on the basis of an individual's previous psychosocial, educational, and vocational experiences and it is not culture bound. From the research using the Goldberg Scale, 13 discrete categories emerged. For example, "rehabilitation outlook" was the label given to the items expressing optimism/pessimism about an individual's future recovery and "motivation to work" represented a desire to prepare for gainful employment.

His assessment interview is intended to elicit information about a person's

vocational plans, interests, work values, motivation to work, and rehabilitation outlook.

Firstly, previous educational and vocational history are reviewed through the onset of injury/disability. Secondly, current vocational plans, school plans, interests, motivation to work, and rehabilitation outlook are evaluated.

According to Goldberg (1992), research on this scale has led to several consistent findings. He found that vocational plans, interests, and work values held prior to disability are more influential than severity of disability on a person's vocational choice. Motivation to work, realistic self assessment, and positive rehabilitation outlook seem to be the most important variables in the evaluation of an individual with disability for employment. Periods of hospitalization, medical treatment, therapies, and other time taken for adjustment to disability can be construed as interruptions of the career pattern. People with disabilities who have developed the basic ability to cope realistically with their limitations appear to have the best chance of obtaining and maintaining employment. The vocational development of people with disabilities is not a continuous, ongoing process, but is episodic in nature, proceeding in spurts, occasionally interrupted by hospitalization and treatment, and following an individual course influenced by the nature of the disability. Also, people with invisible disabilities make more specific, realistic plans than do people with visible disabilities. Cultural expectations and parental aspirations have a marked effect on the vocational plans of people with disabilities and people with disabilities from higher social classes have more mature vocational plans than do people from lower social classes.

Finally, Goldberg (1992) found people with physical disabilities tend to score higher in educational plans, realism, initiative, work values, and average vocational development than do people with developmental disabilities.

Based on these research findings, Goldberg (1992) offers a model for vocational development that can be summarized into several points. Firstly, people with acquired disabilities choose occupations that are consistent with previous vocational goals, interests, and values. Secondly, individuals rarely choose a vocational objective in an entirely different occupational group. When a vocational plan must be altered or redirected to accommodate the disability, the individual tends to remain within the same occupational group. Thirdly, vocational plans, interests, and work values held prior to onset of disability are maintained after onset. Finally, individuals tend to affirm their predisability identities, indicating that the severity of the disability is not as important as predisability personality and vocational plans.

Goldberg (1992) makes a few suggestions for professional practice. He says the research suggests:

that psychological characteristics are more important than the severity of disability in predicting career choice. Rehabilitation counsellors should help clients make vocational choices based upon their abilities, interests, values, and rehabilitation outlook. Counsellors need to examine more closely the developmental and work

histories of their clients in contrast to the functional limitations imposed by their disability. (p. 170).

In summary, there are many important considerations for the development of a vocational rehabilitation counselling program for people who are experiencing mid-career disabilities. The author will now move to a discussion of the factors affecting vocational rehabilitation outcome.

Factors Affecting Vocational Rehabilitation Outcome

Robertson (1992) believes when a person experiences an unexpected injury and/or disability, habitual coping techniques are used to restore balance to one's life. However, sometimes these habitual problem-solving strategies are inadequate and the individual is left to try and deal with the crisis at hand. There are various factors that affect how well a person copes with disability. Robertson (1992) purports factors such as how an individual cognitively appraises events, how one defines the nature of adaptive tasks, and how effectively one chooses coping skills all affect vocational rehabilitation outcome.

Lam, Bose, and Geist (1989) conducted a study in which they considered a variety of factors that could influence vocational rehabilitation outcome. The study involved data related to employment outcome, demographics, disability, occupational, and rehabilitation

services extracted from 216 worker's compensation cases referred to a private rehabilitation firm. Outcomes were categorized into clients who remained **unemployed** (n=84), clients who returned to work with the **same employer** on the same, a modified, or new job (n=78), and clients who returned to work with a **different employer** on the same, modified, or new job (n=54).

Lam et al. (1989) identified nine variables that differentiated among the three outcome groups with 72% accuracy. Firstly, residual physical capacity and physical job demands prior to injury were analyzed. It was found that physical demands and capacity accounted for the majority of the differentiation between the unemployed and the employed/same employer groups. The less physically demanding a job is before injury and the more one is able to achieve physical rehabilitation after the injury, the greater the probability one will resume work activities with the same employer. If one has a heavy, physically demanding job before an injury and residually is capable of only performing light tasks, then usually the worker remains unemployed.

Secondly, the cost of rehabilitation services and medical management services provided were considered. Lam et al. (1989) found the cost of rehabilitation services and medical management discriminated between the employed/same employer and the employed/different employer groups. It is speculated that the cost related to the unemployed worker typically reflects medical management services and that this type of

individual constantly attempts to find a "cure" rather than face the issue that an alternative vocation may be the better goal.

The extent of pre-injury vocational skill level was also studied by these researchers. Workers with the lowest level of vocational skills tended to go back to their same employer, whereas those who had the highest level of vocational skills seemed to be better candidates for employment with an alternative employer. The nature of transferable skills was examined and the study showed workers with the greatest number of transferable skills seemed to be better candidates for a return to the workforce, with their original employer or a new employer.

The researchers also included the months of unemployment from injury to the time of rehabilitation referral. Workers who returned to their same employer had the least amount of unemployment time before the rehabilitation referral, approximately 10 months, whereas those who remained unemployed were unemployed the longest before a rehabilitation referral was made, approximately 21 months.

Months employed at the company before injury was also studied. Lam et al. (1989) found the longer an individual worked at the insured company before the injury, the more likely he/she was to return to the same employer. Conversely, workers who became employed with new employers had worked at their pre-injury job the least amount

of time.

The final factor considered in the study by Lam et al. (1989) was the presence of an attorney. They found 83% of clients who remained unemployed retained an attorney, while 60% of those employed with the same employer and 67% of those employed by a new employer had legal representation. Some attorneys viewed rehabilitation workers as extensions of the insurance company, thereby continuing an already adversarial relationship between the worker and the insurance company. Some also viewed rehabilitation workers as not having the welfare of the client at heart, under the belief that the insurance companies refer individuals to vocational consultants to promote cost efficiency.

Gross (1991) lists a number of negative predictive factors which can influence rehabilitation outcome. The factors that Gross (1991) lists include: more than 90 days off work; doctor shopping; no job to return to; job change or job modification indicated; psychological or social stress; economic stress; substance abuse; multiple medical problems; English as a second language; cultural adjustment; age; being female; lack of education; previous claim with difficult rehabilitation; inconsistent examination; missing appointments; not responding to treatment; pre-existing medical condition; and, third party litigation. He states these factors can be used to identify potential delayed recovery of the client. No one factor is more predictive than another, but the greater the number of

negative factors, the greater the degree of potential disability. According to Gross (1991), these negative predictive factors can alert people involved in the client's care to intervene as soon as possible in assisting the client's rehabilitation in order to increase the likelihood of success.

Early rehabilitation intervention has also been known to influence rehabilitation outcome. Both Gross (1991) and Lam et al. (1989) discuss this topic. Boschen (1989) expanded on this topic by studying the length of time it takes to refer a client for vocational rehabilitation and how it impacts on the length of disability and unemployment.

She critically reviewed the empirical evidence supporting the widely held opinion that early referral and provision of vocational rehabilitation services to injured workers improves the chances of a successful outcome, e.g. return to gainful employment. She found that most of the studies done in this area are anecdotal or observational and that the following reasons are typically cited by researchers for initiating the rehabilitation process quickly:

1. Intervention with the disabled person and the family can help prevent the development of psychosocial problems that could interfere with successful outcomes of rehabilitation.
2. Availability of guidance can ease the process of coping and adjustment.
3. Early rehabilitation assists the individual in making a personal commitment to reestablish a sense of order in his or her life.

4. Feelings of loneliness and abandonment can be decreased or prevented.
5. The person's level of motivation to recover can be stimulated and maintained.
6. Family members can be immediately enlisted to provide positive reinforcement to the person with the disability.
7. The waiting period can be avoided during which individuals often begin to build up resentment toward the family, the medical profession, and the rehabilitation agency or employer for delays in service.
8. The individual avoids the "run-around" or the feeling of being shuffled from one professional to another.
9. Secondary gains of being disabled can be minimized or kept in perspective.
10. Early intervention prevents the person from settling into the sick role, with the disability becoming a way of life. (Boschen, 1989, p.254-255).

An empirical study conducted by Davis (cited in Boschen, 1989), also reveals that the timeliness of referral and treatment is a very important consideration in the rehabilitation of an injured claimant. He found that when clients were referred for rehabilitation 0-3 months post injury 47% returned to work. When referred within 4-6 months 33% returned to work, within 7-9 months 28% returned to work, and within 10-12 months 25% returned to work. Finally, when a client was referred for rehabilitation after one year post-injury, only 18% were successfully returned to work.

Gross (1991) reveals that statistics indicate 80% of injured workers return to work within ninety days following the injury. However, when a worker remains off work for longer than a year, the return to work rate drops to 5%. Therefore, it is essential that the return to work potential is maximized before ninety days.

Furthermore, Gardner (1991) conducted a study that estimated the private and social economic benefits from systematic early referral of injured workers for vocational rehabilitation evaluation services. The results cite gains from referral for evaluation not later than six months from the date of injury. He reports that initial evaluations should not wait until the claimant is physically able to resume working. If referral is postponed to this point, the psychological, or family, situation may deteriorate to a state that could impede, or even preclude, a quick return to work. Gardner (1991) recommends that a rehabilitation "consultation" be held after 30 days of lost work time for back injuries, and after 60 days for other injuries. Day (1992) takes this idea even further and states that rehabilitation should be initiated as soon as a medical diagnosis is established.

Other researchers acknowledge critical elements affecting rehabilitation. Johnston et al. (1991) purport that the most critical element in a client's rehabilitation, aside from the client's own motivation, is early intervention, one of the many factors affecting vocational rehabilitation outcome.

Vocational Rehabilitation Counselling

In Canada, rehabilitation counsellors are still trying to define their role and function. Rubin and Roessler, leading researchers in the area of vocational rehabilitation, believe rehabilitation counsellors have many roles. The following is a summary of the roles Rubin and Roessler (1983) describe.

Rehabilitation counsellors seek information in a specific manner regarding a client's background, e.g. work history and educational experiences, and in an exploratory manner to elicit feelings, attitudes, and so on. Information is also given to clients regarding agency procedures, appointments, the structure of the client-counsellor relationship, educational or vocational information, information on test scores and medical reports. Counsellors have to develop rapport with their clients and convey acceptance, reassurance, and willingness to assist clients. At times, the counsellor clarifies what the client seems to be experiencing and communicates an understanding of the client's feelings and attitudes. There are also times when the counsellor must confront the client regarding possible discrepancies between a client's self-perceptions and behaviours.

" Early assessment of vocational rehabilitation potential and needs, and an aggressive approach stressing claimant responsibility and involvement in the rehabilitation

process, will result in an improved likelihood of success" (Johnston et al., 1991, p. 172). However, the success of vocational rehabilitation counselling will also depend on the whole process. Overall, the vocational rehabilitation counselling process can be divided into four phases. These are evaluation, planning, treatment, and termination (Rubin & Roessler, 1983).

The evaluation phase determines "current and potential client functioning for purposes of identifying occupations that could be opened up to the client through the provision of rehabilitation services" (Rubin & Roessler, 1983, p. 114). There are a variety of factors explored during evaluation, including age and life stage, state of health (physical and psychological factors), personality, cultural background, commitments and values, coping responses, educational-vocational factors, economic factors, and personal vocational choice considerations (Robertson, 1992). Medical evaluation is an important consideration in this beginning phase. In addition, the counsellor may decide that psychological and/or psycho-educational testing may be necessary. Examples of tests the counsellor may have to administer, as cited in Rubin and Roessler (1983), are the Minnesota Multiphasic Personality Inventory, Wechsler Adult Intelligence Scale-Revised, General Aptitude Test Battery, and the Strong-Campbell Interest Inventory.

After the initial evaluation, the counsellor should be in a position to prepare a report which provides the foundation for the planning phase. Based on information

gathered from the intake interview with the client, medical information, and vocational data, the planning phase begins. It is essential that the client work with the counsellor in establishing rehabilitation goals. "An effective goal-setting interview increases the probability of the client selecting an occupation that is compatible with his/her needs and abilities" (Rubin & Roessler, 1983, p.154).

The rehabilitation goals are outlined in what is referred to as the individualized written rehabilitation program (IWRP). It should include four components (Rubin and Roessler, 1983, p.155).

1. A statement of long-term rehabilitation goals for the individual and intermediate rehabilitation objectives related to the attainment of such goals.
2. A statement of specific rehabilitation services to be provided.
3. A projected date for the initiation and the anticipated duration of each service.
4. A procedure for determining whether intermediate objectives and long-term goals are being achieved.

Once the rehabilitation goals have been established, the treatment phase begins. During the treatment phase of rehabilitation counselling, the counsellor, in addition to regular counselling activities, may avail of various facilities and support services. This is particularly important when a client needs (re)training in order to return to active employment. According to Rubin and Roessler (1983):

Many highly trained professionals can play a vital role in the rehabilitation process. Some of these individuals may provide medically oriented services such as physical medicine, rehabilitation nursing, prosthetics-orthotics, physical therapy, occupational therapy, and speech, hearing, and language therapy. Others may contribute valuable services such as rehabilitation engineering, therapeutic recreation, and creative arts therapy... (p.173-174).

Personal adjustment services that foster physical fitness, relaxation, stress management, pain management, rational thinking, assertiveness, problem solving, and time management are also important for the rehabilitation client (Rubin & Roessler, 1983).

The final phase of the vocational rehabilitation counselling process is coined termination by Rubin and Roessler (1983). However, for purposes of this project it is called job placement. Once the client has completed job readiness activities, the counsellor's primary concern is job placement. If the client is unable to return to the pre-injury employer, the client must be trained in job-seeking skills with an emphasis on sources for job leads, instruction on what employers are looking for in employees, instruction on organizing a job search, instruction on completing job application forms, interview training, and supervised practice in job seeking (Rubin & Roessler, 1983).

Sometimes, the rehabilitation counsellor may need to directly intervene with a potential employer, while in other cases this direct involvement is not necessary.

Regardless of the degree of involvement, the rehabilitation counsellor must be cognizant of the attitudes of potential employers. "Employer misperceptions regarding the effects of integrating workers with disabilities into their business must be dealt with in an effective and ethical way by the counsellor" (Rubin & Roessler, 1983, p.203).

Overall, the four phases of the rehabilitation process are designed to facilitate and assist clients' vocational rehabilitation potential. Throughout this process, the counsellor has many roles and functions. It is important that counsellors are aware of various counselling theories so that interventions are always theory based and appropriate to clients' needs. According to Thomas and Parker (1992), psychodynamic, humanistic, cognitive, behavioural, personality, and developmental theories all have something to offer rehabilitation counsellors.

There are advantages to using an eclectic approach to rehabilitation counselling. Kennett (1992) states that this approach provides a framework which "permits the counsellor, over a period of time, to increase his or her options and to vary approaches to assessment and programming by integrating knowledge and experience, thus increasing the maturity or sophistication of any intervention and, ideally, its effectiveness" (p.103).

While the rehabilitation process and interventions may be based in theory, it should be remembered that the heart of the therapeutic counselling process is the relationship

established between the client and the counsellor. Kennett (1992) refers to Egan's (1990) general model for counselling; to explore the problem, facilitate understanding of the problem, and, to promote coping. This provides a good framework for counselling individuals in transition who are experiencing mid-career disabilities.

CHAPTER III - GUIDE TO IMPLEMENTATION

When designing a counselling program of any kind, it is important to develop appropriate goals/objectives and outline its many components. The reader of the proposed program must be able to review detailed guidelines and have a clear understanding of how to implement the program, if desired. Hamilton (1991), indicates that adherence to a structured rehabilitation program plays a critical role in a favoured and positive outcome for the client's rehabilitation.

Summary of Implementation

The process of implementing this Vocational Rehabilitation Counselling Program begins with a good marketing strategy to let potential clients and potential referral agents know that such a program exists. The information in the marketing packages must include the purpose of the Vocational Rehabilitation Counselling Program, qualifications of the counsellor, and information on how to access the program. This information can be disseminated directly to injured clients, or indirectly through insurance personnel and health care professionals, who may potentially refer injured clients to the counsellor.

Once a client has been referred for vocational rehabilitation counselling, the counsellor begins assessment and performs an Initial Rehabilitation Evaluation. This

typically involves an in-take interview with the client, the attending physician, and the employer. During these interviews the counsellor assesses the client's perceptions of how the motor vehicle accident has affected his/her life, the physician's opinion on the client's functional tolerances, and the employer's interpretation of the physical requirements of the client's job.

Based on this evaluation, the counsellor, in cooperation with the client, will engage in individual counselling and establish mutually agreeable goals aimed at facilitating the client's recovery to the point of participating in active employment. This is the planning phase and the goals will be outlined in an Individualized Written Rehabilitation Program.

The counsellor and the client will then continue the counselling process and engage in the treatment phase. This includes individual and group counselling, information sharing, career counselling (e.g. training), crisis intervention, consultation, referral, and continuous follow-up.

The final phase of the vocational rehabilitation counselling process, job placement, involves final follow-up and termination of the counselling relationship. The terms of the termination will be mutually determined between the rehabilitation counsellor and the client. Typically, the process will cease when the client has successfully returned to active

employment.

All of these components compromise a thorough, comprehensive Vocational Rehabilitation Counselling Program. This program can be offered by the rehabilitation counsellor to clients who have been injured in motor vehicle accidents and are in need of vocational rehabilitation services.

Framework for Implementing the Program

Philosophy of Humanity

The task of describing a philosophy of humanity is very introspective and difficult. Whether realized or not, the beliefs in the nature of humanity provide the basis to much of what a person feels, acts, and thinks. Therefore, in the development of a rehabilitation program designed to help others, it is important that attitudes, beliefs, and values are clarified so that the program's rationale and objectives are congruent, and in harmony, with the philosophy. According to Corey (1991), self-exploration is crucial so that practitioners can be "aware of their values, of where and how they acquired them, and how their values influence their interventions with clients" (p.18).

In the process of defining the philosophy of this Vocational Rehabilitation

Counselling Program, it becomes apparent that several principles are inherent. One such principle is the belief in the dignity and worth of every individual, which thus requires that all clients be treated with dignity and respect.

Also inherent in the philosophy of this program is the belief that individuals do not exist in isolation. Adopting a Systems Theory approach, the rehabilitation counsellor believes that a person interacts with his/her social context, e.g. family, school, workplace, and society, in a manner that any change in one part of the system affects the entire system. Taking this a step further, each individual can also be viewed as a system, unto him/herself.

According to Roessler (1988), "Many stress and adult transition models are based on systems theory concepts" (p.99). Furthermore, the basic need of any system is to maintain homeostasis or balance. Because acquired disability and unemployment threaten the individual's system balance, the rehabilitation counsellor needs to assist the client in coping with such stressors in order to re-establish homeostasis. It follows, then, that the rehabilitation counsellor needs to acquire information regarding both the individual and the individual's social context.

Acknowledging that each individual is part of a larger environmental system, clarification needs to be carried out regarding the responsibility of individual behaviour in

his/her larger environment. Recognizing that external conditions, such as an automobile accident, can influence and, at times, constrain a client's behaviour, the rehabilitation counsellor believes that people are essentially free to make their own decisions. Yet, sometimes the decision-making process may need to be facilitated by clarifying the process and exploring various restraints and possible alternatives.

In general, this Rehabilitation Counselling Program views the nature of humanity as one of dignity and freedom of choice in constant interaction with others in a social context. In essence, people are not static, but rather are ever-changing and growing. This belief stems from the idea that in order to develop a program designed to help others, one must believe that people, in their "growth", are capable of change.

Just as individuals grow and develop, philosophies and beliefs continue to emerge. Each individual counsellor who implements this program must realize the importance of defining one's own personal philosophy. While the basic principles underlying a person's beliefs may remain fairly stable, the overall philosophy, with time, will emerge into an integrated set of beliefs that harmoniously guides professional behaviours, objectives, and practices. The contemplative process of "writing down" one's philosophy is one of the many steps this Vocational Rehabilitation Counselling Program will take toward achieving its goal of integration and unity.

Aims and Goals of the Program

According to the Program Development for Psychological Services (source unknown), a statement of purpose for the service should reflect the philosophy of care. The overall purpose of this Vocational Rehabilitation Counselling Program is to facilitate maximum recovery of injured/disabled clients to a level of functioning that closely matches their pre-injury/pre-disability lifestyle. In particular, the objective is to ease and assist the client in his/her return to gainful employment so that he/she may enjoy a work life and overall lifestyle, similar to that enjoyed before the onset of the injury and/or disability.

The Program for Psychological Services also suggests that every program must have goals and objectives that support the purpose of the service. It also suggests that these goals and objectives must be consistent with client needs.

The goals and aims of this Vocational Rehabilitation Counselling Program will include the following:

1. to treat every client with dignity and respect
2. to identify, as early as possible, possible clients who are in need of

rehabilitation services

3. to market the Vocational Rehabilitation Counselling Program to potential clients, outlining the roles of the rehabilitation counsellor and the goals of the Vocational Rehabilitation Counselling Program
4. to establish an effective referral system that facilitates quick, cost-effective referrals to the rehabilitation counsellor
5. to quickly respond to rehabilitation referrals. For example, the client is to be contacted within 24-48 hours of referral and a home visit with the client is to be completed in 5-7 days of initial referral. The Initial Rehabilitation Evaluation is to be completed within 30 days of the date of the referral.
6. to conduct a thorough data collection and assessment of each client for rehabilitation evaluation purposes, e.g. biological/physical information, social information, psycho-educational assessments, vocational assessments, and so forth
7. to visit previous and/or potential employers of clients to gather vocational data and facilitate clients' return to work

8. to visit the client's physician (when necessary) to ascertain a thorough medical assessment
9. to administer vocational/educational assessments, when necessary, for purposes of understanding the whole client
10. to work with clients, individually, in developing an Individualized Written Rehabilitation Program (IWRP) based on information acquired during evaluation
11. to monitor a client's progress with goals outlined in the written rehabilitation plan
12. to assist clients in developing adequate support systems
13. to identify and co-ordinate professional home and community support services that may assist clients return to pre-injury/pre-disability lifestyle and work life
14. to consult with experts in a particular field when the area of expertise goes beyond the scope of the counsellor, e.g. medical evaluation and psychological

evaluation

15. to provide various types of counselling to rehabilitation clients, e.g. individual and group counselling
16. to act as a liaison with clients, insurance personnel and the health care system
17. to avoid stigmatization when counselling the unemployed
18. to attend to the client's needs with the most prominent need receiving priority in terms of attention and intervention
19. to facilitate a client's decision making process, when needed
20. to identify clients with special needs, in addition to disability, such as single parents, widows/widowers, elderly, recent death of a spouse or divorce, and so on
21. to intervene, professionally, in situations where the client is experiencing

crisis

22. to actively assist clients with job placement, e.g. teach job search skills, resume writing, interview skills, and so forth
23. to continuously gather Labour Market Information in order to stay abreast of the latest job prospects
24. to, periodically, research and review the latest literature on the various issues pertaining to vocational rehabilitation counselling
25. to conduct follow-up on clients once bi-weekly during the treatment phase of the rehabilitation process
26. to provide a follow-up report, every 30 days, to insurance personnel regarding each client's progress
27. to follow-up with clients to ensure the success of job placement

28. to effectively terminate the vocational rehabilitation counsellor-client relationship

29. to continually evaluate the effectiveness of services offered by the Vocational Rehabilitation Counselling Program

Principles and Assumptions

1. At the cornerstone of this Vocational Rehabilitation Counselling Program is confidentiality. This is an important element and will be adhered to at all times, with the exceptions determined only by the client and federal or provincial laws. "The counselling relationship and information resulting therefrom must be kept confidential" (Canadian Guidance and Counselling Association, 1989, p.6).

Information will not be released, at any time, without informed, written consent from the client. Confidentiality will be facilitated by the client signing a consent for release of information, which specifies who the rehabilitation counsellor may communicate with and what type of information can be released. It is also important that the client will be able to access the

rehabilitation counsellor during regular working hours through a direct line, with a message manager from which only the counsellor may retrieve messages. This will prevent other office personnel from retrieving clients' personal messages for the counsellor.

2. Privacy will be another dimension of the program. The office will be in a location physically separate from any insurance company that may be referring clients for vocational rehabilitation. The office, however, will also be accessible to the majority of clients with respect to geographic location. In addition, the door of the office will display a sign if the counsellor is busy, or if available, to prevent unwanted or poorly timed interruptions. Privacy is an important characteristic of any helping relationship and frequently encourages client self-disclosure (George & Cristiani, 1990).
3. The office facilities must be equally accessible to all clients. The office will be in a building which is completely wheelchair accessible so that any overt obstacles to receiving vocational rehabilitation counselling may be avoided.
4. The Vocational Rehabilitation Counselling Program must have access to a variety of referral agencies. Referrals are an essential part of any counselling program because it is "unrealistic for counsellors to assume that they can be of

service to every person seeking assistance" (George & Cristiani, 1990, p.142).

5. The Vocational Rehabilitation Counselling Program encourages clients to voluntarily seek help for any problem that may affect, or potentially affect, work performance or vocational potential.
6. The counsellor offering vocational rehabilitation counselling services will have appropriate educational training and provide confidential assessment, counselling, referral (if necessary), and follow-up of clients. Principles, such as these, are consistent with the general Guidelines for Ethical Behaviour (Canadian Guidance and Counselling Association, 1989).
7. The rehabilitation counsellor will act as an advocate for clients who need leave from work to seek further treatment, if necessary. Counsellor, as advocate, is an important role outlined in a number of sources (Egan, 1990; George & Cristiani, 1990; Gibson & Mitchell, 1990; & Corey, 1991).
8. The Vocational Rehabilitation Counselling Program will not be used by any insurance agency for investigative reasons, nor is the program to be used by clients who wish to prolong disability for secondary gain.

9. **The Vocational Rehabilitation Counselling Program will be committed to the on-going education and promotion of counselling services for all clients. Advertising the helping services via media, newspapers, television, radio, in-service workshops, pamphlets, and so on, is an important aspect of establishing a counselling program (Schmidt, 1991), while keeping in mind professional ethical considerations.**

10. **The Vocational Rehabilitation Counselling Program will ensure that clients, at all times, are given information necessary to fully understand the role and function of rehabilitation.**

11. **The counsellor offering the Vocational Rehabilitation Counselling Program must have an extensive knowledge of, and practical experience with, disabilities, including the psychological aspects of disability. Brown (1992) states that for counsellors to be effective, they must have observed disability in a variety of forms and have knowledge about the practical implications of these disabilities.**

Primary Issues

There are a variety of issues that the Rehabilitation Counsellor may face when counselling injured clients. Examples of the salient issues are as follows:

1. **Grief:** A person who suffers from an injury and/or disability experiences a loss of a previous role or function. Perhaps he/she can no longer do favourite hobbies or be the bread winner of the family. In many instances, the claimant's role has to be re-defined because the roles he/she once carried out are no longer possible. As a result of these losses, a client will likely go through various stages of grief, including denial, anger, bargaining, depression and acceptance. The rehabilitation counsellor must realize that a client often needs assistance to work through his/her grief effectively.
2. **Anger:** Often clients will vent anger for various reasons. They may be angry because an accident happened, an injury occurred, and they are unable to work. They may be angry because they suffer from continuous pain, treatments are not working as they initially hoped, the insurance company is threatening to cut off their claims, and so forth. The rehabilitation counsellor must be able to counsel clients through their anger.

3. **Decreased Motivation to Return to Work:** If a client has inadequately worked through grief and anger, or if a general motivation problem existed previous to the injury, the rehabilitation counsellor may need to counsel the client regarding his/her motivation.

Decreased motivation to return to work may be one of the most difficult problems facing the rehabilitation counsellor. Without counselling interventions of a motivational nature, Roessler (1988) purports the counsellor often witnesses clients having increased feelings of depression and tension, decreases in self-esteem and health status, as well as overall decreases in psychological well-being. Bordieri, Drehmer, and Cominel (1988) note that depression, cognitive distortion, malingering behaviour, medication and alcohol abuse, along with difficulty coping with stress are particularly evident in clients experiencing low back pain.

Description of Clientele

The majority of injuries from motor vehicle accidents in Newfoundland involve whiplash associated disorders. These types of injuries often cause a problem for the medical profession to treat because they do not fit into the traditional medical model of

assessment/diagnosis/treatment. Whiplash associated disorders typically affect soft tissues and, therefore, the extent of the injury cannot be assessed by a simple x-ray or blood test. Many times, the physician can only rely on viewing and palpating the injured area and range of motion testing. These are not objective measures, but rather often rely on subjective interpretation by the physician, as well as the subjective reports of the client.

Many times clients are frustrated that nothing specific has been identified on various radiologic tests. They often feel frustrated that their symptoms do not get validated by a specific test. For example, if a client fractured a bone it would be evident on an x-ray, however, if a client sustained a soft tissue (whiplash) injury an x-ray would not reveal it. Clients often report feelings of pain, decreased range of motion, and weakness of one or more body parts, usually involving the neck, arms, and back. They do not feel capable of returning to work, even in sedentary, light duty positions, because of these symptoms. In addition, they get questioned by insurance personnel and employers as to why they cannot return to work.

Whiplash associated disorders have posed problems to the medical profession and insurance industry for years. No medication, treatment, or procedure will guarantee a successful resolution of symptoms. Because of the difficulty in treating these disorders, many clients have symptoms which persist over long periods of time. Physicians now state that the average whiplash case takes approximately two years or more to resolve, if at all.

The result is often a very frustrated individual who, despite various forms of treatment and medication, still experiences symptoms. In some cases, clients are unable to return to work, unable to do activities of daily living, and cease doing hobbies and activities they once enjoyed. Financial burdens rise as do fears of losing a job, especially given the current economic climate of Newfoundland. Chronic pain syndrome and depression are complications which may result. This compounds the problem of trying to adequately treat a client with a whiplash associated disorder.

A person injured in a motor vehicle accident can be of any age and can, therefore, be affected in the manner previously described, regardless of their developmental stage. However, this program is designed to offer rehabilitation counselling to individuals whose vocational lives have been affected, or potentially affected, by the injury sustained in a motor vehicle accident. Therefore, the age span of potential clients could range from approximately 15 to 80 years of age. It can include people who were actively engaged in employment prior to the injury; people who are currently engaged in employment, but need rehabilitation assistance to remain employed; individuals who are attending school and will eventually be seeking employment; individuals who are temporarily unemployed or on social assistance; as well as, retirees.

Description of Setting

The Vocational Rehabilitation Counselling Program will not be part of any particular institution. It will be available to all insurance companies offering medical, liability, and disability insurance to clients, as an independent source of rehabilitation counselling services.

Therefore, it is important that the office of the rehabilitation counsellor be located in a manner previously described in the section entitled "Principles and Assumptions". An example of such a location would be an office space in a facility that offers a variety of services, e.g. a shopping mall. This would be convenient because it is readily accessible by car or bus route and has full wheelchair access.

The office space need not be large, but should provide a private space for counselling clients. Supportive ergonomic chairs would be beneficial, especially when counselling clients with neck and back injuries.

Office equipment does not have to be elaborate. A computer and printer will be necessary to type and print reports. A filing cabinet, with a lock and key, will be necessary to provide confidential storing of client information. In addition to these items, a fax machine will be necessary in case quick correspondence to other professionals is

necessary. It is also necessary for the counsellor to have phone services, such as message manager, allowing the counsellor, alone, to retrieve messages, even while travelling.

While the setting of the Vocational Rehabilitation Counselling Program may be as just described, all the counsellor's work will not take place in the office setting. Therefore, it is also important for the counsellor to have access to an automobile because he or she may need to visit with clients at home, visit with employers or potential employers, visit attending health care professionals, and so on.

Components of the Vocational Rehabilitation Counselling Program

As previously mentioned, the vocational rehabilitation counselling process usually involves four phases. These are evaluation, planning, treatment, and job placement. This Vocational Rehabilitation Counselling Program will include a variety of components that are relevant to these stages.

For purposes of this program there will be five phases. Firstly, there will be a pre-evaluation stage which will entail the marketing of, and referral to, the Vocational Rehabilitation Counselling Program. The evaluation stage will include assessment, while the planning stage will involve elements of individual counselling. The treatment stage of the rehabilitation process will also include individual counselling, in addition to group

counselling, information sharing, career counselling (e.g. training), crisis intervention, consultation, referral, and continuous follow-up. The job placement stage will also involve final follow-up in addition to the termination of the counselling relationship.

Pre-evaluation Phase

Marketing

The number of injured claimants who need vocational rehabilitation services is potentially very large. Therefore, it is essential that the rehabilitation counsellor implement a comprehensive marketing strategy to create an awareness that such a program exists. The various forms of advertising will be intended to reach all those people who could possibly directly refer a client for vocational rehabilitation counselling, e.g. insurance personnel, lawyers, physicians, and related health care professionals. The goal is to let injured clients know that rehabilitation services could possibly be availed of through insurance coverage, if they have Section B (accident benefits) with their automobile coverage.

A well articulated marketing strategy is essential to building a successful program. Trust and competence must be conveyed to potential clients and, while word of mouth will serve this objective to some extent, an ongoing marketing effort is necessary to satisfy

the objectives of the Vocational Rehabilitation Counselling Program.

Marketing the Vocational Rehabilitation Counselling Program will involve selling quality service to potential referral agents, e.g. insurance companies. The rehabilitation counsellor must also ensure that services are accessible to the client population towards which the marketing is directed.

A large portion of marketing the Vocational Rehabilitation Counselling Program will include advertising. Advertising should provide messages that project competence, trustworthiness and availability. Since every individual who has suffered an injury and put forth a claim with an insurance company is a potential client, the target audience is large. It consists of any person or agency who may require rehabilitation counselling services. Advertising strategies should be designed to reach all segments of the target population. Written articles, brochures, personal presentations, fliers, films, posters, newspaper ads, public announcements, and so forth, are examples of ways the rehabilitation counsellor could market the rehabilitation services, keeping in mind professional ethical considerations.

Included in any advertising package should be the professional and educational experiences of the counsellor, a statement on the philosophy and purpose of the program, who can access the services and how they could be accessed, who could benefit from the

program and how they could benefit, a description of the services offered by the counsellor, and how to make a referral to the Vocational Rehabilitation Counselling Program, e.g. a specific name, location, and phone/fax number of the counsellor. Referral forms should also be included with any information packages distributed. A sample referral form entitled, Rehabilitation Referral Form, can be found in Appendix A.

To ensure a comprehensive marketing strategy is carried out the rehabilitation counsellor must incorporate research into rehabilitation practice. Continuous development of new markets and/or new services is essential to enable the rehabilitation counsellor to reach all possible client sources. In conclusion, services must always be professional, accessible and consistent. The rehabilitation counsellor should never promise, or market, anything that cannot be delivered.

Referral

When marketing the Vocational Rehabilitation Counselling Program during the pre-evaluation stage, it is essential to convey the importance of early referral to potential referring agents. The literature shows that the earlier a client is referred for rehabilitation, the greater the likelihood of the client returning to active employment. It is clear that rehabilitation efforts, designed to assist claimants to return to work, will be most appropriate during the earlier stage of increased vigour, effort, and determination, rather

than when the person becomes detached and disengaged from important life goals due to prolonged disability. Boschen (1989) believes that, "The onus is on the rehabilitation specialist to recognize the fine line between pushing the individual to move on too quickly and allowing the person to linger too long in a state of inactivity and depression" (p.260).

It is important for the counsellor to receive a referral as soon as possible after an injury has been sustained. This can curtail the development of long term chronic symptoms, which in turn saves insurers money by preventing prolonged treatments and unemployment.

Evaluation Phase

The evaluation phase of the rehabilitation process begins once the Vocational Rehabilitation Counselling Program has been marketed and the counsellor begins to receive referrals. Evaluation consists of client assessment.

Assessment

During the Vocational Rehabilitation Counselling Process, the counsellor will perform a variety of assessments. Farley, Bolton, and Parkerson (1992) state, "Client assessment has traditionally been a central activity in the vocational rehabilitation process"

(1990) state that assessment:

is often considered a primary skill of the professional (helper) because it provides a data base for more readily understanding the person ..., the effective planning of group ... activities that reflect the client interests and needs, the development of ... human potential development programs, and the organization of systematic placement and follow-up programs. (p.31).

Holosko (1992) purports, before implications for practice are outlined, the counsellor must do an assessment of the client's disability and the nature of the specific work activity. Assessment needs to be integrated into the counselling process of continued interaction between the professional and the client.

After a client is referred to the rehabilitation counsellor, the counsellor will review the information in the client's file before making the initial contact with the client. The counsellor may wish to avail of a checklist, such as the Rehabilitation Screening Checklist found in Appendix B. Factors to look for in this file review, that could indicate a problematic rehabilitation, include:

- a) lack of comprehensive medical information
- b) a vague diagnosis and/or indefinite prognosis

- c) prolonged treatment by a health care provider with minimal effectiveness
- d) compounding disabilities
- e) multiple soft tissue injuries
- f) involvement by numerous health care professionals with minimal effectiveness
- g) prior injuries with problematic rehabilitation
- h) a change in personality, including symptoms of depression
- i) the existence of other psychological/psychiatric problems
- j) apparent difficulty with motivation
- k) financial difficulty and/or family problems
- l) the client receiving about the same or more money on insurance benefits than with previously earned salary

- m) the client having young children who require care during the day
- n) an unstable , seasonal, and/or minimal work history
- o) the client, because of the injury, being unable to return to his/her previous job
- p) the client expressing dislike for the previous job
- q) problems with basic literacy and a limited number of transferable employability skills
- r) the client not having returned to work and 12 months have passed

Dixon, Goll, and Stanton (1988) contend that aside from assessing all the psycho-social factors and all the factors relating to the injury, fiscal and legal realities must also be kept in mind.

Once a thorough review of the client's file has been completed, an Initial Rehabilitation Evaluation is performed. This assessment focuses on a client's physical, psychological, social, economic and vocational self. Vocational assessment is a process of

evaluating the client's social and emotional status in addition to general employability factors such as work habits, physical tolerances, and intellectual functioning (Power, 1984). "The purpose of the rehabilitation assessment is to plan a course of action. It involves exploring a person's strengths and weaknesses and discovering how the individual's potential for vocational adjustment can be enhanced" (Power, 1984, p.19).

In order to effectively develop a rehabilitation plan with the client, the Initial Rehabilitation Evaluation will be completed with information gathered from three main sources: the individual, the attending physician, and the employer. Additional sources, such as medical specialists, physiotherapists, chiropractors, acupuncturists, massage therapists, and so forth, may also be utilized.

Before setting up the first interview with the client, the counsellor must check with the insurer, to see if the client has a solicitor representing him or her. The counsellor should receive the consent of the solicitor to begin rehabilitation with the client. If there is no solicitor involved, the client's consent for rehabilitation is all that is necessary.

The first interview with the client will be an evaluation based intake interview. It is first necessary to explain to the client who the referral agency is, e.g. the insurance company, what the role and function of the rehabilitation counsellor is, and, who will receive a copy of the information disclosed during the interview and counselling process.

Establishing adequate rapport and trust with the client is essential, especially regarding the counsellor's ability to help the client. The client must also feel understood by the counsellor and thus free to express issues that are important.

During the rehabilitation counselling intake interview with the client, information is gathered pertaining to physical, psychological, social, economic, and vocational factors. A questionnaire, found in Appendix C, entitled Client Intake Interview, would be of assistance to the counsellor during this interview. In some instances, it may be necessary for the counsellor to further evaluate the client's psychological well-being and the Mental Status Guide in Appendix D could be useful for this purpose. The counsellor will also need to meet with the pre-injury employer, if one exists, to obtain a thorough job description of the client's pre-injury job and with the attending physician to ascertain an accurate and current medical assessment of the client. The client's consent to disclose information is necessary before the counsellor can meet with the attending physician and employer. A sample consent form, Client Release of Information, is available in Appendix E.

The counsellor can use a standard set of questions, as in the meeting with the client, to facilitate the interviews with the employer and the physician, to guide the development of the rehabilitation plan. Examples of a format the counsellor may use during these interviews can be found in Appendix F and Appendix G, respectively, and are

attending physician, the counsellor will need to get written clarification regarding the client's return to work status and regarding the types of interventions and treatments the physician is recommending and supporting for the client. Forms such as those found in Appendix H and Appendix I, entitled Return to Work Release Form and Medical Support for Intervention, respectively, could be utilized by the counsellor for these purposes. However, recognizing that physicians are not always available for personal interviews, the counsellor could forward a questionnaire, entitled Physician Questionnaire, to the attending physician to be returned at his/her earliest convenience (see Appendix J).

It is recommended that the counsellor meet with the employer after the client and before the physician. This enables the counsellor to provide the physician with a thorough knowledge of the client's current status with the employer and the specific demands of the pre-injury employment, so that the physician is better able to understand the client's potential employability issues.

In order to complete the evaluation, the counsellor may also have to administer tests in psycho-educational and vocational areas. Examples of such assessments have been previously provided in this paper. In addition, the rehabilitation counsellor may wish to avail of nearby resources to facilitate the evaluation, e.g. psychologists, psychiatrists, occupational therapists, physiotherapists, orthopaedic specialists, and so forth. When referring to these professionals the counsellor could use the General Referral Form found

in Appendix K. If the client has already seen a number of other health care providers, it may be necessary to gather information from these sources. A form such as the Related Health Professional Questionnaire, in Appendix L, could be used to guide the gathering of this information.

Once the evaluation is completed, within 30 days of the referral, the counsellor should write a report. This report will outline the information gathered during the Evaluation Phase and provide the foundation of the planning phase of the rehabilitation process.

Planning Phase

Based on all the data gathered during the evaluation phase, the counsellor begins the planning process. Integrating all the available information on the client's physical, psychological, social, economic, and vocational self is essential before determining a client's potential vocational functioning. First, the counsellor must collect and organize the evaluation information gathered. Areas of client functioning, such as physical, psychological, emotional, and social factors must be examined in terms of their relevance to vocational goals. Secondly, the information should be summarized into general and specific interests and abilities, plus how the interests relate to vocational information. Thirdly, the counsellor and the client must develop general rehabilitation goals. The

Thirdly, the counsellor and the client must develop general rehabilitation goals. The counsellor is then in a position to develop the Individualized Written Rehabilitation Program with the client, which involves long-term and short-term goals.

Individual Counselling

An important element of any counselling process is the mutual establishment of goals. The counsellor and the client must work together to develop specific goals to be achieved from the counselling process. Roessler and Rubin (1982) believe it is the rehabilitation counsellor's mission "to enable individuals with severe disabilities to select, attain, and maintain feasible vocational goals, e.g., jobs that they both can and want to do" (p.vii). After the initial evaluation has been completed it may be determined that the client is presently unable to engage in immediate return to work activities because physical tolerances do not match the demands of the job. In these cases, rehabilitation goals must include training options for the client to increase employability.

The goals established in the vocational rehabilitation counselling process will be outlined in the Individualized Written Rehabilitation Program. The following example stems from a model for the formulation of a rehabilitation plan by Power (1984).

A. Long-term Goal: To obtain employment as a word processor.

Short-term Goal #1: To visit at least three of the local educational facilities that offers training as a word processor.

Implementation: Within the next two days

Completion: Within two weeks

Resources: Three out of seven local colleges

Goal Monitor: Rehabilitation Counsellor

Short-term Goal #2: To enroll in a college that offers a course in word processing.

Implementation: Within three months

Completion: Within six months from the start of program

Resource: The chosen college

Goal Monitor: Rehabilitation Counsellor

Short-term Goal #3: To maintain physical functioning by keeping 95% of scheduled appointments with the physiotherapist.

Implementation: Immediately

Completion: When the physiotherapist discharges client.

Resource: Physiotherapy clinic

Goal Monitor: Rehabilitation Counsellor

Short-term Goal #4: Near the completion of the word processing course conduct a job search with at least five potential employers.

Implementation: One month before completing the course.

Completion: The completion date of the course.

Resource: All local businesses

Goal Monitor: Rehabilitation Counsellor

It is important for the counsellor to have accurate occupational information during the planning phase. By participating in the formulation of goals, the client can learn about options and identify a number of strengths and abilities, which actually facilitates, not only job placement, but also career development.

Treatment Phase

During the treatment phase, the counsellor must perform a variety of roles to facilitate the client's vocational rehabilitation. In some cases the counsellor may have to refer the client to an outside service or facility to enhance rehabilitation. The treatment phase will, therefore, involve individual counselling, group counselling, information sharing, career counselling (e.g. training), crisis intervention, consultation, referral, and continuous follow-up.

Individual Counselling

During the treatment phase, the counsellor will engage in individual counselling sessions with the client on a bi-weekly basis. Egan (1990) suggests that counselling is a peculiar kind of service, a collaborative process between helper and client:

It follows that, while counsellors help clients achieve outcomes, they do not control outcomes. When all is said and done, clients have a greater responsibility for both the production and the quality of outcomes. (Egan, 1990, p.8).

This view of counselling is parallel to the philosophy that individuals are ultimately free to make responsible decisions, even when the decision-making process may be facilitated by another person, the rehabilitation counsellor. Walls and Dowler (1987) found that vocational rehabilitation clients face three major decisions as they enter the rehabilitation process: (a) whether to seek rehabilitation services, (b) what vocational goal to pursue, and (c) to what extent they will cooperate in the vocational rehabilitation process.

According to Roessler (1988), re-motivating clients to return to work includes identification of the core problem (or problems), identification of the desired goal, generation of alternatives, review and assessment of consequences or alternatives, solution

selection, solution implementation, and monitoring of outcomes of the action strategy. Roessler (1988) continues to say that problem-solving strategies, relaxation procedures, exercise, hobbies, and so on, have the ability to foster readiness for direct action, whereas responses such as avoidance/withdrawal, suppression/denial, and self-medication are all unproductive short term solutions.

In addition to the primary issues facing the rehabilitation client, there are a number of other issues that may arise once the client - counsellor relationship has begun, e.g. pain management, addiction problems, marital discourse, abuse, financial difficulty and so on. Using a variety of counselling skills such as listening, empathy, questioning, confrontation, role playing, probing, and cognitive restructuring, interviews will be set up with clients at a mutually agreed upon time and location. The rehabilitation counsellor will also keep up to date on new techniques in counselling rehabilitation clients, such as protocol analysis, which provides access to an individual's cognitive processes during problem-solving activities by having the client "think aloud" (Dubé, 1995).

In all, the individual counselling component will be eclectic in nature and will follow Egan's (1990) general counselling guidelines:

- to help clients tell their thoughts
- to challenge new client perspectives
- to facilitate decision making

- to help set goals
- to help clients develop strategies for actions
- to facilitate the formulation of plans
- to prepare clients for termination of the relationship

During the rehabilitation process, there are many issues, concerns and problems facing the rehabilitation counsellor. As one explores these areas it becomes increasingly obvious that in order to ensure highest quality care to clients (keeping in mind the philosophy that all clients must be treated with dignity and respect), ethical guidelines must be followed at all times.

When considering the helping relationship, four basic elements are present for the counsellor to consider. Firstly, there is the client who needs help. The client will, specifically, be an individual injured in a motor vehicle accident. The rehabilitation counsellor will be equally accessible to all injured clients of the insurance company, in agreement with both personal and program philosophy.

The second element in this helping relationship is the helper, the rehabilitation counsellor. This person will be professionally trained, at a graduate level, to work in the counselling field.

The third element of the helping process is the relationship, itself. Through establishing rapport, and with dignity and respect for every human being in mind, the relationship will be established. MacLean and Gould (1988) purport that "it is almost impossible to conceive of helping taking place outside a relationship..." (p.11).

The context or parameters, within which the counselling occurs, is the fourth basic element of the helping relationship. When an injured claimant is visited, the counsellor is encountering a person with a history and who exists within a social context. The counsellor is also setting up a context in which the "helping", itself, will occur.

When closing each individual counselling session, the rehabilitation counsellor must be aware of time and should let the injured client know when the session is near ending. As the session draws to a close, the counsellor may ask the client to summarize main themes, feelings, or issues of the session. This helps the client to crystallize, in his or her own mind, the important things that took place during the session. At times, the counsellor may prefer to do a summary, which can be useful since it recapitulates the whole session and serves as a stimulus to the formulation of goals for the client to work on between sessions, keeping in mind the goals outlined in the Individualized Written Rehabilitation Program.

Group Counselling

There are many aspects of individual counselling that also apply to group situations. For example, counselling skills such as empathy, summarizing, challenging and so forth are very relevant, as well as knowledge of theoretical approaches, stages of counselling and aims of helping. However, group counselling is different from individual counselling.

George and Cristiani (1990) define group counselling as "the use of group interaction to facilitate self-understanding as well as individual behaviour change" (p.200).

While there are many kinds of groups, this Vocational Rehabilitation Counselling Program offers counselling, assessment and information sharing groups. Group size will typically be small (5-10 participants). The role of the rehabilitation counsellor will be to create a safe and secure environment where group members feel comfortable sharing personal concerns on areas of special need, as well as feel open to the information being shared in the group.

1. Counselling Groups

Some advantages of counselling in groups, as cited by George and Cristiani (1990) are presented below:

- a) It is efficient. The rehabilitation counsellor can provide service to many more clients.
- b) It provides a social, interpersonal context in which to work on interpersonal problems.
- c) Clients have the opportunity to practice new behaviours, e.g. role play and job interviews.
- d) It enables clients to put their problems in perspective and to understand how they are different from and similar to others.
- e) Clients form a support system for each other.
- f) Clients learn interpersonal communication skills. These are transferable skills that can increase clients' employability.
- g) Clients are given the opportunity to give, as well as, to receive help. Injured individuals may share with others in the group their experiences of how they cope with their injury. This can be useful for increasing clients' feelings of self-worth.

In implementing a group counselling component in the Vocational Rehabilitation Counselling Program, the rehabilitation counsellor must recognize that not every client benefits from this approach. George and Cristiani (1990) suggest that group counselling is unwise in the following situations: the client is in a state of crisis; interpreting tests other than vocational assessments; the client has an unusual fear of speaking; the client has poor interpersonal skills; the client has very limited awareness of his/her own feelings, motivations and behaviours; and, the client's need for attention is too great to be managed in a group.

Choosing group members is a very important factor in making group counselling an effective intervention. The rehabilitation counsellor must exercise excellent judgement in order to select a combination of members that facilitate, rather than impede group goals.

Even with the noted limitations, groups can be an effective means of counselling. For example, Roessler (1988) proposes a group counselling program that is intended to encourage resumption of the work role by persons who have experienced mid-career disabilities. In a small group counselling format, **Return-To-Work (RTW)** uses structured activities and discussion topics to assist clients in changing and re-defining their roles in order to establish personal directions for their physical and vocational

rehabilitation programs. This program is an excellent example of how the rehabilitation counsellor can use a group setting to facilitate the rehabilitation process.

The purpose of **RTW** is to teach new cognitive coping strategies and effective problem-solving and decision-making skills. Roessler (1988) states "Systematic use of these interpretation and direct action skills increases the probability of an early and successful return to work..."(p.106).

Overview of the **Return-To-Work** Program

Module 1

- orientation to **Return-To-Work**
- group cohesion exercises
- discussion of the implications of the injury/disability, e.g. its effects on personal, social, family, and vocational functioning
- structured activities focusing on how they define and feel about their injury/disability, gains and losses associated with their injury, and the nature of their current self image
- assessment of the adequacy of their current resources to cope with their injury

Module 2

- begins with a "take charge" activity. Using injury and unemployment as a frame of reference, members describe their sense of personal control, adequacy of personal knowledge, and the cause of their current situation.
- discussion of the difference between helpful and unhelpful cognitions
- clarification of hopes and goals
- members consider their need for information and other resources in the pursuit of their goals

Module 3

- after clarifying life goals, members answer questions regarding the importance of each goal and their personal readiness to achieve these goals
- focus on the decision-making model that enables them to determine a goal, the extent of the additional information needed, the effect of future events on the goal, personal resources for achieving the goal, options for achieving the goal, and anticipated outcomes for selected options

Module 4

- stresses the concept of work involvement and the value of the work role
- consists of structured activities, e.g. work involvement scale, appraising the meaning of unemployment, "closing the gap" activity, and examining "jobs

I would like"

- aimed at increasing participant motivation in specifying jobs they would like to investigate

Module 5

- potential jobs are examined in detail, e.g. job demands, adequacy of personal skills, job modifications needed, and so forth
- examination of available supports for each person's return to work efforts

Module 6

- an overall employment goal is formulated, including steps required to reach the goal
- discuss return to work concerns: (a) What concerns you about returning to work? (b) How will you deal with each of these concerns? (c) Do you feel in control of your life? (d) Do you believe you will be able to do the things you need or want to do?

Module 7

- members meet to share their progress in their efforts to return to work
- provide group support
- strategies for removing unexpected barriers are explored

In addition to using counselling groups to facilitate the rehabilitation process, the rehabilitation counsellor must recognize that groups can also be beneficial for assessment and education.

2. Assessment Groups

The administration of various career exploration assessments, e.g. interest inventories and career searches, can be carried out very effectively in group settings. Others, such as intelligence assessments are more in-depth and should only be administered on an individual basis.

3. Information Sharing Groups

Using group approaches, the rehabilitation counsellor can teach the following: job search skills; job holding skills; resume writing; labour market information; interview techniques; basics of injury prevention; medication compliance; relaxation methods, e.g. deep breathing and deep muscle relaxation; stress management; and, problem solving skills.

The use of groups by the rehabilitation counsellor, as previously indicated, can be a very effective tool in facilitating the rehabilitation process. The counsellor must always be sensitive to the needs of each client in order to ensure that group techniques are utilized

only when appropriate to the client's situation. For example, some situations always dictate an individual counselling approach, while other situations are facilitated by both individual and group counselling, e.g. information sharing and career counselling.

Information Sharing

Information sharing is a component that exists in all phases of the rehabilitation counselling process, but probably more salient during the treatment phase. In educating, the rehabilitation counsellor must remember that the sharing of information is a component of both individual and group counselling.

There are numerous topics that could be covered by the rehabilitation counsellor for information-sharing purposes. Examples of such topics were previously mentioned in the section on "Group Counselling" and include topics such as interview preparation, labour market information, relaxation training, and basic body mechanics aimed at prevention of further injury and/or "flare ups" of previous injuries. It is necessary for the counsellor to research and be well versed in areas such as these in order to offer quality vocational rehabilitation. Schoenberg and Erickson (1995) outline numerous resources available on the Internet which are specific to disability and rehabilitation. Over time, the rehabilitation counsellor should develop information packages on the previously listed topics, as they pertain to the special needs of clients who have suffered from various types

of injuries.

Egan (1990) suggests that one way of looking at the goal of helping, in general, is client learning. Thus, helping can be viewed as an educational process in which both the counsellor and the client work to help increase the client's options. According to Egan (1990), educational outcomes can manifest themselves in the client as changes in cognitions, feelings, or behaviours (or some combination of these).

Career Counselling

When assisting clients with vocational rehabilitation, it is essential that the counsellor have an understanding of various career development theories. Career counselling is an important aspect of vocational rehabilitation, regardless of the functional tolerances of the person and whether or not the client can return to pre-injury employment. In some cases, a client may be deemed unable to return the previous job, temporarily or permanently. As a result, (re)training is needed so that the client can seek employment in a modified or alternate job. Clarification regarding the client's aptitudes and abilities must be assessed when considering (re)training because these factors impact on deciding what types of vocational activities a particular client is most suitable to perform. Career counselling is essential in, but not limited to, this clarification process.

The rehabilitation counsellor can assist clients with the following:

- a) **Assessment of clients' interests, aptitudes and/or cognitive abilities.**

- b) **Factors to consider when choosing an occupation, such as physical demands of the job, environmental conditions, educational requirements, aptitudes and temperament needed, and so forth. This type of information can be found in various occupational classification sources.**

- c) **How to select occupations that match personal requirements.**

- d) **General information on occupations, e.g. description of occupations, salary ranges, employment trends and possibilities, and educational requirements. Occupational dictionaries may be able to assist in gathering this information.**

- e) **Job search tips**

- f) **How to prepare a resume**

- g) **Preparation for interviews**

Additional sources to avail of for career information, which are free to the counsellor and client, includes the Career Information Hotline (1-800-563-6600) and the Career Information Resource Centre (CIRC) located on Water Street in the Bowring Building, St. John's, Newfoundland.

Once the client has prepared properly for the job market and has found prospective employers, the rehabilitation counsellor may have to implement programs such as Job Shadowing and Work Trial Experiences.

1. Job Shadowing would allow a claimant to "shadow" someone who is in an occupation that is of interest. Details would be arranged between the employer, the rehabilitation counsellor and the client. It will consist of one full working day and will provide an opportunity for the client to observe the types of work responsibilities involved in the occupation (physical and cognitive).
2. A Work Trial Experience would be an opportunity for the injured claimant to return to his/her job, or a new job, on a trial basis. This trial could provide information regarding the client's ability to resume the occupation he/she once held. "Ease back", a particular type of Work Trial, could also be arranged. The number of hours of work would typically be in progression so that the client gradually increases the number of hours worked per week, until full time

employment is sustained. The details of the Work Trial Experience and Ease Back would be discussed by the counsellor with the attending physician, the employer and the client. Job modifications may also be explored at this time. The rehabilitation counsellor should, at all times, keep the attending physician updated on the Work Trial Experience to ensure that the client is not doing any activities he/she is not capable of physically performing.

Even if the rehabilitation counsellor is involved in career assessments or active job placements, a comprehensive understanding of the local labour markets, job prospects, available government programs and a list of appropriate community resources is always an essential. A rehabilitation counsellor must be familiar with the services and resources provided by local agencies, and with the staff of each agency, so that appropriate referrals for career information can be made. Specific information, regarding community agencies, can be found in the Community Services Council Directory (1995).

Whether the client needs job-seeking skills, direct intervention with job placement, or both, the counsellor must always look at the individual needs of the client. Doing too much for the client, e.g. doing job searches, finding potential employers, making all the Work Trial arrangements, and so forth, when the client does not need intervention to this extent, may be detrimental to finding and sustaining active employment. For example, when the client has invested only minimal personal energy into the process, he/she may be

more likely to leave a job when perceived difficulties arise. However, not assisting the client, who is in great need of intervention, could be equally detrimental.

Sometimes, during individual, group and/or career counselling, client issues may surface that could potentially be very devastating to the entire vocational rehabilitation counselling process. Situations may arise that need and demand immediate attention before the counselling process can continue, e.g. crises.

Crisis Intervention

It is safe to say that counsellors, in almost all settings, encounter crisis situations. Crisis situations are "frequently explosive in nature and often involve a threat to the survival of the individual or to the family unit to which the individual belongs" (George & Cristiani, 1990, p. 208). Examples of crisis could include a person's threat or attempt of suicide, or the death of a family member.

According to Speller (1989), a crisis state is most often characterized by symptoms of stress, extreme discomfort, and lowered efficiency. Usually an attitude of panic or defeat, wherein the individual feels overwhelmed, inadequate, and helpless, but may exhibit either agitation or withdrawal also exists during a crisis. Typically, an individual in crisis focuses on relief, with little interest in the initial problem. Speller (1989) continues

to say that crisis situations are of a limited duration.

The literature purports that the primary goal of crisis intervention is to avoid catastrophe (Pearson, 1990). George and Cristiani (1990) state:

It consists of intensive work over a short period of time, with emphasis on the concrete facts of the current situation and on the client's own efforts at changing it.

While crisis intervention is clearly a "helping" strategy, it is not counselling; it has a narrower and more superficial focus, more modest goals, and briefer duration.

(p.208).

In caring for a client in crisis, the rehabilitation counsellor must be particularly concerned about establishing genuine understanding of what the client is going through - the fears, dangers, feelings, and hopelessness. By getting "into" the client's world, the counsellor will establish him/herself as a professional who can actually help.

In helping the client in crisis, it is essential that the counsellor and client establish rapport (Schur & Broder, 1990). The emphasis should be on communicating genuine warmth and empathic understanding. Once the crisis has been identified, the rehabilitation counsellor assesses the urgency of the situation and sufficiently explores the problem. The counsellor then summarizes and reviews perceptions with the client. This can serve two functions. Firstly, it reassures the client and the counsellor that the counsellor has a

reasonably clear perception of the crisis, as the client perceives it. Secondly, it helps in determining whether the client is ready to consider the possibility and the direction of change (George & Cristiani, 1990).

Once possibility and direction of change is agreed upon, possible alternatives can be considered and a plan of action can be determined. Issues to be explored, at this point, may include: resources and support available; prior methods of coping with crisis; client's ability to help him/herself; and, the facts needed to locate an appropriate agency or practitioner, if necessary (Googins & Godfrey, 1987).

Gibson and Mitchell (1990) suggest various "do's" and "don'ts" in crisis intervention. Examples of these suggestions include the following:

- remain calm and stable
- prepare psychologically for the turbulence of the emotion
- allow the client full opportunity to speak
- ask object-oriented questions
- deal with the immediate situation
- have local resources available
- do not try and cheer up the client
- do not interrupt the client when speaking
- do not deal with underlying unconscious causes, at this point

It is important to note, that while crisis intervention usually involves a high degree of stress and anxiety, it is potentially highly rewarding for the counsellor. In many instances, a crisis presents an excellent opportunity for change. Usually, individuals are more willing and more motivated to change during crisis than they are at other times (George & Cristiani, 1990). However, it is essential the counsellor realizes there will be times consultation with other professionals may be necessary. For example, if the crisis a client is experiencing is financial in nature then a financial advisor may need to be consulted.

Consultation

Consultation, in the human services, involves helping individuals or organizations improve their effectiveness (Gibson & Mitchell, 1990). More specifically, it: refers to a voluntary relationship between a professional helper and help-needing individual, group or social unit in which the consultant is providing help to the client(s) in defining and solving a work-related problem or potential problem with a client or client system. (Stein, 1990, p. 154).

This definition is also consistent with the Guidelines for Ethical Behaviour (Canadian Guidance and Counselling Association, 1989). These guidelines state that

counsellors, acting as consultants, must have a high degree of self-awareness of their values, knowledge, skills and limitations. The focus of the relationship should be on the issues or problems to be resolved, not on the person(s) presenting the problem.

Counsellors must be reasonably certain of their competencies and resources for giving consultative help and there should be agreement between the counsellor and the client of the problem definition.

Once a client has engaged in vocational rehabilitation counselling, the counsellor may need to act as a consultant to the physician, employer, solicitor, insurance personnel, and so forth. In addition, there may be times during the counselling process that the counsellor may need the advice of other consultants, e.g. general practitioners, medical specialists, physiotherapists, occupational therapists, psychologists, chiropractors, employers, acupuncturists, and massage therapists.

Throughout the provision of the Vocational Rehabilitation Counselling Program, the rehabilitation counsellor must recognize the importance of remembering that one person, alone, does not have "all the answers". Therefore, to help establish and maintain credibility, the counsellor will utilize and refer to other professionals who have received specialized training in particular fields.

Referral

It is important for the rehabilitation counsellor to have an early referral of the client. However, it is also important to note that the counsellor may also need to be the referral agent and refer a client to an outside agency once the rehabilitation process begins.

The Community Services Council of Newfoundland and Labrador Directory (1995) can assist the counsellor in making such referrals.

Similar to the counselling process, referral procedures must be based on trust and respect for the individual seeking assistance. Counsellors can only make clients aware of the existence of alternatives that will provide the best means of help on the clients' terms. The role of the counsellor during a referral is to create an awareness of the alternatives and to see that the client has the maximum opportunities to utilize them (George & Cristiani, 1990).

Once an initial interview has taken place, a decision will be made whether or not the client needs a referral to another helping professional. Although referring a client may be viewed as a sign of an inadequacy, by some people, a great deal of competency is needed to identify situations that require specialized services. Examples of times when the rehabilitation counsellor may need to refer to an outside agency include the following:

- The client presents a problem that is beyond the counsellor's level of competency, e.g. may need full medical and/or psychiatric intervention.
- The client is a personal friend or relative. Such a "dual relationship" is against the Canadian Guidance and Counselling Association's (1989) Code of Ethics.
- The client is reluctant to discuss his or her problem with you for some reason. For example, the injured client may view the counsellor as part of insurance administration and fear, if he/she revealed personal information, it may put the insurance claim at risk with the insurer.
- After several sessions, the counsellor feels the relationship with the client is not effective. Sometimes, for ill-defined reasons, the particular counsellor-client relationship may not be beneficial to the client. Therefore, the client needs to be aware that other rehabilitation counsellors do exist and are accessible.

As a skilled professional one must know when to make referrals, how to make good referrals and to whom they should be made. In making referrals, the client needs to be given accurate and specific information. For example, if the client is referred to an outside resource, the address, name, direction, description and phone number of the person in the agency should be given. During the rehabilitation counselling process, referrals may be made to physicians, specialists, occupational therapists, chiropractors, acupuncturists, chronic pain specialists, physiotherapists, massage therapists, aquatic therapists, and a variety of other sources.

Continuous Follow-up

After the rehabilitation counselling process has begun, follow-up with clients will be an integral part of the entire process. It should be done on a bi-weekly basis. Follow-up with attending health care professionals will also be done at time intervals which are appropriate based on the nature and intensity of the medical treatments the client is receiving. Ongoing follow-up with the potential or previous employer is also important to increase the likelihood of cooperation with possible trials of return to work.

Job Placement Phase

Through detailed assessment and appropriate counselling, education, referral, and consultation, the likelihood of a suitable job being found for the injured client increases. By implementing the various components discussed in this paper, the rehabilitation counsellor will hopefully have assisted in the client's return to active employment. The client may be employed in any number of ways:

1. same employer - same job
2. same employer - modified job

3. same employer - new job
4. different employer - same job
5. different employer - modified job
6. different employer - new job

The phase of job placement can be very rewarding for the counsellor and the client, who have both worked hard to ensure the vocational rehabilitation counselling process ends with active employment for the injured client. However, being aware of the local market, as previously stated, is an essential requirement in the career counselling component of the treatment phase. Given Newfoundland's poor economic situation, unfortunately, both the counsellor and the client need to prepare for the potential possibility of not finding employment, even when the client is ready for job placement.

Regardless of whether or not the client is successfully placed in active employment, the important objective is for the client to be "job ready". This readiness will enable the client to find employment when the opportunity arises. When the desired outcome of job placement is met, the rehabilitation counsellor does a final follow-up with the client.

Final Follow-up

During final follow-up, the rehabilitation counsellor arranges to meet with the client at his/her place of work one month after job placement. If there are obstacles to the client's holding the job, they can be discussed at this time, and in some instances seen first hand by the counsellor during the visit. Usually, the counsellor and the client prepare for any potential obstacles before job placement, but sometimes issues arise that are not anticipated.

For example, the client may be required to change his/her office and the new office space cannot accommodate the ergonomic set-up in the previous office. In this instance, it may be necessary to have an occupational therapist visit the client's new office to make the necessary modifications and to ensure the client's working space is ergonomically correct. This is done to prevent the client's motor vehicle injury symptoms from recurring and to prevent new injuries from occurring.

Once obstacles to continued employment are eliminated, the counsellor and the client are ready for termination of the vocational rehabilitation counselling relationship. While termination is the final stage of the entire vocational rehabilitation counselling process, it is important to note that both the counsellor and the client prepare for this stage all through the counselling process.

Termination

During termination there are times when the counsellor may feel that it is time to terminate, but the client may not feel ready. Then, the counsellor must explore and weigh the client's needs to continue against personal feelings about ending the relationship. In other instances, the client may wish to terminate the relationship, but the counsellor may think that this is premature. When this happens, the rehabilitation counsellor can only confront the client's needs to terminate and express reservations about severing the relationship, at that particular time. The counsellor, though, can never force a client to continue against his/her wishes. In most cases, however, termination of the counselling relationship is a natural process in which both the counsellor and the client decide that the relationship should draw to a close.

By the time termination is reached, the counsellor and the client have used all the information gathered in the entire rehabilitation counselling process, including evaluation, planning, and treatment, in order that the final phase of job placement is successful and that appropriate active employment is obtained and sustained by the injured client. Ultimately, this is the goal of the entire vocational rehabilitation counselling process and the goal of this Vocational Rehabilitation Counselling Program.

CHAPTER IV- GUIDE TO EVALUATION

Corey (1991) suggests that evaluation is essential in the delivery of counselling services. It helps assess the effectiveness of the service, provides continuous feedback, and is the basis for an array of program decisions. Evaluation is a process that requires thoughtful consideration and full cooperation of all parties involved in the counselling process.

As previously stated, the present researcher has not done a field evaluation on the Vocational Rehabilitation Counselling Program presented in this paper. However, a guide to evaluation is provided so that the program's effectiveness can be assessed by present and future rehabilitation counsellors to ensure quality of service and accountability.

In evaluating the effectiveness of the Vocational Rehabilitation Counselling Program, the rehabilitation counsellor should employ various methods such as questionnaires, checklists, rating scales, surveys, Likert scales, and narrative reports. It is up to each individual researcher to determine what type of evaluating tool should be used at any one particular time. Depending on the purpose of the evaluation and the person who is completing the evaluation, alternate tools may be appropriate on given occasions.

After reviewing the preceding Vocational Rehabilitation Counselling Program, one

may say that if, at the end of the process, a client is engaged in active employment, the program and the counsellor were successful, and if the client is not employed, then the process was unsuccessful. A counsellor does not need any guides to do this type of evaluation. However, the entire Vocational Rehabilitation Counselling Program is a process, a counselling process, and this must be the heart of the evaluation.

Although many counsellors recognize the importance of evaluation, measuring the effectiveness of counselling continues to be a source of difficulty (George & Cristiani, 1990). Part of the problem is that many counsellors see evaluation as a threatening process. The purpose of evaluation, however, is to provide new insights that will help counsellors perform at higher and more professional levels.

Therefore, the main aim of evaluation is to "ascertain the current status of the counselling service within some frame of reference, and then on the basis of this knowledge to improve its quality and efficacy" (George & Cristiani, 1990, p.277). From this aim, one can see the importance of good operational objectives in measuring counselling effectiveness.

George and Cristiani (1990) identify three major types of criteria for evaluation. **Social Adjustment Criteria** includes changes in the client's "adjustment" measured by the client or by others close to the client. This may involve the client's adjustment to the

injury. It could be measured by questionnaires or Likert Scales given to clients and close family members. **Personality Criteria** includes changes in the kind of self-descriptive adjectives the client uses and/or changes in pre/post scores attained on personality tests/inventories. Finally, **Vocational Adjustment Criteria** includes improvements in performance at work, through clients' self-reports or the employer's reports of the clients' performance on the job. Simple checklists may suffice for this type of evaluation.

Subjectively, clients, themselves, provide a great source of information regarding counselling effectiveness. For example, the client may experience increased use of positive self-statements. Counsellors can, also, subjectively report on client progress.

Objectively, when setting up an evaluation program, counsellors must develop some sort of systematic approach. George and Cristiani (1990) believe that in order for a counsellor to objectively evaluate the program, three sets of experimental variables must be conceptualized.

The first set of variables are those involved in the immediate counselling situation. Each of these input variables must be considered and controlled to determine if the rehabilitation counsellor is effective for some clients, but ineffective for others.

- a) Counsellor variables include age, sex, socioeconomic background, training, and

institutional role.

- b) Client variables include age, sex, socioeconomic status, nature of presenting problem, and expectations for counselling.
- c) Situational variables include nature of referral and the institution in which the counselling takes place.

The second set of variables are process variables. These include what actually happens in the counselling situation:

- a) the kind of relationship established
- b) the number of contacts with the client
- c) the theoretical approaches utilized

The third set of experimental variable are outcome variables. These are based on the mutually agreed goals set up in the planning phase and written in the Individualized Written Rehabilitation Program. They include the changes that have occurred in the injured client during the counselling process, as a result of counselling intervention. Such

outcome variables may include differences in how clients think, feel, and/or behave, especially with respect to adjustment to injury and vocational activity. They must be evaluated to determine whether the counselling process has succeeded in meeting its goals, expectations, and objectives.

The evaluation of the overall program adheres to a similar type of evaluation process, as with the counselling relationship. The consideration of all the preceding factors serve to increase the effectiveness of the evaluation process, in general. With a thoughtful, systematic evaluation process, the rehabilitation counsellor is provided with feedback that is essential in making important decisions regarding the Vocational Rehabilitation Counselling Program, including direction for any modifications that need to be made. The present researcher believes that evaluation is essential to ensuring the continuation of a quality counselling program.

CHAPTER V - SUMMARY AND RECOMMENDATIONS

All the components presented in this project are very important in the delivery of a successful Vocational Rehabilitation Counselling Program. Great care has been given to ensure that the components are, not only relevant to the program, but are very interesting to the person who has to carry them out - the rehabilitation counsellor. This is done to enhance the likelihood that the counsellor will be guided by the components of a structured, well-researched program.

While all aspects may be interesting, some may be more challenging than others. For example, marketing, information sharing, consultation, assessment, counselling, and evaluation will be very interesting. They involve the skillful sharing of information. Crisis intervention may be, particularly, challenging for the counsellor because it can require intensive training and experience, as well as the consumption of a great deal of the counsellor's energy. Other challenges to counsellors are results of the recent health care climate of fiscal restraints and cutbacks in Newfoundland and Labrador. Trujillo, Beggs and Brown (1996) discuss the impact "doing more with less" has on rehabilitation counsellors. They state that emerging challenges for rehabilitation practitioners include increased caseloads, additional administrative and supervisory responsibilities, and dissatisfaction in operating in an environment that does not promote expected career paths.

This Vocational Rehabilitation Counselling Program is applicable to clients who have been injured in motor vehicle accidents and, as a result, the rehabilitation counsellor will be working with motor vehicle insurers who are funding the client's rehabilitation and treatments. It is very important for the counsellor to realize there is a difference in working for privately owned insurance companies as opposed to working for a government funded agency because this can present special issues to the counsellor.

At times the insurer may place restrictions on what the counsellor is able to do. The counsellor makes recommendations which must be approved, financially, by the insurer before being implemented, e.g. occupational therapy assessment. Sometimes, such a recommendation could be refused because of the associated cost to the insurer. This can be frustrating to the counsellor who believes this recommendation would be beneficial to the client and would facilitate the client's rehabilitation. The counsellor must then explore alternate options which could facilitate the client's rehabilitation, at a lower cost to the insurer. There are times, however, when the cheaper alternative is not always the best option for the client. The counsellor must remember to act as a client advocate and try to ensure quality vocational rehabilitation.

Another issue that may face the counsellor stems from the current writing of the Newfoundland and Labrador insurance policy. Under the present policy, a person's own

insurer has the right to request that the client be assessed by an independent medical examiner of the insurer's own choice. Regardless of what other health care providers are recommending for the client, the insurer can choose to implement only what the independent specialist recommends. This can be quite devastating to the client. For example, a client may be deemed unable to return to work by the family doctor, the physiotherapist, the psychologist, and the rehabilitation counsellor, but the independent specialist states the client can return to work. As a result the insurer ceases benefits to the client in the form of treatment, loss of wages, and rehabilitation services. The client, therefore, is often left with two options. Firstly, the person may not physically be able to return to work and ends up on social assistance because there is no source of income. Secondly, the client may return to work, prematurely, and risk re-injury. A counsellor can easily see the frustrations this could cause when trying to implement a comprehensive vocational rehabilitation counselling program. Adding to this problem is the lack of local resources to assist clients who have been injured in motor vehicle accidents. Presently, there is no committee set up to protect the rights of injured motor vehicle accident clients. There is no independent medical review board which can examine insurers' decisions, with the right to overturn them, if necessary.

Typically, if the philosophy of the referral agent is not congruent with the counsellor's philosophy, the likelihood of counsellor dissatisfaction increases and the likelihood of successful rehabilitation decreases. However, the issues that are currently

present in working with motor vehicle accident insurers and injured motor vehicle accident clients cannot be avoided and must be dealt with by the counsellor in an effective manner, e.g. acting as an advocate for clients' rights and attempting to lobby appropriate sources so that the rights of injured clients can be protected, including the right to rehabilitation services that are not impeded by financial decisions. Of course to fully understand the presenting issues and act as an instrument of change to "the system", the counsellor must first decide to implement this vocational rehabilitation counselling program.

Because rehabilitation counselling is a relatively new counselling domain in Canada, the present researcher recommends the preceding program be field tested, as per the guidelines, and evaluated accordingly, recognizing the obstacles that may occur. While this particular program involves the vocational rehabilitation counselling of clients injured in motor vehicle accidents in Newfoundland and Labrador, it does not have to be limited to this population. Many of the rehabilitation principles discussed in this paper apply to other injured and/or disabled clients, not only those injured in motor vehicle accidents. However, if one decides to implement this program with another population, adjustments will be needed. For example, if a counsellor was working with a client disabled from a work related injury, the guidelines of the Workers' Compensation Commission would have to be followed. Adjustments would also be needed if the counsellor was working with a client injured in a motor vehicle accident while residing in another province. Each province has its own provincial legislation of policies that the

rehabilitation counsellor would have to be aware of in order to offer rehabilitation services to that population.

In addition, the researcher recommends the counsellor review and perform ongoing research on the topic of rehabilitation, given that it is a newly developing field in Canada. Topics this researcher suggests include: the differences in vocational rehabilitation outcome between government funded and privately funded agencies; the effect of local unemployment on rehabilitation potential; and, the effects, financial and otherwise, of “bad” insurance company decisions on injured clients.

Overall, each and every component of this program may, or may not, be interesting and/or challenging to future researchers/counsellors. However, one must always remember that, even though challenging obstacles may arise, the personal rewards that a successful counselling service brings will be a testament to the hard work inherent in a thoughtful, well-planned, and comprehensive counselling program.

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APPENDICES

APPENDIX A Rehabilitation Referral Form



REHABILITATION REFERRAL FORM

Source of Referral:	_____
Address:	_____
Telephone No.:	_____

Client Name: _____

Address: _____

Phone No.: _____

Date of Accident: _____

Diagnosis: _____

Attending Physician: _____

Address: _____

Phone No.: _____

Occupation: _____

Employer: _____

Address: _____

Phone No.: _____

Lawyer: _____

Firm Address: _____

Phone No.: _____

APPENDIX B Rehabilitation Screening Checklist

REHABILITATION SCREENING CHECKLIST

(a) **Biological**

- lack of comprehensive medical information
- diagnosis is vague
- prognosis is vague and/or indefinite
- prolonged treatment by traditional treatment modalities
- compounding disabilities, e.g. vision and hearing loss
- multiple soft tissue injuries
- a large number of health care professionals involved
- previous injury

(b) **Psychological**

- client reports a change in personality
- client reports a number of symptoms of depression.
- other psychological/psychiatric problems exist.
- appears to have a problem with motivation

(c) **Social (Economic, Family, Vocational and Insurance Factors)**

i) **Economic Factors**

- claimant in financial difficulty
- claimant receiving about the same or more money on insurance benefits
- spouse is unemployed or on benefits/pension/social assistance

ii) Family Factors

- family difficulty such as marital problems or difficulty with the children
- claimant has a large number of dependants
- claimant has young children who require care during the day

iii) Vocational Factors

- claimant has had an unstable work history
- client has mostly worked in seasonal types of employment
- claimant, because of injury, cannot return to previous job
- there is a minimal work history
- expresses dislike for previous job and talks frequently about retraining
- problems with basic literacy
- failed to complete high school
- limited number of transferable employability skills

iv) Insurance Factors

- claim has extended beyond 12 months and claimant still receiving accident benefits
- previous disability claims from motor vehicle accidents or Workers' Compensation
- lawyer is retained for a very minor injury
- benefits are approximating income previous to injury

APPENDIX C Client Intake Interview

CLIENT INTAKE INTERVIEW

Demographic Factors

- 1. Date of Interview? _____
- 2. Client's Name? _____
- 3. Age? _____
- 4. Address? _____
- 5. Date of Injury? _____
- 6. Marital Status? _____
- 7. Dependents? _____

Physical Factors

- 1. Weight? _____
- 2. Height? _____
- 3. Current diagnosis? _____
- 4. Previous Hospitalizations (provide dates & reasons)?

- 5. Is the disability temporary or permanent?

- 6. Any other medical problems?

7. Medications?

8. Do any of these medications affect activities of daily living? How so?

9. Health professionals involved (date of referral and reason)?

10. Describe the results of these health professionals, thus far?

11. Current physical limitations and symptoms?

12. Do these limitations affect the ability to perform pre-injury job? In what manner?

13. Would modifications to the job description/environment be helpful? Describe.

14. What types of hobbies/activities were enjoyed before the injury?

15. How has the injury affected the ability to perform these hobbies/activities?

16. How has the injury affected the ability to perform household maintenance and chores?

17. At this time, which type of activity could the client become involved in?

volunteer work full-time employment part-time employment

light work at home pre-injury occupation work trial (ease back)

18. Prognosis?

19. Future course of treatment?

20. Could the client benefit from any of the following?

physiotherapy occupational therapy chiropractic treatments

pain relief equipment ergonomic equipment orthotic aids

individual counselling group counselling relaxation training

vocational testing back care education intelligence testing

massage therapy acupuncture aquatic therapy

other (Describe) _____

Psychological Factors

1. Personality and mood before and after the accident?

2. Any symptoms of depression?

3. Any increased feelings of dependence?

4. Is there an overconcern about general health?

5. Are there any physical symptoms which are psychologically based?

6. Any negative thought patterns?

7. Adequacy of coping with stress?

8. Any secondary gain from the disability?

9. Any history of psychological problems?

10. The usual style of problem-solving, e.g. impulsive, rational, trial-and-error style?

Social Factors

1. How is the relationship with the spouse and children?

2. Number of dependants and their ages?

3. Describe the support system?

4. Will family facilitate rehabilitation?

5. Any overprotectiveness from family members?

6. Are friends and family supporting (un)realistic goals?

Economic Factors

1. Presently experiencing financial difficulty?

2. Is the spouse employed? In what capacity?

3. What are the main sources of income, at present?

4. Receiving any disability benefits?

5. Is there effective management of finances?

6. Are financial concerns impeding rehabilitation?

Vocational Factors

1. Summary of Education?

2. Summary of Work Experience?

3. Enjoy the pre-injury job?

4. Work well with others?

5. Desire to return to pre-injury occupation?

6. Are perceptions of skills and abilities accurate?

7. Any skills or talents under-developed?

8. Are there any future career goals?

9. Is there an adequate understanding of the labour market?

10. Is additional employment information required?

11. Is training necessary to achieve employability?

12. Do physical limitations currently prevent employment?

APPENDIX D Mental Status Guide

MENTAL STATUS GUIDELINE

APPEARANCE AND BEHAVIOUR

- How does the client present him/herself?
- General appearance, e.g. height, weight, cleanliness, facial appearance, clothes, and handicaps?
- How does the client act during interview, e.g. are there any bizarre gestures or actions, repetitive movements, abnormal posture, eye contact, inappropriate facial expressions, abnormally slow movements, excessive movements, or special mannerisms?
- Is the client's behaviour appropriate for his/her education/age/vocational status?
- How does the client relate to Rehabilitation Counsellor, e.g. wary, submissive, attentive, friendly, manipulative, approval seeking, excessively conforming, hostile, and/or superficial?

SPEECH AND COMMUNICATION

- Describe general flow of speech, e.g. rapid, controlled, hesitant, slow, and/or pressured?
- General tone and context of speech, e.g. over/under production of speech, flight of ideas, paucity of ideas, loose associations, change associations, rambling, circumstantiality, vagueness, and/or incoherence of speech?
- Describe relationship between verbal and nonverbal communication. Are they congruent?

THOUGHT CONTENT

- What did the client discuss?
- Any recurrent themes?
- Any signs of psychopathology, e.g. delusions, hallucinations, phobias, obsessions or compulsions?

SENSORY AND MOTOR FUNCTIONING

- How are the client's sense of hearing, sight, touch and smell?
- How adequate is his/her gross motor coordination?
- How adequate is his/her fine motor coordination?
- Any signs of motor difficulty such as exaggerated movements, repetitive movements (tics, twitches, tremors), grimaces or slow movements?

COGNITIVE FUNCTIONING

- Oriented to time/place/person?
- Ability to concentrate?
- Alertness of client, e.g. responsive to changes in the interview's questions?
- Memory for immediate, recent and remote events?
- Does client's vocabulary and general fund of information reflect his/her occupational and educational background?
- Can he/she read, write and spell?

APPENDIX E Client Release of Information

EMOTIONAL FUNCTIONING

- Describe the general mood of client, e.g. sad, elated, indifferent, angry, irritable, changeable, anxious, tense, suspicious and /or perplexed?
- Any fluxuation of mood during the interview?
- How does the client react to the interviewer e.g. cold, friendly, cooperative, suspicious, and/or cautious?
- Was the client's affect appropriate for the speech and context of the communications?
- How does the client describe his/her mood?
- Is his/her mood congruent with behaviour?

INSIGHT AND JUDGMENT

- What does the client believe about rehabilitation being involved in his/her case?
- Is this belief realistic and appropriate?
- Is the client aware of his/her problems?
- How good is the client's judgement related to Activities of Daily Living?
- How does the client problem solve, e.g. impulsively, rationally, independently, responsibly or through trial and error?
- How much help does the client desire for his/her problems?

Note: This is information acquired during the researcher's training and education as a nurse. The exact source is not known to this researcher.

CLIENT RELEASE OF INFORMATION

I authorize the release of any medical, psychological, vocational, social and health related information pertaining to my care and treatment as a result of an injury I sustained on _____ (date of injury).

This information may be released to the following professional/organizations in order to assist me with my rehabilitation program:

- ___ Vocational Rehabilitation Counsellor
- ___ Health care providers involved in the treatment of my injury/disability
- ___ Professionals involved in management of my insurance claim
- ___ Individuals involved in my present or potential employment

I agree that a photostat copy of this Release of Information is acceptable and I realize that this consent form is valid up to one year after the date it is signed.

Signature of Client: _____

Address of Client: _____

Date: _____

Signature of Witness: _____

Address of Witness: _____

Date: _____

APPENDIX F Employer Interview

12. Describe the physical demands of the job.

<u>Physical Demand</u>	<u>Description</u>
lifting	_____
carrying	_____
pushing	_____
pulling	_____
reaching	_____
sitting	_____
standing	_____
walking	_____
running	_____
climbing	_____
bending	_____
twisting	_____
crawling	_____
writing	_____
other	_____

12. Describe the physical demands of the job.

<u>Physical Demand</u>	<u>Description</u>
lifting	_____
carrying	_____
pushing	_____
pulling	_____
reaching	_____
sitting	_____
standing	_____
walking	_____
running	_____
climbing	_____
bending	_____
twisting	_____
crawling	_____
writing	_____
other	_____

APPENDIX G Physician Interview

PHYSICIAN INTERVIEW

- 1. Date of Interview? _____
- 2. Physician's Name? _____
- 3. Address? _____
- 4. First saw this patient? _____
- 5. Last saw this patient? _____
- 6. Current diagnosis? _____
- 7. Previous Hospitalizations (provide dates & reasons)?

- 8. Permanent Disability?

- 9. Any other relevant medical problems?

- 10. Medications prescribed?

- 11. Do any of these medications affect the patient's ability to work?

- 12. Any other health professionals involved in the patient's care and reason for same?

13. How would you describe the results of these health professionals, thus far?

14. Describe patient's current physical limitations.

15. Describe the current symptoms the patient is experiencing.

16. Do they affect the ability to perform his/her job?

17. Would job modifications or changes to the work environment be helpful?

18. At this time, which type of activity can this patient become involved in?

volunteer work full-time employment part-time employment

light work at home pre-injury occupation work trial (ease back)

19. Describe the patient's emotional condition and coping abilities?

20. Describe prognosis.

21. Describe future course of treatment.

22. Could the patient benefit from any of the following?

___ physiotherapy ___ occupational therapy ___ chiropractic treatments

___ pain relief equipment ___ ergonomic equipment ___ orthotic aids

___ individual counselling ___ group counselling ___ relaxation training

___ vocational testing ___ back care education ___ intelligence testing

___ massage therapy ___ acupuncture ___ aquatic therapy

___ other (Describe) _____

23. What tests and investigations have been performed, including results?

APPENDIX H Return to Work Release Form

RETURN TO WORK RELEASE FORM

I, _____, am the attending physician for this client, _____.

Based on examination and assessment, I believe the following is an appropriate recommendation for this client.

Please place a check mark by the sentence that best describes this client's present abilities.

This client will never be able to return to preinjury employment.

This client is not able to return to the preinjury employment, at this time.

This client is now able to return to preinjury employment without restrictions.

This client is currently able to return to preinjury employment with restrictions (modifications and/or Easeback).

NOTE: A description of these modifications are as follows:

Additional Notes:

PHYSICIAN SIGNATURE

DATE

APPENDIX I Medical Support for Intervention

MEDICAL SUPPORT FOR INTERVENTION

Name of Client: _____

Date of Injury: _____

Rehabilitation Counsellor: _____

Due to an injury/disability that this client sustained, the above named Vocational Rehabilitation Counsellor has been assigned to assist in the coordination of services that are aimed to facilitate the client's gradual return to pre-injury status. In an effort to maximize the client's recovery process to its best possible potential, various treatments may be necessary.

Which treatments would you be in support of, for your patient, at present?

Physiotherapy Occupational Therapy Chiropractic Services

Acupuncture Massage Therapy Aquatic Therapy

Psychological Counselling Orthopaedic Assessment

Other (Please specify) _____

Are there any reasons why this client cannot actively participate in the treatments indicated? **Yes/No** If Yes, explain. _____

PHYSICIAN SIGNATURE

DATE

APPENDIX J Physician Questionnaire

PHYSICIAN QUESTIONNAIRE

1. Length of time treating this patient? _____
2. Current diagnosis? _____
3. Any significant test results or findings on investigation?

4. Previous Hospitalizations (provide dates & reasons)?

5. Any other relevant medical problems?

6. Medications prescribed for this injury?

7. Any other health professionals involved in the patient's care and reason for same?

8. How would you describe the results of these health professionals, thus far?

9. Describe patient's current physical limitations and symptoms.

APPENDIX K General Referral Form

10. Do these symptoms affect the ability to perform his/her job?

11. Would job modifications or changes to the work environment be helpful?

12. At this time, which type of activity can this patient become involved in?

volunteer work full-time employment part-time employment
 light work at home pre-injury occupation work trial (ease back)

13. Describe prognosis.

14. Any recommendations that could facilitate this patient's vocational rehabilitation?

Additional comments?

PHYSICIAN SIGNATURE

DATE

GENERAL REFERRAL FORM

To whom is the referral being made?

Who is making the referral?

Name: _____

Name: _____

Address: _____

Address: _____

Telephone no.: _____

Telephone no.: _____

Client Information

Name: _____

Address: _____

Phone No.: _____

Accident Date: _____

Attending Physician: _____

Name of Clinic: _____

Diagnosis: _____

Employer: _____

Occupation: _____

Lawyer and Firm: _____

Reason for Referral:

Signature of Referral Agent: _____ Date: _____

APPENDIX L Related Health Professional Questionnaire

RELATED HEALTH PROFESSIONAL QUESTIONNAIRE

1. Length of time treating this patient? _____
2. Current diagnosis? _____
3. Any significant findings on examination?

4. Describe patient's current physical limitations and symptoms.

5. Describe the treatments utilized in this client's care, including effectiveness?

6. Do the client's symptoms affect his/her ability to perform his/her job? How?

7. Would job modifications or changes to the work environment be helpful?

8. At this time, which type of activity can this patient become involved in?
____ volunteer work ____ full-time employment ____ part-time employment
____ light work at home ____ pre-injury occupation ____ work trial (ease back)

9. Describe prognosis.

10. Any recommendations that could facilitate this patient's vocational rehabilitation?

Additional comments?

PRACTITIONER SIGNATURE

DATE



