

DEPARTMENT OF EDUCATION

National Institute on Disability and Rehabilitation Research; Notice of Proposed Priorities for Fiscal Years 1997–1998 for a Research and Demonstration Project and Rehabilitation Research and Training Centers

AGENCY: Department of Education.

SUMMARY: The Secretary proposes priorities for the Research and Demonstration Project (R&D) Program and the Rehabilitation Research and Training Center (RRTC) Program under the National Institute on Disability and Rehabilitation Research (NIDRR) for fiscal years 1997–1998. The Secretary takes this action to focus research attention on areas of national need consistent with NIDRR's long-range planning process, to improve rehabilitation services and outcomes for individuals with disabilities, and to assist in the solutions to problems encountered by individuals with disabilities in their daily activities.

DATES: Comments must be received on or before December 2, 1996.

ADDRESSES: All comments concerning this proposed priority should be addressed to David Esquith, U.S. Department of Education, 600 Independence Avenue, S.W., Switzer Building, Room 3424, Washington, D.C. 20202–2601. Internet: NPP_ADA@ed.gov.

FOR FURTHER INFORMATION CONTACT: David Esquith. Telephone: (202) 205–8801. Individuals who use a telecommunications device for the deaf (TDD) may call the TDD number at (202) 205–8133. Internet: David_Esquith@ed.gov.

SUPPLEMENTARY INFORMATION: This notice contains proposed priorities to establish one R&D project for research on improving employment practices covered by Title I of the Americans with Disabilities Act (ADA), and two RRTCs for research related to personal assistance services (PAS) and employment for persons with long-term mental illness (LTMI).

NIDRR is in the process of developing a revised long-range plan. The proposed priorities in this notice are consistent with the long-range planning process.

These proposed priorities support the National Education Goal that calls for all Americans to possess the knowledge and skills necessary to compete in a global economy and exercise the rights and responsibilities of citizenship.

The Secretary will announce the final funding priorities in a notice in the Federal Register. The final priorities

will be determined by responses to this notice, available funds, and other considerations of the Department. Funding of particular projects depends on the final priorities, the availability of funds, and the quality of the applications received. The publication of these proposed priorities does not preclude the Secretary from proposing additional priorities, nor does it limit the Secretary to funding only these priorities, subject to meeting applicable rulemaking requirements.

Note: This notice of proposed priorities does not solicit applications. A notice inviting applications under these competitions will be published in the Federal Register concurrent with or following publication of the notice of the final priorities.

Research and Demonstration Projects

Authority for the R&D program of NIDRR is contained in section 204(a) of the Rehabilitation Act of 1973, as amended (29 U.S.C. 760–762). Under this program the Secretary makes awards to public agencies and private agencies and organizations, including institutions of higher education, Indian tribes, and tribal organizations. This program is designed to assist in the development of solutions to the problems encountered by individuals with disabilities in their daily activities, especially problems related to employment (see 34 CFR 351.1). Under the regulations for this program (see 34 CFR 351.32), the Secretary may establish research priorities by reserving funds to support the research activities listed in 34 CFR 351.10.

Priority

Under 34 CFR 75.105(c)(3), the Secretary proposes to give an absolute preference to applications that meet the following priority. The Secretary proposes to fund under this program only applications that meet this absolute priority:

Proposed Priority: Improving Employment Practices Covered by Title I of the Americans with Disabilities Act

Background

The intent of Title I of the Americans with Disabilities Act (ADA) is to include and empower people with disabilities in the workforce (P. Blanck, *The Americans with Disabilities Act: Putting the Employment Provisions to Work*, Annenberg Washington Program, page 9, 1993). Title I provides that employers, employment agencies, labor organizations, or joint labor-management committees may not discriminate against a qualified individual with a disability in regard to

job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training and other terms, conditions, and privileges of employment. Discrimination under Title I includes not making reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, unless such covered entity can demonstrate that the accommodation would impose an undue hardship on the operation of the business.

The employment status of persons with disabilities is a matter of critical importance, both in terms of public expenditures and in the right of persons with disabilities to participate fully in the labor market (J. McNeil, *Americans with Disabilities: 1991–1992*, Household Economic Studies, p. 70–33, December, 1993). One of the assumptions underlying the ADA is that discriminatory employment practices are contributing significantly to the depressed employment status of persons with disabilities. For 1994, of the 29.41 million persons 21 to 64 years old who had a disability, 14.03 million or 47.7 percent were unemployed. For the same year, the mean monthly earnings of workers with disabilities was \$1,713 compared to \$2,160 for workers without disabilities (J. McNeil, U.S. Bureau of the Census, *Survey of Income and Program Participation*, 1994).

The Equal Employment Opportunity Commission (EEOC), which has enforcement responsibility for Title I of the ADA, estimates that Title I covers approximately 666,000 businesses employing approximately 86 million workers (EEOC Press Release, July 19, 1994). Title I became effective for employers with 25 or more employees on July 26, 1992, and on July 26, 1994 for employers with 15 or more employees. Partially as a result of the recency of these effective dates, little is known about the actual impact of Title I on the employment practices of covered entities. The research that has been conducted on the impact of Title I on employment practices relies primarily on attitudinal surveys of employers toward the ADA, and the anticipated impact that Title I might have on their employment practices (see Baseline Study to Determine Business' Attitudes, Awareness, and Reaction to the Americans with Disabilities Act, Gallup Survey Report, 1992).

While little is known about the actual impact of Title I on employment practices, data collected by the EEOC provide information about alleged Title I ADA violations involving employment

practices. Since July 26, 1992 the EEOC has maintained a database regarding the number of ADA violations that have been cited in charges and the impairments cited in those charges. For the cumulative reporting period between July 26, 1992 and June 30, 1996, the EEOC reports that a total of 68,203 ADA charges were filed. Of the 68,203 charges, 52,448 or 76.9 percent have been resolved. The majority of resolutions are either "Administrative Closures" (40.2 percent) or "No Reasonable Cause" (45.2 percent). While it is impossible to determine what percentage of the "Administrative Closures" involve charges that are meritorious, the remaining 14.6 percent of the charges resulted in "Merit Resolutions" (settlements—4.9 percent, withdrawals with benefits—7.2 percent, reasonable cause 2.5 percent) (EEOC Office of Program Operations from EEOC's Charge Data National Data Base).

The complaints filed with the EEOC that result in "Merit Resolutions" may be indications of not only discriminatory employment practices, but also the difficulties that employers are having understanding or implementing Title I's requirements. In a 1992 survey of 618 employers in Georgia, 84 percent of the companies indicated that they would like to receive more information concerning ADA requirements, 65 percent wanted more information about financial incentives, and 62 percent wanted disability awareness training for employees and having access to trained, motivated employees with disabilities (J. Newman and R. Dinwoodie, *Impact of the Americans with Disabilities Act on Private Sector Employers*, Journal of Rehabilitation Administration, Vol. 20, No. 1, February, 1996).

Persons with disabilities may be exposed to substantial emotional and financial hardship as a result of discrimination or an employer's lack of understanding of the employment practice requirements of the ADA. Attempting to resolve Title I disputes through the complaint process or litigation, can be costly and time-consuming for persons with disabilities, employers, and the EEOC. Preventing employment discrimination and disputes through the provision of information and technical assistance enables employers and persons with disabilities to share in the benefits of productive and financially rewarding employment.

Proposed Priority

The Secretary proposes to establish a research and demonstration project on

improving employment practices covered by Title I of the ADA that will:

- (1) Investigate the impact of the ADA on the employment practices of private sector small, medium, and large businesses;
- (2) Identify the ADA employment practice requirements (with a special emphasis on hiring) that have been most challenging for employers to implement successfully;
- (3) Identify interventions that can be used by private sector employers and persons with disabilities to address the challenging employment practice requirements identified in (2) above;
- (4) Demonstrate the effectiveness of the interventions involving small, medium-sized, and large businesses; and
- (5) Widely disseminate information on effective interventions to employers and persons with disabilities.

In carrying out the purposes of the priority, the proposed R&D project shall:

- Consult with the EEOC in order to determine how EEOC public-use data demonstrate the findings of compliance problems in covered areas, especially in hiring, and how those and future data may be available for the purposes of the project;
- Complement the General Accounting Office qualitative evaluation of the employment provisions of the ADA; and
- Use a variety of information dissemination strategies to reach as wide an audience as possible, including using the ten regional Disability and Business Technical Assistance Centers.

Rehabilitation Research and Training Centers (RRTCs)

Authority for the RRTC program of NIDRR is contained in section 204(b)(2) of the Rehabilitation Act of 1973, as amended (29 U.S.C. 760–762). Under this program the Secretary makes awards to public and private organizations, including institutions of higher education and Indian tribes or tribal organizations for coordinated research and training activities. These entities must be of sufficient size, scope, and quality to effectively carry out the activities of the Center in an efficient manner consistent with appropriate State and Federal laws. They must demonstrate the ability to carry out the training activities either directly or through another entity that can provide such training.

The Secretary may make awards for up to 60 months through grants or cooperative agreements. The purpose of the awards is for planning and conducting research, training, demonstrations, and related activities

leading to the development of methods, procedures, and devices that will benefit individuals with disabilities, especially those with the most severe disabilities.

Under the regulations for this program (see 34 CFR 352.32) the Secretary may establish research priorities by reserving funds to support particular research activities.

Description of the Rehabilitation Research and Training Center Program

RRTCs are operated in collaboration with institutions of higher education or providers of rehabilitation services or other appropriate services. RRTCs serve as centers of national excellence and national or regional resources for providers and individuals with disabilities and the parents, family members, guardians, advocates or authorized representatives of the individuals.

RRTCs conduct coordinated and advanced programs of research in rehabilitation targeted toward the production of new knowledge to improve rehabilitation methodology and service delivery systems, alleviate or stabilize disabling conditions, and promote maximum social and economic independence of individuals with disabilities.

RRTCs provide training, including graduate, pre-service, and in-service training, to assist individuals to more effectively provide rehabilitation services. They also provide training including graduate, pre-service, and in-service training, for rehabilitation research personnel and other rehabilitation personnel.

RRTCs serve as informational and technical assistance resources to providers, individuals with disabilities, and the parents, family members, guardians, advocates, or authorized representatives of these individuals through conferences, workshops, public education programs, in-service training programs and similar activities.

NIDRR encourages all Centers to involve individuals with disabilities and minorities as recipients in research training, as well as clinical training.

Applicants have considerable latitude in proposing the specific research and related projects they will undertake to achieve the designated outcomes; however, the regulatory selection criteria for the program (34 CFR 352.31) state that the Secretary reviews the extent to which applicants justify their choice of research projects in terms of the relevance to the priority and to the needs of individuals with disabilities. The Secretary also reviews the extent to which applicants present a scientific

methodology that includes reasonable hypotheses, methods of data collection and analysis, and a means to evaluate the extent to which project objectives have been achieved.

The Department is particularly interested in ensuring that the expenditure of public funds is justified by the execution of intended activities and the advancement of knowledge and, thus, has built this accountability into the selection criteria. Not later than three years after the establishment of any RRTC, NIDRR will conduct one or more reviews of the activities and achievements of the Center. In accordance with the provisions of 34 CFR 75.253(a), continued funding depends at all times on satisfactory performance and accomplishment.

General

The Secretary proposes that the following requirements will apply to these RRTCs pursuant to the priorities unless noted otherwise:

Each RRTC must conduct an integrated program of research to develop solutions to problems confronted by individuals with disabilities.

Each RRTC must conduct a coordinated and advanced program of training in rehabilitation research, including training in research methodology and applied research experience, that will contribute to the number of qualified researchers working in the area of rehabilitation research.

Each Center must disseminate and encourage the use of new rehabilitation knowledge. They must publish all materials for dissemination or training in alternate formats to make them accessible to individuals with a range of disabling conditions.

Each RRTC must involve individuals with disabilities and, if appropriate, their family members, as well as rehabilitation service providers in planning and implementing the research and training programs, in interpreting and disseminating the research findings, and in evaluating the Center.

Priorities

Under 34 CFR 75.105(c)(3), the Secretary proposes to give an absolute preference to applications that meet one of the following priorities. The Secretary proposes to fund under these competitions only applications that meet one of these absolute priorities:

Proposed Priority 1: Personal Assistance Services

Background

Over the past 20 years, various forms of home-based assistance have emerged

as alternatives to institutional or congregate care for individuals who are unable to perform activities of daily living (ADLs, such as eating, speaking, toileting), or instrumental activities of daily living (IADLs, such as housekeeping, shopping, or food preparation). This assistance often comes in the form of chore services or home health aides provided for older persons through community agencies or corporations and financed through public or private health insurance. However, individuals with disabilities, particularly through the independent living movement, have developed and promoted an alternative model of personal assistance featuring consumer direction. In this priority, personal assistance services (PAS) is used to refer to the full range of service delivery models for providing home-based support services, including chore services, home health care, and consumer-directed personal assistants (PAS).

Programs to fund and provide personal assistance services for individuals with severe disabilities have developed in response to the increased numbers of persons with disabilities living independently in their homes (Kennedy, J., Policy and Program Issues in Providing Personal Assistance Services, *Journal of Rehabilitation*, July/August/September, 1993). The term "personal assistance services" was added to the Rehabilitation Act of 1973, with the 1992 amendments, and defined as "a range of services, provided by one or more persons, designed to assist an individual with a disability to perform daily living activities on or off the job that the individual would typically perform if the individual did not have a disability" (section 7(11)). The provision of on-the-job or related PAS is specifically authorized under the Vocational Rehabilitation Services Program while an individual is receiving services under the program (section 103(a)(15)). In addition, PAS is considered to be an element in the definition of "independent living services" in section 7(30)(B)(vi) of the Act.

PAS is also supported by health care agencies, public welfare agencies, educational institutions, private insurance providers, nonprofit organizations, client self-funding, and a host of less common sources. Indeed, researchers have identified more than 300 State level PAS programs, and suggest that they may be categorized by: (1) Target population, such as persons who are aged, persons with developmental disabilities, persons with mental illness; (2) type of service, such

as chore services and medical services; and (3) method of funding, such as public Medicaid assistance or private individual or insurer purchase of care from home health care providers (Medlantic Research Foundation, *The Feasibility of Establishing a Regional Personal Assistance Program in the Metropolitan Washington D.C. Area*, 1991).

Information from the 1990 Survey of Income and Program Participation (SIPP) and the 1990 Decennial Census indicates that about 4.1 million nonelderly adults, and 5.8 million elderly persons living in community settings have acute or chronic health conditions that may make them candidates for individual personal assistance in their homes (Adler, *Population Estimates of Disability and Long-Term Care*, ASPE Research Notes, 1995). The population potentially in need of PAS is very diverse in terms of geographic location, disability or medical condition, personal health care needs, and psychosocial characteristics.

Two major contrasting models of personal assistance may be identified as the independent living (IL) model, and the medical model. The range of personal services programs may be arrayed on a continuum between the two pure archetypes, with many variations falling at various points on the continuum. The original, or medical model, is characterized by professionalism; agency control and supervision of service providers; and strictly specified tasks that generally must be provided in the home. An agency hires, trains (usually under a medical, nursing, or health services approach), pays, assigns, supervises, and fires the workers, commonly referred to as health aides, and the user has a limited role in planning, directing, and assessing this delimited range of services. In the IL model, individuals with disabilities have a substantial role in determining the terms and conditions of PAS, and they hire, train, and supervise their PAs (A Comparison of Some of the Characteristics of Two Models of Personal Assistance Services, World Institute on Disability, 1995). Although research has shown that PAS are effective, cost efficient, and popular with those assisted under the IL model, the medical model predominates throughout the United States (Kennedy, 1991; Kennedy and Litvak, S. Case Studies of Six State Personal Assistance Service Programs funded by the Medicaid Personal Care Option, 1991). The reasons for the prevalence of the medical model are not entirely clear, but there are several possible explanations. The medical model emerged earlier, in

response to the needs of elderly persons, who were then being cared for in a medical or quasi-medical environment. It was a logical extension to duplicate the medical model in home-based services, including elements of medical prescriptiveness, health services training and qualifications, and focus on such things as security and accountability. It is also possible that older clients are less comfortable with learning new roles in determining their own needs and supervising their care, and that some may lack the physical or cognitive capacities to assume these roles. On the other hand, it may be that younger disabled individuals place much higher value on autonomy, social integration, self-determination and independence than do many of the frail elderly.

Although researchers have described these two models of PAS, there is insufficient information on the characteristics of the PAS that is available to various subgroups of individuals with disabilities, including not only information on the service delivery models, but also factors such as eligibility criteria, quantity and nature of services provided, sources of financing, and costs (per client, per unit of services, and total). Researchers, service providers, policymakers, and advocates would benefit from greater knowledge about the kinds of PAS services available to disabled individuals with various characteristics, including age, type of disability, geographic location, work history, and residential and family status. A comprehensive database of available PAS, on a State-by-State basis, is fundamental to conducting the analyses that will accomplish the purposes of this priority.

Beyond improving understanding of what exists, it is important to both assess the contributions of these services to individuals with disabilities and to society, and to anticipate new developments in service provision and planning. The objectives of the IL model of PAS are somewhat different from those of the medical model. To some extent, these are the individual goals and objectives of the disabled persons who use PAS. However, there are some overall objectives or expectations that society has in their establishment and funding of these programs. It is important to define both sets of objectives and develop standards and measures that will permit an assessment of the effectiveness of PAS in achieving societal objectives as well as in satisfying the expectations of the users of PAS. The objectives of these two groups are expected to be similar,

although not necessarily identical and not prioritized in the same order. Societal objectives may include the avoidance of costly future interventions through health maintenance, prevention of further disablement, safety, and return to work, and these may be reasonably objective and quantifiable outcomes. Consumer objectives may focus on more subjective measures such as autonomy, social integration, and quality of life. Consumers and policymakers will be best served by a comprehensive assessment of PAS outcomes. This priority focuses on the access to, use and outcomes of, and satisfaction with, various configurations of PAS by individuals of working age.

Increasingly, individuals using PAS, and often the PAS as well, are entering the worksite as a result of innovations in telecommuting, flexiplace, home businesses, and individual accommodations for workers in traditional work sites. There is need for studies that will examine alternative approaches to providing PAS to individuals with disabilities in employment settings, including on-site versus off-site assistance, configurations of services necessary to support employment, and that examine relations between PAS and job coaches, rehabilitation counselors, interpreters, and other service personnel. The relationship between the types of services available through PAS and the likelihood of maintaining employment is an area for investigation.

The introduction of managed care approaches to health care delivery and financing and the influence of Federal court decisions are likely to result in extensive changes to State-administered Medicaid programs providing PAS. In addition, the Robert Wood Johnson Foundation is providing \$3 million in grants to stimulate States, nonprofit organizations, and communities to demonstrate the effectiveness of the choice concept in PAS. There is also an anticipated decentralization of responsibility for service delivery and devolution of regulatory control over funds and services to the States or local government levels. It is unclear what effect these new patterns will have on availability, eligibility, and service configurations. There is a need to analyze the impact of these anticipated new public program and policy directions on the administration of PAS, and to improve public information, increase interagency collaboration on effective program features, and develop strategies to address shortages of trained personnel for providing PAS.

Proposed Priority 1

The Secretary proposes to establish an RRTC that will contribute to the understanding of personal assistance services that informs policymaking and practice throughout the nation by:

(1) Analyzing the patterns of access to PAS in terms of the characteristics of the consumers with disabilities, the components of the PAS programs, and the administrative requirements;

(2) Assessing the impact of devolution/decentralization on PAS through the analysis of trends in the availability of PAS and the correlation of these trends with new developments in State policies;

(3) Evaluating the impact of various types and amounts of PAS on desired consumer outcomes, including health maintenance and secondary prevention, appropriate versus inappropriate health care utilization, productivity and employment, community participation, emotional well-being, and life satisfaction; and

(4) Developing strategies to increase the availability of effective PAS and qualified PAS.

In addition to activities proposed by the applicant to carry out these objectives, the RRTC must conduct the following activities:

- Develop and maintain a comprehensive database on types of PAS available on a State-by-State basis, including relevant descriptors of the PAS and the clients served;
- Investigate existing practices of integrating PAS into the workplace, and disseminate models of effective practices;
- Assess the availability of qualified PAS and develop strategies to increase the pool, skill levels, work performance, job satisfaction, and sustained involvement of qualified PAS in the field;
- Identify new models at the State level, including service configurations, financing methods, or delivery practices that have the potential to make more effective PAS available to individuals with disabilities who need PAS;
- Conduct at least one conference for consumers and one conference for policy makers in the final year of operations to share findings with these target audiences and to obtain feedback on outstanding issues; and
- Coordinate with ongoing research activities in the Robert Wood Johnson Independence initiative and the Department of Health and Human Services Cash and Counseling demonstration, as well as with other relevant NIDRR research centers and projects.

Proposed Priority 2: Vocational Rehabilitation Services for Persons With Long-Term Mental Illness

Background

The National Institute of Mental Health estimates that there are over 3 million adults ages 18–69 who have a serious mental illness (Manderscheid, R.W. & Sonnenschein, M.A. (Eds.), *Mental Health, United States 1992* U.S. Department of Health and Human Services, Rockville, MD; DHHS Publication No. (SMA) 92–1942). Estimates of unemployment among this group remains in the 80–90 percent range (Baron, R., NIDRR Public Hearing on Disability Research, November 28, 1995).

The Social Security Administration (SSA) operates the nation's two largest Federal programs providing cash benefits to people with disabilities—the Supplemental Security Income (SSI) and the Social Security Disability Insurance (SSDI) programs. The number of SSI/SSDI beneficiaries with severe mental illness, and the nation's expenditures for them, has continued to grow over the last ten years and SSA expects the number will increase still further (SSA, *Developing a World-Class Employment Strategy for People with Disabilities*, September, 1994). A recent study by the U.S. General Accounting Office (GAO) found that by 1994, mental impairments, which are associated with the longest entitlement periods, accounted for 57 percent of the SSI beneficiary population aged 18 to 64 and 31 percent of the SSDI beneficiary population (GAO Report, *SSA DISABILITY, Program Redesign Necessary to Encourage Return to Work*, April, 1996).

There are significant complexities in designing effective return-to-work strategies to assist individuals in the SSA caseload. Assisting those individuals who can return to work will require varying approaches and levels of support. Individuals who have completed the process of establishing themselves as disabled for SSA purposes may find it difficult to later view themselves as having remaining work potential. The transfer payments and other benefits contingent on SSI/SSDI eligibility (especially medical insurance benefits) may increase the opportunity costs involved in return to work beyond the level acceptable to the individual. The benefit structure may provide a particular barrier for low-wage workers, those who are unskilled, or had marginal attachments to the labor market in the past. Beneficiaries face the loss of Medicare or Medicaid benefits if they return to work and marginal jobs

may not offer adequate, or any, medical coverage, especially for pre-existing conditions. Relinquishing these benefits is particularly risky for individuals with LTMI, since recurring episodes of their illnesses may result in repeated job loss and the need for quick access to benefits.

SSA has implemented several work incentive programs to help people with disabilities enter or re-enter the workforce by protecting their cash and medical benefits until they can support themselves (Red Book on Work Incentives—A Summary Guide to Social Security and Supplemental Security Income Work Incentives for People with Disabilities, SSA Pub. No. 64–030, U.S. Government Printing Office, June, 1992). For individuals with an LTMI, the Social Security Work Incentives (SSWI) have the potential to be a valuable component of the overall rehabilitation process. However, there has been neither a comprehensive assessment of the effectiveness of the SSWI programs nor an identification of possible improvements to the program. There is some evidence, especially anecdotal evidence, that rather than using SSA work incentives, individuals may decide to work for earnings at a level that does not threaten continued eligibility for benefits (Rehabilitation Services Administration (RSA), *Program Administrative Review—The Provision of Vocational Rehabilitation Services to Individuals Who Have Severe Mental Illness*, 1995).

The State Vocational Rehabilitation (VR) Program provides services to nearly 1,000,000 individuals with disabilities each year. In fiscal year 1992, individuals with the primary disabling condition of a mental illness made up about 19 percent of those who received services from the State VR Program, the second largest disability group. However, RSA has reported that the success rate for this population generally falls below the average success rate for the VR program. In 1993, RSA conducted a Program Administrative Review (PAR) in order to improve the provision of vocational rehabilitation services to individuals who have severe mental illness. Specifically, the study examined the use of identified best practices and their relationship to successful outcomes and made recommendations for actions to be taken by VR State agencies to improve employment outcomes. In their review of a sample of case records of individuals with severe mental illness, documentation of the use of SSWIs was found in a relatively small percentage of the records of those individuals eligible for such incentives. RSA also found that

individuals who obtained employment were more likely to have used work incentives.

There are numerous other barriers facing individuals with severe mental illness seeking vocational rehabilitation including the often chronic and episodic nature of the illness, the iatrogenic effects of pharmacological and psychological treatment interventions, difficulties in assessing clients' work readiness, and stigma toward persons with mental illness. There is still much to be learned about the interaction of diagnosis, symptoms, skills and job environment. Because the severity of symptoms does not necessarily correspond with an individual's functional limitations, it is important to develop a better understanding of how psychiatric symptoms and diagnosis affect vocational outcomes (Cook, J.A. & Pickett, S.A., *Recent Trends in Vocational Rehabilitation for Persons with Psychiatric Disabilities*, *American Rehabilitation*, 20(4), pages 2–12, 1995).

There has been a variety of types or models of vocational rehabilitation programs and techniques that have been developed to increase the employment of individuals with mental illness, including models which have demonstrated effectiveness in returning persons with LTMI to competitive employment. What we do not know is which types of vocational rehabilitation models are most beneficial for which types of consumers and at which stages of their recovery process (McGurrin, M.C., *An Overview of the Effectiveness of Traditional Vocational Rehabilitation Services in the Treatment of Long Term Mental Illness*, *Psychosocial Rehabilitation Journal*, 17(3), pages 37–54, 1994).

In addition, there is a need for more information on duration and quality of employment, including issues of disclosure and consumer choice. Individuals with mental illness bring to the work place a range of unique needs. Because the episodic nature of the disability may cause intermittent instability, ongoing support is often needed for both the employee with mental illness and the employer in order to maintain employment. One study of outcomes among this population found that the occurrence of uninterrupted vocational support was a major predictor of employment status, even controlling for prior work history, client demographics, and level of functioning (Cook, J.A. *et al.*, *Cultivation and Maintenance of Relationships with Employers of People with Psychiatric Disabilities*,

Psychosocial Rehabilitation Journal, 17(3), pages 103–115, 1994).

RSA in its examination of the use of best practices in VR State agencies found that the use of ongoing vocational support services and community-based support services were not frequently planned for at the time individuals' service plans were being developed nor routinely planned for at the time individuals were leaving the VR program. However, individuals who achieved employment outcomes were more likely to have had post-employment needs assessed during the development of their individualized rehabilitation program.

There is a need for studies that examine long-term employment issues including the experiences of employers and employees with LTMI in long term employment relationships and that assess the vocational and community supports needed to maintain employment.

Proposed Priority 2

The Secretary proposes to establish an RRTC for the purpose of conducting a comprehensive program of research on the achievement of high quality employment outcomes for persons with LTMI. The RRTC shall:

(1) Examine how public policies and benefit programs affect the employment of individuals with LTMI;

(2) Identify the characteristics of consumers (including their stage in the recovery process) that benefit from various types of vocational rehabilitation models;

(3) Examine factors that promote long-term job retention such as workplace strategies that assist in the maintenance of employee-employer relationships and the availability of long-term supports; and

(4) Develop and deliver training and technical assistance to rehabilitation service providers and consumers of mental health services on new and effective rehabilitation techniques and accommodations and evaluate the efficacy of the training.

In addition to the activities proposed by the applicant to fulfill these objectives, the RRTC shall:

- Identify effective strategies to broaden the understanding and use of the SSA's Work Incentives Program for individuals with LTMI;
- Conduct studies on long-term relationships between employers and persons with LTMI including in-depth assessment of disclosure issues, career patterns, accommodations and conflict resolution in the workplace;
- Analyze the relationships between employment experiences and the characteristics of impairment (e.g., diagnosis, periodicity, medication, symptoms), and between employment experiences and the characteristics of the work environment; and
- Identify successful models of long-term vocational and community support for persons who have achieved an employment outcome after the receipt of VR services.

In carrying out the purposes of the priority, the RRTC shall:

- Involve individuals with psychiatric disabilities in all phases of the planning, implementation, evaluation and dissemination of project activities; and

- Coordinate with the Social Security Administration and with other relevant research and demonstration activities sponsored by the Center for Mental Health Services, Rehabilitation Services Administration, and NIDRR.

Invitation to Comment

Interested persons are invited to submit comments and recommendations regarding these proposed priorities.

All comments submitted in response to this notice will be available for public inspection, during and after the comment period, in Room 3423, Mary Switzer Building, 330 C Street S.W., Washington, D.C., between the hours of 8:00 a.m. and 3:30 p.m., Monday through Friday of each week except Federal holidays.

Applicable Program Regulations: 34 CFR Parts 350, 351, and 352.

Program Authority: 29 U.S.C. 760–762. (Catalog of Federal Domestic Assistance Numbers: 84.133A, Research and Demonstration Projects, 84.133B, Rehabilitation Research and Training Center Program)

Dated: October 28, 1996.

Judith E. Heumann,
Assistant Secretary for Special Education and Rehabilitative Services.

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