# VOCATIONAL ASSESSMENT OF WORKERS WHO BECOME DISABLED

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**ABSTRACT**

Every year in this country, more than 569,000 workers become so severely disabled that they are unable to work for five or more months. Over the next 28 years the number of workers becoming disabled each year will increase steadily, so that in 2015 more than 780,000 workers will be entering the disability support system.

While many millions of dollars per year are being spent in the rehabilitation of workers who become disabled, very little of this money is currently going to rehabilitation facilities. One of the major reasons for the lack of referrals is that facility programs have not been tailored to meet the needs of the worker who becomes disabled. It is well within the means of any existing vocational evaluation program to expand its funding base by developing the capability to assess disabled workers. However, in order to do this, evaluators need to know more about workers who become disabled including their backgrounds, disabilities, needs, and aspirations. In addition, they need to understand the operations, philosophy, needs, and program constraints of the private sector payors, as well as those in the public sector.

This paper addresses the above issues as well as suggesting a three-step model assessment program specifically designed to serve workers who become disabled.

In Coming Back: Directions for Rehabilitation and Disabled Workers, Frank Bowe (1985) states that, "Faced with a declining demand from 16-24 year-olds, rehabilitation needs to focus more than it has in the past upon older individuals who have disabilities." He goes on to say that, "Early retirement in particular appears to be a reversible trend. Because it is usually counterproductive for the employer and for the economy, it may represent a window of opportunity for rehabilitation programs."

Indeed, every year in this country more than 569,000 workers become so physically disabled that they are unable to work for five or more months (Hester & Decelles, 1985). On the other hand, there are 4,255,000 handicapped children from three years of age to 21 in special education classes in this country (World Almanac, 1987). If we assume a constant annual rate of graduation, it means that only about 236,389 disabled students per year will need assistance in transitioning to work. Therefore, the current need for return to work services is twice what the need is for services leading to transition to work.

Due to the aging of the American work force, the number of workers becoming disabled over the next 28 years will increase steadily each year, so that in the year 2015 alone more than 780,000 workers will enter the disability support system (Hester, Decelles, & Hood, 1986).

Contrary to popular opinion, worker disability is not merely a workers' compensation problem. In fact, only 15.5% of workers who become disabled do so because of work-related injuries (Hester & Decelles, 1985). The majority (64%) of serious worker disability is caused by acute and progressive illnesses.

## USE OF REHABILITATION SERVICES

In view of the growing concern about workers who become disabled, in 1983 the National Institute on Disability and Rehabilitation Research established a Research and Training Center at the Menninger Foundation.

Through our studies of workers who become disabled it became very clear that although vocational rehabilitation services can substantially aid disabled persons return to work, outside of the workers' compensation (WC) system, they are rarely used. For instance, of those persons allowed SSDI benefits only about 10% are referred to VR by state disability determination services (DDS)

agencies. In a study which we conducted in Illinois (Hester & Faimon, 1985) we found that over a five-year period, less than 2% of SSDI beneficiaries were successfully referred by DDS to VR. That is, they were referred by DDS and accepted for services by VR. Likewise in the private sector, referral of long term disability (LTD) beneficiaries to vocational rehabilitation is the exception rather than the rule.

## MOTIVATION TO RETURN TO WORK

Unfortunately, those of us non-profit rehabilitation agencies have tended to exclude this population of older workers from our services. Sometimes this exclusion has happened involuntarily because agencies such as VR, which refer clients to our services, do not have a representative group of disabled workers among their clientele. Other times, we believe, it is because of a deep-seated conviction on our part that the worker who is eligible for disability benefits, especially SSDI, is not motivated to return to work. However, it is our contention that many, if not most, workers under the age of 65 want to return to work. Indeed, at this time, despite little assistance from the formal rehabilitation establishment, almost half of the workers, who become disabled return to work (Hester & Decelles, 1985). Most of these workers return to their former jobs or at least another job with their former employer.

No doubt, there are a few workers who could return to work but choose not to do so because of the amount of wage replacement they are receiving. However, it seems that the disincentive value of SSDI payments has been greatly overrated. The average SSDI payment to a disabled worker in March of this year was $483.13 per month or $5,786 per year. A person does not have to make much more than the minimum wage ($6,968 per year), even considering taxes and transportation, to do better. It is important to realize that the average disabled worker is 50 years old at the time of leaving the work force. Therefore, with about 30 years of work experience, the worker is not very likely to have been in an entry level job at the time that he or she became disabled. In fact, we can expect the person to have been earning more than the average, rather than the minimum wage. In June of 1986, the average wage was $396 per week for workers in manufacturing or $20,592 per year (World Almanac, 1987).

## FUNDING OF SERVICES

The state VR systems do not, nor can they be expected to, deal with the problem of workers who become disabled. In fact, in 1985 the state VR systems reported that they served slightly more than 555,000 individuals. Since public VR services tend to last for several years, state VR agencies under their current funding level cannot possibly serve all of the workers who become disabled. Who then is funding the services? The workers' compensation system in some states is a major source of funding, at least for 15.5% of the workers who become disabled.

A potentially large source of funding in the future is from LTD carriers, either insurance companies or self-insured employers. LTD has become one of the fastest growing employee benefits in the country today. In 1971, only 2% of SSDI beneficiaries were also receiving private insurance benefits (Muller, 1981). However, according to the U.S. Department of Labor (1985), 47% of all employees of medium and large firms in 1984 were covered by LTD policies. A recent as yet unpublished study conducted jointly by The Menninger Research and Training Center and the National Safety Council (NSC) indicated that 75% of NSC members surveyed have LTD policies for their salaried staff which are at least partially paid for by the employer. Forty-nine percent have this benefit for their hourly employees.

This is potentially a very expensive employee benefit. The average LTD policy guarantees the employee 60% of their salary for as long as they live, up to the age of 65. For the average worker in manufacturing making $20,592 per year this means that LTD benefits will be $12,355 per year. Since the average disabled employee who does not go back to work receives disability benefits for 6.2 years, this amounts to $76,602 for each employee. Due to the fact that this is a relatively new benefit, most employers have not taken a hard look at the costs of this program. However, when they do, it will not take them long to realize that to invest $3,000 or even $5,000 in vocational rehabilitation services will make great economic sense.

Another source of considerable funding for vocational rehabilitation of disabled workers is most likely going to be the Social Security Administration (SSA). This year SSA plans to spend $6,500,000 on various types of demonstration projects to test new approaches to returning SSDI beneficiaries to work. The magnitude of SSA's problem is staggering. In 1986 alone, 1,138,524 disabled workers applied for SSDI benefits of whom 460,188 were allowed. Currently, there are 2,739,186 disabled workers receiving SSDI benefits.

## RETURN TO WORK PHILOSOPHY

Before we rush out to serve the disabled worker and open up new sources of funding for our programs, we need to recognize that many in the public and non-profit sectors have tried and few have been successful. This has mainly been the result of an inappropriate philosophy (Emener & Ferrandino, 1983) and the use of VR programs designed for transition to work rather than return to work.

Julian Nadolsky (1986) began his now notorious editorial on private rehabilitation by declaring that, "Rehabilitation is a generic field of practice designed to assist people with disabilities in their restoration to the fullest physical, mental, social, vocational, and economic functioning that they are capable of attaining." This definition of rehabilitation, developed by the National Council on Rehabilitation in 1942, is possibly appropriate for the services provided to persons who are developmentally disabled but it is totally inappropriate to describe the rehabilitation services needed by the worker who becomes disabled. The proper definition of rehabilitation, in regard to the worker who becomes disabled, was given by Richard La Fon (1986) as the field of practice designed to assist disabled workers in returning as close to their pre-disability medical and vocational functioning as is reasonably attainable.

The inappropriateness of the first definition can be seen in the fact that the average disabled worker is a man, 50 years old, who has worked for the same employer for 17 years. His life has been turned upside down by an illness or injury and now he may be forced to live at or below the poverty level. All he wants from rehabilitation is to get back to his old job, even if it was not using his talents to the fullest, so that he can resume his former lifestyle. The fact that he may be a social misfit whose greatest enjoyment in life is sitting alone in front of a TV watching wrestling is not an appropriate concern for the vocational rehabilitation specialist. How many of us can say that we have reached the fullest physical, mental, social, vocational, and economic functioning that we are capable of attaining? I would certainly be depressed if I thought I had. In other words, the best we can do for workers whose careers have been "derailed" is to help them get back on the track, so that they can get on with living their lives as close to where they were as possible.

## COST OF RETURN TO WORK SERVICES

This incongruity of philosophies is only one of the reasons why most insurance companies purchase rehabilitation services from private vendors rather than get free services through state VR agencies. Another major reason is the difference in time perspectives between the state VR system and the insurance carrier. This difference is in the order of four to one. In an unpublished study, we found that the average amount of time taken by one state VR agency to achieve a Status 26 closure was 17 months (SD = 13.7). On the other hand, private rehabilitation specialists generally expect to return the client to work in less than five months.

In estimating the cost of rehabilitation services, the insurance carrier must not only consider the amount of money to be paid to the provider, but also the amount of benefits which will be paid to the claimant while rehabilitation services are being provided. As an example, let us take the case of our average manufacturing worker mentioned before. This person is receiving LTD benefits of $12,355 per year or $1,030 per month. Imagine for a moment that both public and private sector rehabilitation programs would be equally successful in returning the person to work, but only within the average time frames of their respective programs. If the private sector provider charged $3,000 for services rendered over a period of four months, the total cost to the insurance carrier would be $7,120 when $4,120 for four months of benefits to the claimant is added. In using the state VR agency, the costs would solely be the benefits paid out over the 17 months, or $17,510. In other words, it would cost the insurance company $10,390 more to make use of "free" rehabilitation services than to pay a private provider.

## PROGRAM DEVELOPMENT

Now that we have established the fact that there is a tremendous need for the rehabilitation of workers who become physically disabled, that private and public (SSA) sources are willing to pay for appropriate and cost-effective services, and that the traditional rehabilitation programs are not appropriate for the vast majority of disabled workers, we can begin to develop an appropriate vocational assessment program.

I have found that in beginning program development, it is very helpful to employ the generic model shown in Figure 1. In using this model one needs to start at the ends and work toward the middle. In other words, one first has to look at the characteristics of the targeted clients. Then one examines the desired goals. Next, the antecedent programs need to be considered in terms of what type of programs has the person been exposed to before the program under development. Subsequently, one must consider what other programs can possibly assist in achieving the desired goals. Finally, we have to consider the constraints which are placed on the program to be developed. Whether or not they seem sensible, these constraints exist, and one has to live within them or face loss of funding or failure to meet the program goals.

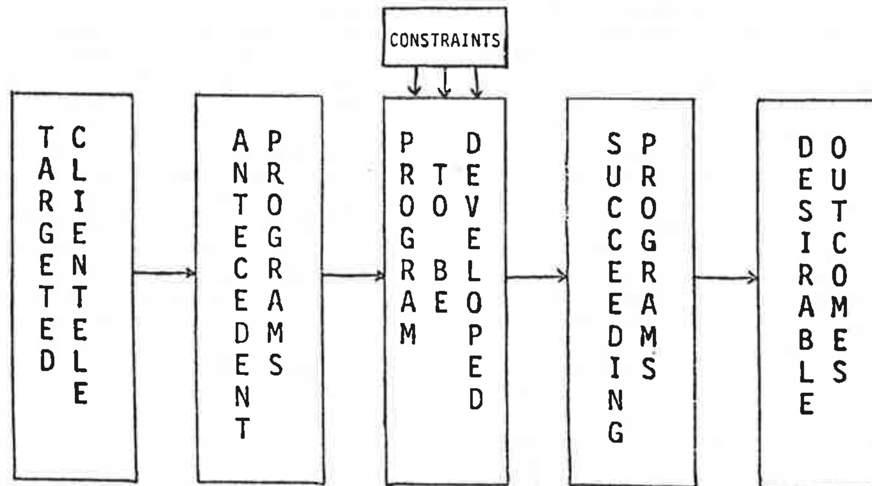


Figure 1. A generic model for use in program development.

## CLIENTELE

Obviously, before designing a program, we have to consider the general characteristics of the clients to be served. Based on our studies of individual LTD claimants, (Hester & Decelles, 1985; Hester, Decelles, & Gaddis, 1986) as well as our analysis of the SSA 1982 New Beneficiary Survey (NBS), we can describe the worker who becomes disabled, with a reasonable degree of accuracy.

The average age of workers who become disabled is 49.9 years of age (SD = 10.43), with a median age of 51.9 years.

The vast majority of disabled workers are men. Fifty percent of workers who become disabled have had only one or two jobs in their adult life. The average amount of time that they worked for their last employer is 17.8 years (SD = 10.77).

One of the greatest differences between LTD and SSDI beneficiaries is in their level of education. Among individual LTD claimants only 23% did not complete high school, compared to 55% for new SSDI beneficiaries.

As far as domestic life is concerned, 75% of the LTD claimants are married, compared to 65% for SSDI beneficiaries. In addition, 63%, of SSDI beneficiaries own or are buying their home. Seventy-eight percent own a car or truck. Only 3% still have children under 18 years of age at home.

The average LTD claimant was earning $2,515 (1985 dollars) per month prior to becoming disabled (SD = $1,918). After becoming disabled, 46% were receiving benefits which amounted to no more than half of their previous earnings. Only 24% received more in benefits than they previously earned.

As far as the cause of an LTD claimant's disabling condition is concerned, an equal number (36% each) left the work force because of either a progressive illness or an injury (on or off the job). The remaining 26% become disabled by acute illness. When looked at from the point of view of the Merck (Berkow, 1982) classification system, we found that 34% of disabled workers have musculoskeletal or connective tissue disorders. Twenty-one percent have neurological disorders and 20% are disabled because of some form of cardiovascular disease. The only other classifications which account for substantial numbers of workers' disabilities are pulmonary (8%) and gastrointestinal (4%).

## DESIRABLE OUTCOMES

Considering the fact most workers who become disabled want to return to their previous job with their same employer, this then becomes the primary goal of any return to work service. Currently, 48% of seriously disabled people return to work; 87% of these return to their former job with the same employer. Among those persons who returned to work after vocational rehabilitation services, the largest percentage (42%) returned to the same job with the same employer.

Since the vast majority of older workers have built up a loyalty to their employer and coworkers, the second most desirable option is to return to the same employer but in a different job. Only 3% of those who return to work without rehabilitation services have this outcome, compared to 21% for those who received services. This difference may be attributable to a tendency, by workers who know that they cannot return to their former job, not go back to the employers to find out if they can do a different job. On the other hand, 52% of the NSC member employers surveyed offer this possibility to their employees who become disabled.

The third most desirable outcome is for disabled workers to engage in their former occupations but with new employers. This outcome is very rare without the assistance of vocational rehabilitation services. Even then, it accounts for only 8% of the placements. It is probably most appropriate for those disabled individuals who worked for small companies where the company could not hold the jobs open.

The fourth next desirable outcome is placement into a new job with a new employer, preferably without the need for any additional formal education or training. A less desirable outcome is one in which the new job requires the worker to engage in additional education or training. The training option is usually not wanted by the insurance carrier nor the disabled worker. As pointed out by Sobel (1966), fewer older than younger workers are interested in retraining. If training is required, it should be a short program, definitely no more than two years in duration.

The fifth most desirable outcome is for the client to enter self-employment. It should be mentioned that this is the fifth option only for those individuals who were not self-employed immediately prior to becoming disabled. If they had been self-employed, then the most desirable objective is to actively operate their company. For the previously employed person, self-employment is not so desirable because of the capital required and the insecurity of new small businesses.

The least desirable positive outcomes are part-time or sheltered employment. The obvious reason is that both the disabled worker and the insurance carrier want the post-disability wage to be as close as possible to what was earned previously. In fact, at this time 93% of those persons who return to work earn as much as they did before they became disabled. In only 4% of the case, do workers who become disabled obtain subsequent jobs which pay less than 80% of what they were earning prior to becoming disabled.

## ANTECEDENT PROGRAMS

In considering antecedent programs, one should not only consider the services provided but how relevant they are for the desired outcome and what expectations have they created for the client.

Almost all seriously injured or acutely ill workers have spent days or weeks in a hospital. While this service is literally vital, when the patient asks when he or she can return to work, too often the response by medical professionals is that the person should not even think about returning to work. Even worse is when he or she is told not to worry because he or she will now be able to collect disability benefits.

Depending upon the type of disabling condition and the health benefits the person has, physical therapy may be provided. Unfortunately, it is the exception rather than the rule where the goals of physical therapy are related to the physical demands of the person's former job (Raderstorf, Hein, & Jenesen, 1984).

At this time, relatively few disabled workers are provided with medical management services. The medical management specialist determines, interprets, implements, and monitors individualized rehabilitation plans expediting physical restoration and return to employment of the disabled worker. The medical manager coordinates the efforts of the physician, employer, insurance company, and the disabled worker in the rehabilitation and return to work processes. Normally, the vocational evaluator will only see those clients of a medical manager where the previous job is no longer feasible. In these cases, obviously, the objective of the vocational assessment program is to determine what other types of occupations are appropriate based upon the person's skills, aptitudes and residual physical or mental abilities.

## SUCCEEDING PROGRAMS

Succeeding programs are an important consideration since they will define the options available to reach the desired objective. The insurance carrier will usually be able to purchase these services if a reasonable case is made that the recommended services will enable the client to return to work. Such needed programs may be available through the disabled worker's former employer, particularly if the person worked for a major corporation.

Work hardening programs are basically an outgrowth of occupational and physical therapy. They are therapeutic programs utilizing real or simulated work environments to improve workers' physical work tolerance and enable them to return to work. The Menninger/National Safety Council survey found that 21% of the employers who responded offer this service to their employees who become disabled.

Transitional employment is somewhat akin to work hardening in that it offers employees who became disabled an opportunity to improve their physical work tolerance. However, transitional employment programs are usually not under the supervision of a therapist or other medical professional. Generally, these programs offer the person the opportunity to engage in part-time and/or light work while recuperating from a disabling condition. The above mentioned employer survey indicated that a few employers (14%) actually have separate areas set aside for transitional employment. An employer who has popularized this concept is Herman Miller of Zeeland, Michigan (Hood & Downs, 1985). On the other hand, 40% of the surveyed employers offer part or full time return to a temporary job. The majority of

employers surveyed (69%) were at least able to provide a light work opportunity as a transitional program.

Job duty redefinition is an option which 26% of the employers whom we surveyed said that they allowed. This may sound more like an outcome than a program. However, if job duty redefinition is going to be successful, it most often involves the active participation of a rehabilitation specialist, who not only does job analysis but also may assist in informal negotiation with the supervisor and/or the union.

## CONSTRAINTS

The constraints placed upon a program can come from a variety of sources: the clients to be served; the funding parties; legal considerations; organizational resources; the Board of Directors; certification bodies; professional traditions; etc. Sometimes these program constraints keep us from doing what needs to be done. At other times they protect us from our own mistakes. However, whether we feel that the constraints are positive or negative, they are the reality in which we have to operate. In regard to developing a model vocational assessment program, we will only consider the constraints placed upon the program by the nature and needs of the potential clients and the expectations and requirements of the funding sources.

Of all the possible program constraints, the most important are those imposed by the clients who are to be served, because these constraints are the most difficult to change. Most of the program constraints have been implied in the previous section on clientele. However, we will state them more explicitly here.

Many, if not most, workers who become disabled were previously independent and resent the dependency status which has been forced on them by their disabling condition. This means that they must be treated with respect. They must not be kept waiting when they have an appointment nor forced to do tasks or take tests which they feel are demeaning and are given just to keep them busy. In other words, we must realize that their time is as valuable as ours; in fact, when they were working many of our clients were making more than we are, especially if we work for a non-profit facility.

In keeping with this philosophy, we must also recognize that they are reasonably intelligent individuals who have made their own decisions for most of their lives. Thus, they will respond to vocational guidance but not to a return to work prescription. This also means that they must be provided reasons for what they are asked to do and their questions should be taken seriously and answered intelligently.

Most often, they do not want to learn a new occupation but to return to their old job or a similar one in days or weeks rather than months or years. In addition, most workers who become disabled have not taken tests in the last 20 years and do not want to do so now unless it is absolutely necessary and they are given adequate justification.

Finally, they normally do not want to be identified with the permanently disabled. In their minds they are only disabled as long as they cannot work. This has been a major problem in developing data on workers who are disabled, since many workers who are disabled will not respond as a disabled person to surveys or census reports. The practical program implications are that workers who become disabled should be served at a separate location from programs serving the developmentally disabled, and the name of the program should not be one which is associated with disability. In other words, while the name "Pleasantville Industries for the Hopelessly Crippled and Pathetically Disabled" might be great for fund raising, it will not do much to attract disabled workers. While these potential clients do not want to be identified as permanently disabled, they do know that they are unemployed. Therefore, names which stress employment or vocational services are far more acceptable than those stressing disability or rehabilitation.

The funding sources, whether they be insurance carriers, self-insured employers, workers' compensation funds, or social security disability insurance, also want rapid return to work for the disabled worker at a reasonable cost. In recent years, insurance carriers have been cracking down on medical providers for unnecessary tests and treatments as well as unnecessarily long in-patient care. We can keep vocational rehabilitation free of continuous audits and DRG°s, if we provide appropriate services at reasonable costs. Remember that when disability insurers are confronted with rapid but expensive services and cheap but slow services, they normally choose the more expensive one.

Another payer concern is that of the claimant who cannot go to the facility; the program should go to the claimant (Siefker, 1984).

## ASSESSMENT PROGRAM

Figure 2, on the next page, shows a three-step approach to assessment for workers who become disabled. This type of programming should not be confused with the triadic approach of Stewart, Peacock, Parsons, & Johnson (1985) nor the hierarchical model presented by Victoria Mason (1985).

As opposed a distinct evaluation program, the Three-Step Assessment Process is just that--a process which begins with the initial interview and continues until the person returns to work or is terminated from rehabilitation services. Essentially, at each step in the process a hypothesis may be formulated concerning a possible positive

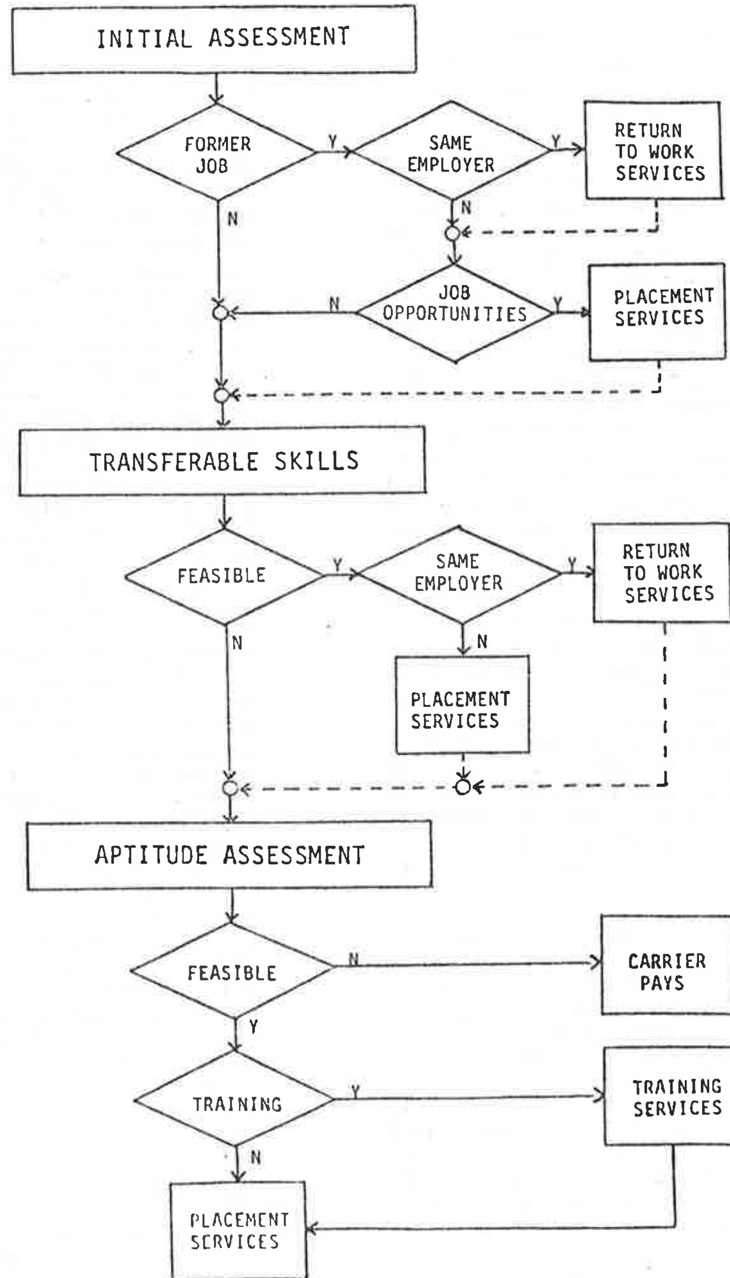


Figure 2. A three-step assessment program for use with workers who become disabled.

outcome and the services which are needed to achieve that outcome. If the outcome is achieved, the vocational assessment is complete. If the outcome is not achieved, the assessment continues to the next level in which another return to work strategy can be formulated.

In private sector rehabilitation, this entire process is usually done by one rehabilitation specialist. However, in large offices, this process can be done by one vocational evaluator and several rehabilitation specialists. In the description of the process, which follows, we will assume that clients are served by an evaluator and a rehabilitation specialist.

The initial assessment is done by the evaluator, who should normally assume that every client is able to return to his or her former job until proven differently. Obviously there are certain cases, such as a lineman who has lost an arm, where it is known before the initial assessment that the person cannot return to the former job.

During this initial assessment, it is most important to determine if the clients believe that they can return to their former jobs. Too often the disabled workers' perceptions in this regard are discounted in favor of objective testing and formal job analysis. Sometimes, when the person feels that return to the former job was impossible, further probing reveals that person was doing more than actually required by the job. At this time also a functional assessment is done through questioning and casual observation. This initial interview/assessment normally takes on or two hours.

After the initial interview and assessment, the evaluator usually telephones the former employer, with the permission of the disabled worker, to determine if there is a job to which the worker can return. If so, the evaluator discusses the case with a rehabilitation specialist who will be following through on the return to work. This process involves a personal meeting with the employer, job analysis, and physician contact. If all goes well the client returns to work, with or without special return to work services such as work hardening or job modifications.

If the person can do the same type of work but there is no opening with the former employer, then, consideration should be given to the possibility of finding the same job with a new employer. If this does not seem realistic in the terms of the local job market, the client is referred back to the evaluator. If the placement services are tried but are not proving to be successful the person should also be rereferred (shown by the dotted line) to the vocational evaluator for transferable skills assessment.

Those persons, who are provided transferable skills assessment, may be ones for whom return to the former job was attempted unsuccessfully or who were identified in the initial assessment as being unable, or unwilling, to return to their former jobs. For the transferable skills assessment it is very important to do it with the client present. Not only can the client supply some important information, but through the observation of the process, should be more acceptant of the results.

If is seems that the use of transferable skills will lead to employment, the person is again picked up by the same rehabilitation specialist for return to work and/or placement services. If these services do not result in employment, then the final step in the assessment process in warranted.

Only about 20%, or less, of a normal caseload will need aptitude assessment. However, for those who reach this step it is critical if they are ever to return to work.

The actual aptitude assessment should take no more than one day. The very rare physically disabled person who has had a spotty work history may need to be referred to a facility-type evaluation program in which work behavior can be assessed over a one or two week period. The same is usually true for those former workers who have experienced prolonged emotional problems.

This one-day aptitude assessment should be based on the psychometric measurement of work-related abilities, such as dexterity, perception, intelligence, reading, and arithmetic, as well as an interest test. Traditional job sample tests are usually not appropriate. Also, the person who lives in another city, should be tested in the home for an accurate assessment.

There are three possible decisions which can be made from the aptitude assessment. The first is that the person can be placed in a job for which no formal training is needed. Second, that the person will be employable in a particular job, after formal training. Finally, there are some who will not be employable even with training. In this latter case, the insurance carrier continues to pay benefits to the policy limits.

## REFERENCES


Berkow, R. (Ed.). (1982). The Merck manual of diagnosis and therapy. Rahway, NJ: Merck and Co.

Emener, W.G. & Ferrandino, J. (1983). A philosophical framework for rehabilitation: Implications for clients, counselors, and agencies. Journal of Applied Rehabilitation Counselling, 14 (1), 67.

Hester, E.J. & Decelles, P.G. (1985). The worker who becomes physically disabled: A handbook of incidence and outcomes. Topeka, KS: The Menninger Foundation.

Hester, E.J., Decelles, P.G., & Gaddis, E.L. (1986). Predicting which disabled employees will return to work: The Menninger RTW Scale. Topeka, KS: The Menninger Foundation.

Hester, E.J., Decelles, P.G., & Hood, L.E. (1986). The relationship between age and physical disability among workers: Implications for the future. Topeka, KS: The Menninger Foundation.

Hester, E.J. & Faimon, G.R. (1985). Project report: The effectiveness of vocational rehabilitation services with the SSDI recipient. Topeka, KS: The Menninger Foundation.

Hester, E.J. & Stone, E. (1984). Utilization of worksite modification. Topeka, KS: The Menninger Foundation.

Hood, L.E. & Downs, J.D. (1985). Return-to-work: A literature review. Topeka, KS: The Menninger Foundation.

Lafon, R.H. (1986). [Letter to the editor]. Journal of Rehabilitation, 52 (2) 76-78.

Mason, V.A. (1985). A hierarchical mode of vocational evaluation: Flexibility means better service. In C. Smith and R. Fry (Eds.), National Forum on Issues in Vocational Assessment: The Issues Papers (pp. 265-268). Menomonie, WI: University of Wisconsin-Stout.

Muller, L. (1983). Receipt of multiple benefits by disabled worker beneficiaries. Washington, DC: U.S.H.H.S., Social Security Administration.

Nadolsky, J.M. (1986). Ethical issues in the transition from public to private rehabilitation. Journal of Rehabilitation, 52 (1) 6-8.

Raderstorf, M., Hein, D.M., & Jenesen, C.S. (1984). A young stroke patient with severe aphasia returns to work: A team approach. Journal of Rehabilitation, 50 (1) 23-26.

Siefker, J.M. (1984). Vocational evaluation...new concepts. Rehabilitation Forum, 11 (2) 22-24.

Stewart, W.W., Peacock, C.F., Parsons, D.R., & Johnson, P.N. (1985). Triadic approach to the vocational assessment of the industrially injured. In C. Smith and R. Fry (Eds.), National Forum on Issues in Vocational Assessment: The Issues Papers (pp. 185-189). Menomonie, WI: University of Wisconsin-Stout.

Sobel, I. (1966). Promoting the placement of older workers. Paris: Organization for Economic Co-operation and Development.

U.S. Department of Labor (1985). Employee benefits in medium and large firms, 1984. Washington, DC: U.S. Government Printing Office.

The World almanac and book of facts (1987). New York: World Almanac.

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