

**PRINCIPLES AND PRACTICES  
OF CASE MANAGEMENT IN  
REHABILITATION COUNSELING**

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Second Edition

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*Edited by*

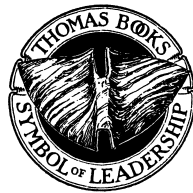
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*With a Foreword by*

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**CHARLES C THOMAS • PUBLISHER, LTD.**  
*Springfield • Illinois • U.S.A.*

*Published and Distributed Throughout the World by*

CHARLES C THOMAS • PUBLISHER, LTD.  
2600 South First Street  
Springfield, Illinois 62704

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ISBN 13 978-0-398-07697-9 (hard) ISBN 10 0-398-07697-9 (hard)  
ISBN 13 978-0-398-07698-6 (paper) ISBN 10 0-398-07698-7 (paper)

Library of Congress Catalog Card Number: 2006045671

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*Printed in the United States of America  
MM-R-3*

**Library of Congress Cataloging-in-Publication Data**

Principles and practices of case management in rehabilitation counseling / edited by Ed. Davis Martin, Jr., with a foreword by Philip Browning—2nd ed.  
p. cm.

Includes bibliographical references and index.

Contents: Rehabilitation policies and perspectives—Rehabilitation approaches to case management—Psychosocial case studies.

ISBN 0-398-07697-9 – ISBN 0-398-07698-7 (pbk.)

1. Rehabilitation counseling. 2. Vocational rehabilitation. I. Martin, E. Davis.

HD7255.5.P75 2007  
361'.06—dc22

2006045671

*For  
my much beloved daughter  
Michele Martin Murmer,  
a shining light in my life  
and  
my esteemed students  
past and present,  
a guiding force in my life*



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## FOREWORD

Chapter 1 of this book is properly placed, for it provides the learner with an important foundation for the remainder of the text. Its substance lies in an assemblage of landmark legislation that now assures people with disabilities of their human and civil rights as *abled citizens*. In addition to presenting the infrastructure for civil rights, the chapter also reflects a philosophical and best practices framework that serves as a standard and guideline throughout the book. What follows in this foreword is a historical backdrop to this chapter. Subsequent attention is devoted to the following chapters in their order of appearance.

The lives of people with disabilities have been dramatically affected over the past forty-plus years, a time span that parallels this country's unfolding journey toward human and social change. Joining in this awakening were movements of society at large, including civil rights, the consumers' marketplace, equal rights for women, and social welfare reform. Civil rights for people with disabilities, which did not take hold until the 1970s, was preceded by the Civil Rights and Voting Rights Acts in the 1960s. African-Americans marched on Washington in 1963, the Poor People March on Washington occurred in 1968, and four years later people with disabilities traveled the same route for the same reason. And, that same year, women were given equality of rights under the law. These reforming crusades advocated many dramatic changes for racial minorities, women, the poor, and people with disabilities. A window to this period of social enlightenment is captured by such slogans as *Nader's Raiders*, *Citizen Participation*, *We Shall Overcome*, *I Have a Dream*, and *The Times They Are A' Changin'*.

The year 1970 was a significant year for people with disabilities in that the Developmental Disabilities Act was signed into law and, five years hence, became the "bill of rights" for their integration into our

communities. This national declaration set in motion the dismantling of our institutions while building for these individuals a foundation for normalization. Alongside this was the Rehabilitation Act of 1973 that provided them, including those with *severe* limitations, many employment services and civil rights mandates. Within the same time frame, the passage of the All Handicapped Children Act would permanently change this country's educational philosophy, programs, and practices for students with disabilities. The year 1990 was yet another dramatic year in that an amendment to the earlier education act, now known as the Individuals with Disabilities Education Act, provided all students with disabilities equal educational opportunities and the most appropriate services in an inclusive setting with students without disabilities. A final cornerstone was laid that same year with the passage of the Americans with Disabilities Act, which extended the federal civil rights laws that apply to women and minorities to all Americans with disabilities. In the words of President George H. W. Bush, who signed the Act on July 26, 1990, “. . . every man, woman and child with a disability can now pass through once closed doors into a bright new era of equality, independence and freedom.” In summary, these five legislative landmarks ensured people with disabilities of the rights and opportunities entitled to all U.S. citizens. They provided a foundation of permanent social change by safeguarding rights to education, to the workplace, and to the community.

Since the 1960s, one essential change that has emerged for people with disabilities is their assimilation into a world ever more welcoming to diversity. While their integration into our schools, the work force, and communities has been borne out of larger social influences, their inclusion in American life has been spearheaded by the enactment of the above legislation. A congressional sponsor noted, for example, that the Americans with Disabilities Act was their “emancipation proclamation.” The 1992 Rehabilitation Act underscores this claim by inscribing Independent Living to “maximize the leadership, empowerment, independence, and productivity of individuals with disabilities, and the integration and full inclusion of individuals with disabilities, into the mainstream of American society” (Rehabilitation Act, 1992 amendments, PL 102-569). Chapter 1 provides a framework that underlies the concepts and practices of integrated residential living, mainstreaming in education, inclusion in the work force, and independent living in the community. Clearly, the assimilation of peo-

ple with disabilities into society's mainstream is a philosophy that navigates contemporary practice.

Related to assimilation is the person-centered concept that grew out of this nation's consumer movement and is now embedded in the cited legislation. In the 1960s, people in all walks of American life began to express and organize their rights as consumers. Buyers in the marketplace, for example, led to Nader's Raiders, recipients of social services led to the National Welfare Rights Organization, and those with disabilities led to the founding of the American Coalition of Citizens with Disabilities. This crusade of social reform manifested a climate of consumer assertion of special interests, rights, and citizenship for groups facing discrimination. Growing out of these consumer crusades led by racial minorities, the poor, women, and people with disabilities inspired person-centered slogans such as *Power to the People*, *Citizen's Advocacy*, *Women's Lib*, and *People First*.

Legislative safeguards for individual rights and opportunities, coupled with the consumerism movements, have resulted in persons with disabilities increasingly asserting their rights and becoming self-advocates for their own interests. Central to this self-directed principle is the concept and practice of choice-making. For too long, consumer-choice, self-determination, and self-advocacy were absent from our thinking and practice. The field in its earlier years, and society for that matter, operated primarily on a deviancy model that highlighted the "limitations" of people with disabilities. The significance of this practice is especially telling when we referred to persons with severe cognitive impairments as individuals who were not capable of even making a decision, much less the right one! As an alternative to the definition of functional limitations, a sociopolitical definition of disability has now entered the professional scene. Disability, from this vantage point, is not a personal defect or deficiency but instead is a product of a disabled environment such as attitudes, lack of opportunities, and environmental constraints.

Rightfully so, we continue to move from viewing people with disabilities as being passive recipients of services to that of active participants who are capable of making their own choices, and mapping-out and steering their own future. Parent's (1993) words tell it all:

. . . consumers should have the opportunity to choose their jobs, the places they would like to live, the activities in which they would like to

participate, the community environments they would like to access, and the friends they would like to have, as well as the opportunity to alter their decisions as preferences, needs, and desires change. Having the ability to control the direction and outcomes in one's life is a critical factor in achieving personal satisfaction and quality of life. (p. 36)

These are indeed self-empowering experiences that greatly enhance one's level of human pride and sense of self-worth. They are experiences that help people with disabilities become the masters of their own lives. The significance is far reaching. Not only is it right for one to have control over one's own choice-making, but research shows that individuals (with disabilities or without) tend to participate more and experience greater benefit from those happenings in which they can experience choice and control over their outcomes.

The 1980s and 1990s (and beyond) can be partly characterized by the host of best practices that began to be articulated. The identification and proclamation of these practices are due largely to three inter-related factors—societal values, legislation, and the profession. Legislation reflects society's values; the profession is influenced by it; and, in turn, the profession—through its philosophy, research, and clinical practice—provides a basis for legislative policy change. The best practices presented in this book are considered contemporary in that they are based on a growing body of knowledge in rehabilitation and are in congruence with societal, professional, and legislative values. A sample of the best practices that are intertwined in the cited legislation, and are articulated (or implied) throughout the book, are advocacy, consumer involvement, consumer choice, empowerment, self-determination, individualized plans, independent living, community integration, competitive employment, collaborative services, to name a few. I consider these to be some of the more important principles and practices upon which this book (and the profession) is based. It is within the context of these introductory remarks that I will now briefly speak to each of the chapters.

Chapter 2 is a much-welcome addition to the book's second edition. Both education and rehabilitation legislation recognize the nature and importance of the transition-age group, which represents some 2 million students with disabilities between the ages of 14 and 22. In 1984, Madeleine Will, then assistant secretary of the U.S. Department of Education, set in congressional motion transition from school-to-work



as a national priority. While in office, she wrote the “bridges model,” in which she identified three optional bridges for the successful crossing from school to adult roles. Of these, Bridge Two requires “time-limited services” that lead to eventual employment, and partners rehabilitation counseling services with the educational system. Interestingly, the idea for this partnership is over forty years old. In the 1962 National Action to Combat Mental Retardation Report prepared for President John F. Kennedy, one of the recommendations was: “It is clear that the first line of attack is through the educational system, and that vocational rehabilitation for the mentally retarded must be coordinated with our secondary education system” (p. 125). Rehabilitation must have a partnership role with education to provide time-limited services to assist many of our nation’s youth with disabilities in becoming responsible and productive citizens.

The living words presented in Chapter 3 underscore the human pain and suffering that can be associated with disabilities. Free of professional jargon, technical writing, literature citations, and research statistics, the stories constitute a clear and emotional understanding of what it means to have a disability. With that acknowledgment, I wish to make three points. First, we must be careful not to totally excuse ourselves from their states of helplessness and powerlessness. In other words, such reactions experienced by them not only may be due to the physical and psychological limitations or impairments resulting from the disability itself but also may be aided by external sources such as service providers, social institutions, and society at large. Second, as consumers, we must view them as our allies, not only as consumers and clients. We must allow them to be partners in the rehabilitation mission. We have much to learn from them; they have much to teach us. And finally, let us be reminded that, in addition to hardship tales, there are also literally thousands of triumphant stories of how individuals have captured the American Dream. And herein lays the mission of rehabilitation.

I suspect that the readers of this book are rehabilitation counselors in-the-making. Therefore, they should find Chapter 4 to be especially germane to their career aspirations. While counselors are at the heart of the rehabilitation profession, it is important to note that they represent more than just service providers who simply assist people with disabilities to enter, or re-enter, the world of work. In essence, they manifest a belief in the spirit of the human being, a value in their inde-

pendence, and a commitment to the ideals of inclusion in all walks of life. While best practices are the tools to be applied in our rehabilitation practice, best values should serve as a decision-making foundation for their application as discussed in Chapter 7. The values of *independence* (having choice and control of one's life), *productivity* (working in the primary labor market), and *inclusion* (to live, work, and play in one's community of choice) drive the ideals of rehabilitation counseling and that of its practitioners. It is through this legislative, philosophical, and best practices window that the counselor must be prepared to assist persons with disabilities toward a more complete and satisfying life. The counseling itself is expressed in the dialogue between the client and counselor, in the trust that emerges from the relationship formed between the rehabilitation counselor and client, and in the nonintrusive manner in which men, women, and youth learn to become independent, self-sustaining members of our American democratic society.

Over the past thirty years, functional assessment has emerged as a best practice in which information is obtained for developing, designing, implementing, and evaluating specific interventions for the individual. By contrast, traditional assessment is often agency-oriented (e.g., disability diagnosis, service eligibility, classification, record keeping). Traditional assessment typically uses norm-based, psychometric tests that compare a person's test performance to the test performance of his or her peers. It relies on the individual's prior learning. Unfortunately, persons with developmental disabilities who are subjected to this "prior learning" assessment are uniquely vulnerable to inappropriate judgments because, by definition, they are deficient in their background, knowledge, and experience. Also, for people with severe cognitive disabilities, standard low scores most often prove to be rather redundant for what we already know about their performance level. Functional assessment, which relies on an array of less formal measurement tools such as self-reports, observational checklists, and situational assessments, addresses the individual's current learning. A typical functional assessment standard is the criterion-based measure that assesses the performance in terms of what and how well the individual learns, without comparison to the norm standard of others. The rehabilitation agency's traditional assessment practice has been to determine vocational capability and then attempt to predict success (or failure) in the work setting, often using standard norms. Instead of

attempting to predict one's potential for work, or to use standard scores to underserve (or exclude) persons, especially those with significant disability, from programs and services, assessment concerns should direct the focus toward intervention strategies needed for the individual to achieve the goal of employment. In this regard, assessment as a best practice in rehabilitation has expanded from being agency-oriented to person-oriented.

The purpose of employing best practices in rehabilitation is to ensure that clients with disabilities will be well prepared and enabled to independently and successfully meet the demands of their needs and preferences, especially in the occupational world. In addition to best practices, however, *best values* also should be considered for their potential effect on the client's outcomes. Thus, where best practices are the tools to be applied in our rehabilitation trade, best values should serve as a decision-making foundation for their application. In other words, just as the rehabilitation counselor must be equipped with a set of professional attributes (e.g., best practices), he or she should also possess a set of personal attributes as they pertain to a philosophy, the values inherent in that philosophy, and a commitment to those values. It would be one thing for the counselor simply to solicit the client's interests in developing the individualized work plan because it is legislatively required. It is quite another, however, when the counselor is committed to the value of consumer empowerment and therefore truly believes that the *Plan* must come from, and belong, to the client. I say commitment because one's philosophy and values are not enough in and of themselves. There must be a commitment to what one believes for, in its absence, a claimed philosophy and its related values are limited, at best. Finally, values can serve as standards that guide and significantly influence the entire rehabilitation service delivery process, including the formulation of objectives, the search for alternatives, and the choices among them. Through the process of value identification and clarification, rehabilitation counselors will make their decisions among alternatives in current modes of practice and choose which rehabilitation path to travel in order to reach the goals for which his or her clients strive. The phrase "to travel" is significant because a value is not just a matter of what one believes to be desirable but also entails what he or she does about that belief. As such, a commitment to a value requires a prescriptive action that leads toward some desired goal, such as a client's desire to posi-

tively affect his or her quality of life through the world of work.

The importance of facilitating entry into the primary labor market should not be underestimated, nor should the fruits of participation in the primary labor market be diminished; that is, employment that has a career ladder, which progresses in terms of emoluments and benefits, helps to pave the way to the American Dream. I will never forget when I first met a young man who was the co-author of a best selling book entitled *Count Us In: Growing Up with Downs Syndrome*. I invited him as the keynote speaker for an annual conference and had prepared for his arrival by reading his book and becoming familiar with his portfolio. Even though he had an impressive work record, the number of jobs he had held caught my attention since he had done so well in each. In the course of our becoming acquainted, I asked him why he had elected to leave so many jobs, given that he was successful in each preceding one. Without pause, he informed me that these were not just “jobs” he had held. Rather, they served as important vocational experiences that in turn allowed him to develop a career. “Dr. Browning,” he said, “where I worked was more than just a job.” To paraphrase our continued conversation, his work experiences in multiple settings were stepping stones to his career-in-the-making. Through my restrictive lens I saw a job and disability; through his expansive lens he saw a career and pride! I will always be grateful to Levitz for teaching me so much on that day. I embarrassingly learned what I should have known already, that his vocational hopes and aspirations were no different than mine and yours and those of most all other people.

Parts 1 and 2 provide the learner with a person-centered philosophy and substantial knowledge base in case management, whereas the opportunity to begin applying this comprehensive foundation is presented in Part 3. By analyzing the thirteen psychosocial case studies, the learner will be challenged to examine his or her philosophy and identify and clarify the values derived from that philosophy, better understand the social and psychological concepts in rehabilitation practice, and get in closer touch with the meaning and importance of “best practices” and “best values” in case management. Representing an array of physical, mental, cognitive, and sensory disability conditions, these cases will require the application of a wide array of information, ranging from medical to psychological, from counseling to occupational analysis and career planning, and from job development

to job placement, with disability rights serving as the common thread throughout.

Undertaking this final section will prove to be the most exciting, yet difficult and challenging, part of the book. Exciting, in that it will provide the learner with a simulated experience in professionally serving people with disabilities, and what a rewarding experience that should prove to be. Difficult, in that it will require the learner to engage in a critical decision-making process as he or she identifies and interprets the necessary parts to be assembled and integrated into the case management portfolio. And, challenging, in that the goal will be to facilitate each individual in achieving full utilization of his or her potential and to advocate on his or her behalf the fair and equal opportunities necessary to live a productive, responsible, and satisfying life in the mainstream of America.

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## PREFACE

This edition of the text represents a major revision and update of *Rehabilitation and Disability: Psychosocial Case Studies* originally published in 1990. Similarly, the purpose of this edition of the text is to provide a realistic perspective of the role and function of the rehabilitation counselor relative to the utilization of effective principles and practices of case management from the vantage point of the vocational rehabilitation process. The text has been written and designed so multiple aspects of the vocational rehabilitation process may be examined, and differing paradigms of intervention can be applied for the benefit of recipients of these services. While this text has been developed principally for use in graduate rehabilitation counseling programs, it has great utility for in-service or short-term training programs and may be employed in related psychological and social service educational programs where an understanding of the vocational rehabilitation process may be facilitated from a client centered perspective. The benefit for such professionals is an in-depth knowledge of the vocational rehabilitation process, where such knowledge and understanding have the capacity to yield great benefits relative to referral and advocacy for persons with disabilities to the state-federal program of vocational rehabilitation. The ultimate goal of the vocational rehabilitation process for persons with disabilities is the opportunity to access the American Dream; that is, to live, work, and play in the community of their choice. A unifying theme in each case study presented is to emphasize the holistic nature of people.

The new *Principles and Practices of Case Management in Rehabilitation Counseling* contains some material from the previous edition, although new material regarding the vocational rehabilitation process is reflected in the various chapters in Parts 1 and 2 of the text relative to transition, adaptation to disability, vocational evaluation, assistive technol-

ogy, and ethics. Within this edition, the reader will find significant updating of original material and expansion and reorganization of material related to service priority and legislation, the rehabilitation process, and career and occupational information. Part 3 of the text contains thirteen case situations, although not exhaustive of all disabilities, they are, however, representative of major disabilities. The case studies in this section of the text are composites of various individuals representing reality concerning the challenging circumstances that people with disabilities, family members, and others close to the person with a disability confront daily.

An outstanding group of contributors were selected to co-author or to author the various chapters, providing an added dimension of excellence to the finished manuscript. These contributors have achieved a balance in their academic training, professional experience, community service, publications, and credentialed status ranging from a lifetime of service to those in the beginning stages of their careers. Their collective achievements have included agency-executive leadership, university professorships, state, national, and international committee and consultative activities, extensive publications in the form of books, refereed articles, and other media. These talented and giving persons represent a blending of mentors, colleagues, and students, all who have given their time, energy, and commitment for the development of educational and rehabilitative systems that provide *equality of opportunity* for persons with disabilities. These are persons who live and reflect the values of *independence*, *productivity*, and *inclusion* for all people.

A special debt of gratitude is extended to my former colleagues in the Department of Rehabilitation Counseling at Virginia Commonwealth University, who initially assisted Professor Jerry Gandy and me in the development of the original case management text. This influence remains an integral part of this second edition. Professors Keith Wright, George Jarrell, and Warren Rule deserve particular recognition and appreciation for so generously giving their time, expertness, and commitment to the ideal of rehabilitation counseling that not only is reflected in this text but resides in all those persons who studied with these masters. Professor Gandy belongs in this elite group of professional colleagues; he is, as well, a master teacher, superb colleague, and great friend. Professor Dick Hardy, chairman of the Department of Rehabilitation Counseling for more than twenty-five years, who



continuously provided emotional and financial support as well as sound advice and counsel to all of the above-noted persons in the development of this and many other writing projects, deserves special recognition and appreciation for his superb leadership. Dr. Hardy is a master teacher, an ideal colleague, and leader.

Professor Jerry Gandy was the coauthor of the original text, *Rehabilitation and Disability: Psychosocial Case Studies*, and while choosing not to continue in the role of co-author for this edition, is, nevertheless, a prime collaborator and contributor to the development of the thirteen cases presented in Part 3 of the text. Dr. Gandy and I believe that an important aspect of the professional content of the assessments for each case is the nature of the information that provokes the types of discussion questions identified at the end of each case study. In some instances, this information may be sufficient and relevant to the resolution of the case; in other situations, the discussion questions help to suggest additional information or other interpretations that may be needed to contribute to an improved rehabilitation outcome. In prefatory material in this section of the text, instructions and a structure are provided that will facilitate case resolution.

Dr. Larry L. Sinsabaugh deserves recognition as a talented academic and professional colleague, former doctoral student, former employer, and great friend who has taught me much about career and occupational information. As a prominent private sector rehabilitation practitioner, his thoughts regarding the rehabilitation process are tempered from the perspective of the public sector, private sector, and the nonprofit private sector that have resulted in a particularly insightful commentary regarding the practice of rehabilitation counseling. He, too, is a master teacher and superb colleague.

Special recognition and appreciation are extended to my colleagues at Auburn University, particularly to Dr. Phil Browning, Wayne T. Smith Distinguished Professor and head of the Department of Rehabilitation and Special Education, for his support of this project and his insightful foreword, and especially to Dr. Becky Curtis, Dr. Karen Rabren, Ms. Allison Shipp, and Mr. Chad Duncan for their participation and involvement in the development of this edition of the text. Drs. Rabren and Curtis' chapter on the partnership between special education and vocational rehabilitation regarding the transition of youth with disabilities from the secondary school system is particular-

ly relevant and timely given the emphasis placed on this group within current federal legislation. Dr. Curtis provides an insightful perspective on the nature of values in the chapter on ethics she coauthored. Ms. Shipp provides a very useful and insightful perspective on assistive technology in the chapter focusing on disability assessment. Ms. Shipp and Mr. Duncan each provide a narrative approach to case resolution and a sample case resolution that are highly instructive and illustrative for use by readers and students.

I am grateful to all of my students, at both Auburn University and Virginia Commonwealth University, who, over the years, have taken the case management course and persevered in the development of realistic case resolutions that allowed entry or approximation to the primary labor market and, more importantly, for the persons they have served to this end in the state-federal vocational rehabilitation program and elsewhere—kudos to each and everyone, for you bring reality to the ideal of vocational rehabilitation and to our profession of rehabilitation counseling.

I am especially indebted to Ms. Altamese Stroud-Hill for her knowledge of APA style, and her usual thoroughness, good humor, and word processing ability in formatting the final manuscript for transmission to the publisher, Charles C Thomas. Similarly, appreciation is extended to the Learning Resources Center within the College of Education at Auburn University and to Dr. Susan Bannon, the director of this unit, for the provision of this service to faculty members of the college.

Finally, a special tribute of gratitude is extended to my wife and children, Ruth, Richard, Michele, and Matthew, for their support and assistance throughout each phase of writing and editing of the manuscript and for their enduring patience—four persons who make my life especially meaningful and fulfilling.

War Eagle!

E. DAVIS MARTIN, JR.  
*Auburn, Alabama*

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**PRINCIPLES AND PRACTICES  
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**PART 1**  
**REHABILITATION POLICIES**  
**AND PERSPECTIVES**



## Chapter 1

# DISABILITY IN AMERICA: ISSUES, SERVICE PRIORITY, AND LEGISLATIVE RESPONSE

E. DAVIS MARTIN, JR.

Disabilities that are regarded as significant have been given increasingly greater emphasis since the passage of the historic 1973 Rehabilitation Act and, in fact, selection priority in the delivery of vocational rehabilitation services. The Rehabilitation Act amendments in 1992 and 1998 have continued and expanded this mandated priority. Programs and activities created by these legislative events have moved the delivery systems toward a client or consumer perspective with greater control vested in the person with a disability regarding choice. The Americans with Disabilities Act (ADA), for instance, mandated that educators, employers, businesses, and governmental agencies were to provide goods and services to persons with disabilities from a posture of anti-discrimination. The major difference articulated in the ADA when compared to Section 504 of the 1973 Rehabilitation Act is its effect on the private sector of the economy. Similarly, the education of children and youth with disabilities has moved from segregated self-contained classrooms to mainstreaming to full inclusion through passage of P.L. 94-142 to the now entitled Individuals with Disabilities Education Improvement Act (IDEA 2004). IDEA 2004, for example, calls for greater coordination in the transition of youth with disabilities from secondary schools to that of further education or work through a partnership with vocational rehabilitation for those students who meet the vocational rehabilitation agency's eligibility cri-