Second Edition

Rehabilitation Caseload Management

Concepts and Practice

- Improved Management Model, with new terminology
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Lee Ann Grubbs Jack Cassell S. Wayne Mulkey

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Lee Ann R. Grubbs, PhD, CRC, CFLE, is a Research Assistant Professor in the Department of Educational Psychology and Counseling, College of Education, Health and Human Sciences at the University of Tennessee-Knoxville, where she serves as a Training Coordinator with the Regional Rehabilitation Continuing Education Program (RRCEP). She obtained an MS degree from the University of Tennessee in the area of rehabilitation counselor education, and a PhD degree from the University of Tennessee with emphasis in child and family studies. Dr. Grubbs worked as a rehabilitation counselor with the State of Tennessee, which sparked her interest in the area of caseload management. She has professional experiences in the areas of adult mental health, family support, disability and aging, and as an instructor in the Rehabilitation Counselor Education program at the University of Tennessee-Knoxville. She has served in several organizations at the state, regional and national level.

Jack L. Cassell, PhD, is a Research Professor in the Department of Educational Psychology and Counseling at the University of Tennessee, Knoxville. He took his Bachelor's degree from Berea College, Kentucky with an emphasis in Psychology. His Master's degree was taken from the University of Kentucky in Rehabilitation Counseling. He then managed a caseload in a psychiatric hospital setting for the state of Kentucky before returning to academics. He took his Doctorate from the University of Kansas in Psychology. Briefly, he was a psychological consultant for a rehabilitation facility in Kansas. He then accepted a position with the Regional Rehabilitation Continuing Education Program (RRCEP) at the University of Tennessee. Here he conducted extensive training sessions in Supervision and Management, Stress Management, and Ethics. He also taught Caseload Management classes at the University, and for professionals in the field, he conducted over 100 training sessions in Caseload Management in wide geographic settings from New York to Florida to Texas to Minnesota. He also published articles, chapters in books, and coauthored a text in Rehabilitation Caseload Management.

S. Wayne Mulkey, PhD, CRC, is a Research Professor in the Department of Educational Psychology and Counseling, College of Education, Health and Human Sciences at the University of Tennessee-Knoxville, where he serves as Director of the Regional Rehabilitation Continuing Education Program (RRCEP). He obtained an MS degree from the University of Tennessee in the area of rehabilitation counseling and a PhD degree from Florida State University with an emphasis in public administration and research. Dr. Mulkey worked as a rehabilitation counselor, which inspired his interest in rehabilitation caseload management. He has also supervised rehabilitation counseling students during their development of critical case management and caseload management skills. Additionally, his experiences include working in the central office of a state rehabilitation agency, and in a psychiatric hospital. Dr. Mulkey has received recognition at the national level for his leadership activities in the area of human resource development. He has served in numerous organizations and has coauthored one book. Dr. Mulkey has published several articles and serves on the editorial board of the Journal of Rehabilitation.

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LEE ANN R. GRUBBS
JACK L. CASSELL
S. WAYNE MULKEY
The University of Tennessee

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Foreword

The first publication of *Rehabilitation Caseload Management: Concepts and Practice* in 1985 addressed a major void in the rehabilitation literature. Both preservice and continuing rehabilitation educators, as well as rehabilitation counselors and case managers, will herald this updated edition that incorporates not only the basic elements of the first edition, but new technologies that have developed since the original publication. This second edition is particularly timely in the current era of increased accountability and limited resources.

The term *multi-tasking* has long been synonymous with the work of the rehabilitation counselor. The many and varied caseload management skills help counselors who are struggling with increased caseload sizes, providing rehabilitation services to individuals with the most serious disabilities, and working in governmental agencies that are reducing, rather than increasing budgets.

The authors of this second edition of *Rehabilitation Caseload Management: Concepts and Practice*, Lee Ann Grubbs, Jack Cassell, and Wayne Mulkey, have a long history of practical experience and training others in caseload management, all of which is reflected in the applied, practical aspects of this book. Also, as part of a Rehabilitation Services Administration Regional Rehabilitation Continuing Education Program (RRCEP), the authors focus on caseload management with the primary, target audience counselors who work in the state-federal vocational rehabilitation program. Case managers in other settings will also find value in this text, as issues such as decision making, time management, and case recording exist in all service settings (e.g., caseload management in the Department of Veterans Affairs Vocational Rehabilitation Program, disability management programs, independent living programs, community-based rehabilitation programs, and workers' compensation programs).

A philosophical belief that has been reinforced by legislation is the right of individuals with disabilities to receive services from *qualified* rehabilitation counselors—those individuals who have the basic knowledge and skills in rehabilitation counseling. However, knowledge and skills in counseling and medical, vocational, and psychosocial aspects of disability may benefit only

a few individuals if counselors lack caseload management skills. A direct parallel exists between the manner in which counseling skills undergird the delivery of services to a person with a disability and the role of caseload management skills in promoting timely and appropriate services to all individuals on the counselor's caseload. Thus the real recipients of the knowledge areas addressed by this book are people with disabilities whose rehabilitation experiences, both the goal and the process, are enhanced when served by an effective caseload manager. Enhanced rehabilitation experiences contribute to consumer satisfaction, which is an important consideration of any individual involved in the delivery of rehabilitation services. This book, written by pioneers in the rehabilitation field, will help counselors in the 21st century continue to manage caseloads effectively by providing principles that endure beyond changing settings and service systems.

Jeanne Patterson, Ed.D., CRC
Professor and Director, Rehabilitation Counseling Program
President, National Council on Rehabilitation Education 2004–05

Preface

Caseload management is . . . work. More specifically it is the work of caseload managers in both the public and private rehabilitation sectors. Caseload management is not merely relying on intuitive strategies, but rather, it is the disciplined application of skills, tools, and techniques that facilitate positive movement toward a desired, successful, productive outcome. It is the skilled interaction of managers and management constructs that produce responsible performance. Such achievement is a positive alternative to random behaviors, confusion, and inappropriate decision making in rehabilitation caseload functions and practice.

Prior to the 1985 text, *Rehabilitation Caseload Management: Concepts and Practice*, instruction, training, and information acquisition in rehabilitation caseload management was generally fragmented into areas of concern specific to perceived individual needs. Caseflow or case-movement concerns were understood to be caseload management as if these were synonymous activities. Frequently, case recording, statistical note keeping, and cost containment were noted as caseload management. In fact, comprehensive instruction, training, and/or information in caseload management was quite elusive.

During the decade from 1985 to 1995, considerable attention was focused on rehabilitation caseload management. Preservice training programs incorporated a course in rehabilitation caseload management into the graduate curriculum, in-service caseload management training programs emerged, and other continuing education programs stressed the importance of managerial skills for rehabilitation counselors.

Perhaps the most crucial indictment against any preservice training program emerges from employers of program graduates regarding the assumption that the trained counselor will also be a trained manager. Two assumptions that undoubtedly deal a fatal blow to effective caseload management practices are (1) that managerial skills are a given that will naturally evolve with experience on the job, and (2) that managerial skills are not within the purview or responsibility of the counselor. The authors do not question the importance of learning while on the job because many successful rehabilitation practitioners have learned to manage while performing in job situations. Our concern is with

the time required and the cost to performance for such trial-and-error learning environments, as well as the sometimes haphazard, unsystematic procedures developed purely for the sake of survival. Clearly, learning to swim after one has been thrown into the swimming pool is considerably risky. Following the acquisition of survival skills, subsequent training would likely be slowed by the unlearning process and the application of new techniques and principles of management. The managerial responsibilities of a caseload can be overwhelming to the ill-equipped practitioner who fails to develop managerial skills.

This book has been developed with consideration for two groups of individuals. The first group consists of graduate students in preservice training programs. For educators, this text fills a void in academic courses and training seminars/workshops. Educators will find that the rationale and conceptual framework provide a solid foundation for teaching managerial principles and skills to complement aspiring students' programs of counseling and/or vocational guidance.

The second group contains the numerous rehabilitation professionals who could learn and/or refresh principles of management for application to existing caseloads. Even the most counseling-oriented rehabilitation practitioner cannot survive without at least minimal skills in management. In fact, because of the managerial focus of this text, its utility as a desk reference would expand beyond public and private rehabilitation caseload management situations into other human services and counseling professionals.

Throughout this text, the reader will find the term *client* used as a reference for individuals identified in rehabilitation caseloads. Such usage should never be interpreted as other than positive. Recent terminology has enhanced the terms *consumer* and *customer* as role identifiers germane to these identities. However, as clients have limited influence on rehabilitation caseload management terminology, the use of the term *client* was selected as the appropriate identifier.

Of course, we have been the students of our students. Our thanks for their perception, wisdom, and fortitude in presenting us with challenging inquiries that have provided insight into and clarification of numerous ideas. It is the needs of our students, public and private rehabilitation practitioners, and other colleagues that have motivated us to revise and develop the second edition of *Rehabilitation Caseload Management: Concepts and Practice*.

Hope Moore-Webb made a significant contribution to the development of this book. She provided clerical assistance, language refinement, and development of all tables and figures. Clearly, she was a very valuable influence in bringing the book to fruition.

Others who contributed to the revision initiative include Dr. Ralph Pacinelli, Dr. Jerry Abbott, and Patricia Nash of the Rehabilitation Services

Administration. Those who additionally supported the need for a revised text on rehabilitation caseload management include Dr. Julie Smart, Dr. William Fennessee, Dr. David DeLambo, Dr. Alan Davis, Dr. Amy Skinner, Commissioner Steve Shivers, and Assistant Commissioner Carl Brown. Finally, thanks to our independent reader who could separate thoughts of content from those of style and jargon. Dr. Richa C. Russell, you have our gratitude.

Lee Ann R. Grubbs, Ph.D.
Jack L. Cassell, Ph.D.
S. Wayne Mulkey, Ph.D.

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Part I

Conceptual Aspects of Caseload Management

The first segment of this text provides insight into the concepts and the philosophy of managerial aspects related to roles and functions of the rehabilitation caseload manager. The practical aspects of any job must have a supporting theoretical or philosophical base. Caseload management has had many philosophers or theorists, but to date no real theory has evolved. Part I merges various conceptual aspects of management into a theoretical approach. Thus, it provides a foundation for developing rehabilitation caseload manager skills.

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CHAPTER 1

Rehabilitation Caseload Management

Definition, Rationale, and Benefits

QUEST FOR COMPETENCE

Some of the most ambiguous descriptions for guiding behavior ever confronted by developing professionals begin with the phrase "Caseload management is. . . ." In the field of vocational rehabilitation these descriptions range from general to specific. However, for more than half a century, lack of comprehension of what constitutes caseload management has plagued professional practice. Because caseload management functions are so intricately entwined with all counselor functions, any quest for a competency base that uniquely characterizes this group of practitioners must take into account the role of caseload management.

The quest for a unique competency base, or what Rubin and Roessler (2001) term "*professionalization*," has led to the compilation of a vast array of abilities and skills. Historically, McGowan (1960) gives a list of counseling competencies, each of which could take extensive elaboration to enumerate the subparts. This list includes (1) an ability to establish and maintain a counseling relationship with individuals, (2) an ability to evaluate aptitudes, skills, interests, and educational background, (3) an ability to recognize manifestations of physical and mental disabilities and their relationships to vocational adjustment, (4) an ability to analyze occupations and workers in terms of job requirements, the skills required, and the physical demands of the job, and (5) an ability to make discriminating use of available community services and to maintain a cooperative working relationship with such sources.

In contrast, in the last 40 years the field of rehabilitation has seen an increase in specialization in multiple areas. Rubin and Roessler (2001) reflect

on the increase in professionals and specialists as accompanied by greater societal influence. "In general, professionals act as gatekeepers of information and services; help define appropriate behaviors, goals, strategies, and treatment for clients" (p.176). Other areas important to the "professionalization" of counselors are medical-related knowledge, vocational and personal counseling skills, implementation of minimal skills in management, ability to analyze occupational and industrial trends, and an understanding of legislative trends and federal laws relevant to rehabilitation programs (Mullahy, 1998, 2004; Shrey & Lacerte, 1995). Cassell and Mulkey (2004) point out that at the lowest level of career adjustment (i.e., mere survival) the counselor must have some management skills.

The complexities involved in rehabilitation counseling in the public sector continue to be enumerated in the ongoing process of defining and/or redefining counselor competencies and skills. Several authors have addressed the need for an overall improvement in counselor skills development (Power, 1991; Roessler & Rubin, 1982; Rubin & Roessler, 2001; Sink, Porter, Rubin, & Painter, 1979). Although counselors bring with them a wealth of educational knowledge, professional development must include job activities, requisite knowledge, and skills development. Rubin and Roessler (2001) further state, "Regardless of setting or specialization . . . a common core set of skills is important for direct service providers in rehabilitation" (p. 261). They identify five competency areas as most important for rehabilitation counselors in the public sector as (1) vocational counseling, (2) assessment planning and interpretation, (3) personal adjustment counseling, (4) case management, and (5) job analysis.

Similarly, rehabilitation counselors in the private sector are presently seeking similar definitions of the skills and knowledge required for their professional roles (Kontosh, 2000; Lynch & Martin, 1982; Mullahy, 1998, 2004; and Shrey, 1995). Although each professional brings a competency core of knowledge and skills from past educational encounters, Hursch (1995) states, "To be effective, disability managers must recognize and understand the characteristics and trends of the system and how each must be integrated into disability programs and practices" (p. 304). Hursch concludes that competencies required by independent and private rehabilitation practitioners will most often depend on the characteristics of the work environment and of the client population.

Patterson (1957), in his pivotal publication regarding the counselor-versus-coordinator controversy, offers what even today can be considered a summary statement to a process of compiling lists of performance competencies. He noted that these long lists of abilities, skills, and knowledge bases for

rehabilitation counselors give one the impression of reading the curriculum for the complete content of the social and biological sciences. However, these lists cannot be summarized in any simple manner to produce a complete picture of a competent rehabilitation professional. This conclusion may have prompted Rubin and Roessler (2001) to call for the development of multifaceted counselor roles. This multifarious approach continues to perpetuate a dualism between counselor competencies and coordinator or manager competencies, that is, the Patterson (1957) "two hats" perspective. The field is long overdue in developing an integrative approach to rehabilitation counselor competency. Therefore, rather than continue in the current vein of broadening perspectives on counselor performance areas, a more productive approach would be the integration of the numerous functions of the rehabilitation professional into a core area toward which a majority of the competencies are directed.

The Core of Counselor Competency

The base of competency has long been centralized in the counseling function and has prompted authorities to consider counseling the core of the rehabilitation professional's activities (Bellini & Rumrill, 2002; Riggar & Maki, 1997; Thomason & Barrett, 1959). Yet, the counselor continues to come under a great deal of pressure, both internally (i.e., intrapersonally generated) and externally (e.g., from organizational demands), due to the accountability factors inherent in fulfilling the responsibilities for an entire caseload. However, whether considering the accountability demands of the organization or personal accountability, the same end result is sought: *the successful managing of individuals with disabilities through an informed process.*

Contrary to the perception that competency in management may not be needed in direct client contact (Harrison & Lee, 1979), the true core of rehabilitation counselors' work lies with their management activities and the manner in which they establish order over, and eventually control of, total caseload demands. Successful counselors in the vocational rehabilitation field have accepted this precept (Willey, 1978). Indeed, counselors in the private sector are guided by a shift of focus from the typical vocational rehabilitation concept to that of "disability management" (Kreider, 1983; Mullahy, 1998, 2004; Shrey, 1995). The three distinct elements of disability management (health-care delivery, cost-containment programs, and vocational placement) clearly demonstrate that caseload management in the private sector relies heavily on a management model.

Management is a function of counselor performance. Whether the setting is a public agency, a private organization, or an independent facility, it is

the outcome of a well-constructed management process that gives any counseling activity its authority and accountability. As such, this process and its power-pivoting potential is not intended to replace counseling as acritical responsibility. On the contrary, the intention is to give this counseling function the power base it requires through fully effective caseload management.

The Common Thread

In examining the long lists of abilities, skills, and knowledge bases required of counselors, we need to understand that the time is long overdue to put them into a unified perspective and to tie them together with a common thread. *This common thread is caseload management.* As a 1965 study group on caseload management stated: "The group thought CLM [caseload management] should be defined in terms of total work activities which would include case *work*, case *load*, case *management*, and other job activities of the counselor. . . . " (Muthard, 1965, pp. 12–13).

Management concepts and principles underlie the entire gamut of scattered functions and duties of counselors to give the solidarity and consistency required. Management of a caseload in the past has not been given the strength of purpose required to establish it as a unique, viable area for intensive study and research. McLelland (1977), when addressing caseload management in the rehabilitation process, proclaimed that "the counselor's competence has more to do with the success of this process than any other variables one may list" (p. 25).

DEFINING CASELOAD MANAGEMENT

The Definition Dilemma

One explanation for the lack of a consensus for determining a common competency base is the ambiguity surrounding what precisely constitutes caseload management. Caseload management must be given a workable objectivity that will contribute to resolving the search for this elusive competency base.

Currently, very little agreement is found among practitioners and administrative personnel, researchers, and writers as to how the term *caseload management* is defined. In fact, case management is defined in the dictionary, but not *caseload management*. Without a consensus among those in the field on the meaning of caseload management, the competency level of the professional will be as inconsistent as the varieties of definitions. A working definition is explored in great detail later in this chapter. However, the concepts provided

are a beginning point only. Further elaborations and requirements must be developed as the field adds subsequent research and renewed thinking.

Conceptual definitions give perspectives or even quasi-boundaries wherein individuals respond with appropriate duties and responsibilities. Therefore, if a definition of a concept is consistently vague, ambiguous, or incomplete, expected performance derived from this definitional base will be less than effective. If basic definitions are not developed through organized research, documented writings, and shared discussions among professionals, definitions will never evolve that have commonalities with potential for mutual acceptance. The end result will be individually derived definitional bases likely to be fragmented, unclear, incomplete, and disorganized.

The term *case management* has often been confused with *caseload management*. "In fact, these terms are sometimes used synonymously, without attempting to distinguish any difference" (Cassell & Mulkey, 2004, p. 254). This misuse adds to the confusion and frustration of establishing definitions. There are differences that have implications for the way counselors mentally rank germane activities as to their importance and value. Consequently, the motivational set that follows is affected also.

The *Certified Case Management Guide* states, in the revision of July 2002, that *case management* is not considered a profession within itself, but an area of practice within one's profession. Thus, with casework practices the counselor's perspective is naturally focused primarily on case-by-case specifics and not the more encompassing, interacting whole, which is the entire caseload. Casework is immersed in activities involving (1) moving clients from intake to closure, (2) performing proper case-by-case documentation, (3) acquiring necessary evaluations and examinations for justification purposes and satisfying established guidelines, (4) execution of masterlist activities and case findings, (5) individualized medical management programs, and (6) concern for case-by-case cost-containment practices. Rubin and Roessler (1983, 2001) offer procedures and techniques for developing case management skills. Their work delineates operational strategies and guidelines for the diagnosis, evaluation, treatment, and follow-up of the individual case.

In contrast, *caseload management* is considered to be performance encompassing, totally involving of counselor attention, and integrating the coordination and control of many activities, one of which is case management. As the term *caseload management* implies, "it is a systematic process of organizing, planning, coordinating, directing, and controlling for effective and efficient counselor and manager decision-making, to enhance proactive practice" (Cassell & Mulkey, 1985, p. 11). In contrast to casework management, Henke, Connolly, and Cox (1975) bring to prominence a description

of *caseload management*. This description reads: "how to work with more than one case at a time, how to select which case to work with, how to move from one case to another, how to establish a system to insure (sic) movement of all cases, and how to meet the objective one has established in terms of numbers served" (p. 218).

Other distinct characteristics are prominent when trying to define *caseload management*. These include (1) establishing a calendar of activities for a reasonably structured day or week for the most effective use of the counselor's time by filling the day with high-priority tasks, (2) orchestrating a group of other professionals to rehabilitate clients through this coordinated group effort, and (3) initiating actions through a consistent decision-making style that keeps activities moving toward targeted goals.

Whereas control is prominent in both caseload management and casework activities, it is much broader and more encompassing in *caseload management* functions. Casework goals and objectives are typically microcosmic in scope, whereas caseload management goals and objectives are more macrocosmic. Implied also is the fact that counselors must effectively invoke salient counseling and managerial skills to be in control of a caseload management process.

This discussion has served to highlight a few of the identifying distinctions between the concepts of case management and caseload management. A more complete, more functional definition of caseload management will evolve in subsequent discussions. For *efficient* action, a counselor's extensive array of responsibilities must be met with case manager skills. Roessler and Rubin (1982) state that "while they must be skilled vocational counselors, rehabilitation counselors must also be competent case managers" (p. 33). However, without the perspective and skills founded in *effective* caseload management practices, overall competency will elude the counselor.

Definitions in a Historical Context

The field has not yet accurately collected the components of caseload management into a basic definition that will serve as a major guidepost for describing the functions and actions required of the professional counselor. Thus, sustained efforts for upgrading knowledge and improving skill levels continue to be thwarted. Of those definitions existing in the literature, most are vague and general, some are scantly specific, and only a few are hauntingly accurate. Examples of past definitions for caseload management were noted by members of the Third Institute of Rehabilitation Services study group (Muthard, 1965). The first is "the objective of CLM [caseload management] is to vocationally

rehabilitate the greatest number of disabled persons at the least possible cost, consistent with the highest standards of quality" (p. 12).

Although this definition is easily generalizable to a private or public rehabilitation setting, it is actually an outcome or result and does not describe the process of caseload management. As an objective or goal the definition offers no real guidelines on which managerial behaviors can be founded. This is because *one can never "do" a goal*. That is, one can engage only in those activities that lead toward the goal. A second definition of caseload management is "the total techniques, procedures, and the like used to achieve the agencies' objectives" (Muthard, 1965, p. 12). This definition is succinct to the point of complete vagueness. No functional base of operations could emerge from this beginning point. Also, the end result toward which the caseload management activities are to be directed is for the benefit of the fulfillment of agency objectives. Thus, the definition addresses only one of the four elements of caseload management to be described later in this chapter.

The study group gave the following definition as the one they would collectively support: "the use of techniques (methods or details of procedure) to control the distribution, quality, quantity, and cost of all aspects of casework activities in order to accomplish the program goals of the agency" (p. 12).

This definition admirably delineates process specifics (i.e., "techniques to . . . ") and outcomes (i.e., program goals). However, the definition is restricted in its perspective and does not deal with caseload management as a more encompassing, systematic, gestalt-like entity. It narrows to a case management definition and thus is circular: in other words, it makes an inference that caseload management is case management and case management is caseload management.

Henke, Connolly, and Cox (1975) define caseload management with broad "how to" statements. They describe it as "how to work with more than one case at a time, how to select which case to work with, how to move from one case to another, how to establish a system to insure (sic) movement of all cases, how to meet objectives one has established" (p. 218). Greenwood (1982) characterized caseload management as a plan-manage-review conceptualization. He further states that "his approach to systematic caseload management is integrated into a case management model of rehabilitation counseling" (p. 159). Cassell and Mulkey (1985) provide an instructive definition as "a systematic process merging counseling and managerial concepts and skills through application of techniques and research . . . and other relevant related factors for anchoring a proactive practice" (p. 10).

Confusion over the nature of caseload management is not limited to academic groups, researchers, and writers. Counselors in the field also have

a great deal of difficulty defining caseload management as it relates to them. To focus on recent definitions, the authors in training sessions asked counselors employed by state rehabilitation agencies to write definitions of caseload management in their practices. They were told that definitions do indeed serve as descriptors for action or as guides to determine the direction of future activities. Therefore, serious consideration was to be given to writing definitions that accurately depicted what each counselor does as a caseload manager. The definitions presented below were written by the counselors. For purposes of description and analysis, the authors independently judged the definitions as falling into three categories: (1) Functional Definitions, (2) Minimally Functional Definitions, and (3) Nonfunctional Definitions. The three categories were created in an effort to investigate the definitional formats that counselors most often utilize to guide their caseload management activities.

Functional Definition

A Functional Definition would be one on which the counselor could base an adequate program or management system. It would have enough elements to demonstrate that the counselor had a good grasp of what needs to go into a descriptive guide for behavior or an adequate perspective on the caseload as a more complete, systematized entity. Counselors were asked to complete the statement: "Caseload management is . . ." to form practical definitions. Three examples of those judged to be Functional Definitions are listed below:

1. *the process of analyzing, planning, supervising, and administering the smooth flow of rehabilitation services to the number of clients for which you have responsibility and the coordination of other professionals and resources utilized.*
2. *to effectively coordinate a system whereby individual clients are provided services toward eventual rehabilitation by predicting through evaluation, setting objectives, processing, coordinating, and maintaining an equitable and just flow of clients toward individual goals.*
3. *the ability to organize, coordinate, and effect the smooth flow of cases and services with maximum return from the services, to be utilized in returning clientele to the most independent status of which the counselor is capable.*

Definitions in this category are characterized by (1) the conceptualization of caseload management as a process or system, (2) the owning of mana-

gerial functions, such as planning, supervision, coordinating, and organizing as a necessary part of a counselor's responsibility parallel to the therapeutic functions, (3) adequate length to "get into" the definition, (4) integration of work responsibilities and personal characteristics, (5) the proper differentiation between aspects of efficiency and effectiveness, and (6) the recognition of a dual role requirement, that is, counselor responsibilities and casework or caseflow responsibilities.

Minimally Functional Definition

A Minimally Functional Definition would demonstrate that the counselor was giving thought to an adequate definition but could focus only marginally on the elements involved. That is, as a definition it would be a beginning, but it lacks completeness as an adequate behavioral guide. Examples of Minimally Functional Definitions are given below. These follow the stem "Caseload management is. . . ."

1. *the effective use and control of time, money, and people in such a way as to produce a desired result with a given case.*
2. *the effective administration and management of services to clients within a reasonable time period.*
3. *the process by which clients' cases are initiated and carried through the rehabilitation process in the most facilitative way possible by the vocational rehabilitation counselor.*

Minimally Functional Definitions are characterized by (1) vague generalities such as "*in the most facilitative way possible*," (2) a focus on smaller units at the expense of a gestalt conceptualization of a caseload, (3) brevity but not succinctness, and (4) minimal concern for a sophisticated managerial approach.

Nonfunctional Definition

Nonfunctional Definitions would be incomplete or inadequate attempts to describe the functions that make up d the activities required in caseload management. Examples of Nonfunctional Definitions are given below. also follow the stem "Caseload management is. . . ."

1. *primarily "paper work." Your caseload is, however, those cases you choose to accept or ones you feel that you must accept based upon your interpretation of the regulations and what you can get by your supervisor.*

2. *your arrangement and coordination of client services.*
3. *the fine art of shuffling paper more effectively, in order to facilitate a smooth transition from where the client is to a predetermined goal.*

Finally, Nonfunctional Definitions (1) have very little goal direction written in or are simply rambling collections of words, (2) are either vague to the extreme or attempt a universal explanation, (3) have a dearth of descriptive content, and (4) display some hostility or displeasure toward performing caseload management activities.

Of the 98 definitions gathered for analysis, the following percentages by categories were obtained: (1) 15% were judged to be Functional Definitions, (2) 45% were Minimally Functional Definitions, and (3) 40% were Nonfunctional Definitions. Thus, 85% of the counselors in this study could not clearly demonstrate that they had an adequate base of knowledge or understanding of what constitutes caseload management and upon which they could base progressive caseload management activities.

The implications of this analysis are readily apparent, as is the awareness of the impact of attempting to function from some of these definitional bases. Again, if 85% of these counselors, the large majority of whom had more than three years of experience, have only a vague concept of themselves as in control of a process that necessitates managerial principles and concepts, then clearly a great deal of training or retraining lies ahead. Failure to arrive at more complete and comprehensive activity bases will perpetuate the tendency to manage by crises or, in many cases, not manage at all.

External forces and issues acting upon counselors and forces within their settings influence current definitions of caseload management. However, the basics are seldom altered or undergo any drastic revision over time. These basics stem from self-management issues, situation or setting management issues (i.e., private or public rehabilitation issues, state agency guidelines, or federal mandates), economic principles, and client management issues. These basics can be addressed with a knowledge base and practice format that will stabilize new counselors coming into the field as well as continuing counselors who still grope for stability in an environment that often appears to have boundaries and limitations that will not stay constant for any extended period of time.

A Basic Definition

To this point, different definitions, all of which appear to be in various stages of incompleteness, have been given. All those we have encountered

thus far have varying degrees of functionality but none have a completeness that could be considered a standard. All counselors, of course, will arrive at some definition to guide their own behavior. However, for effective caseload management practices, an instructive definition is provided as follows:

> *Caseload management is a systematic process merging counseling and managerial concepts and skills through application of techniques from intuitive and researched methods, thereby advancing efficient and effective decisionmaking for functional control of self, client, setting, and other relevant related factors for anchoring a proactive and outcome-focused practice.*

This definition contains components that provide greater depth than the majority of definitions found in the literature or in the field. A closer look at what this definition is communicating can be done by examining its individual components.

Systematic Process

Consistent patterns for performing caseload management responsibilities cannot exist without the counselor-manager being conceptually aware of the systematic process. These concepts establish two major points. First, counselors must operate from a model or system in order to achieve consistency. Whether practicing counselors realize it or not, their efforts to cope with or to control elements of caseload management activities fall into a system they have already devised for themselves. Assuredly, although consistency is the key element that signifies that a systematic approach is being taken, it does not ensure efficiency nor does it address the extent of the effectiveness of counselors. Secondly, caseload management has beginning and ending phases that must be hierarchically and systematically arranged. The caseload management process consists of stages or a series of activities that must be sequenced properly in a logical, rational manner. The beginning and ending stages have separate requirements and considerations, but the idea of a flow or pipeline is paramount. The hierarchical arrangement (see Figure 1.1) of the process develops from a base of referral and interview biographical data. From this base develop interpersonal relationships, formalized and intuitive evaluations and insights, and, finally, professional judgments or decisions, all of which peak with an eventual successful rehabilitation. Each of the conceptual areas, of course, has its own skill and expertise requirements that must be well developed if the caseload manager is to be in effective control of this process.

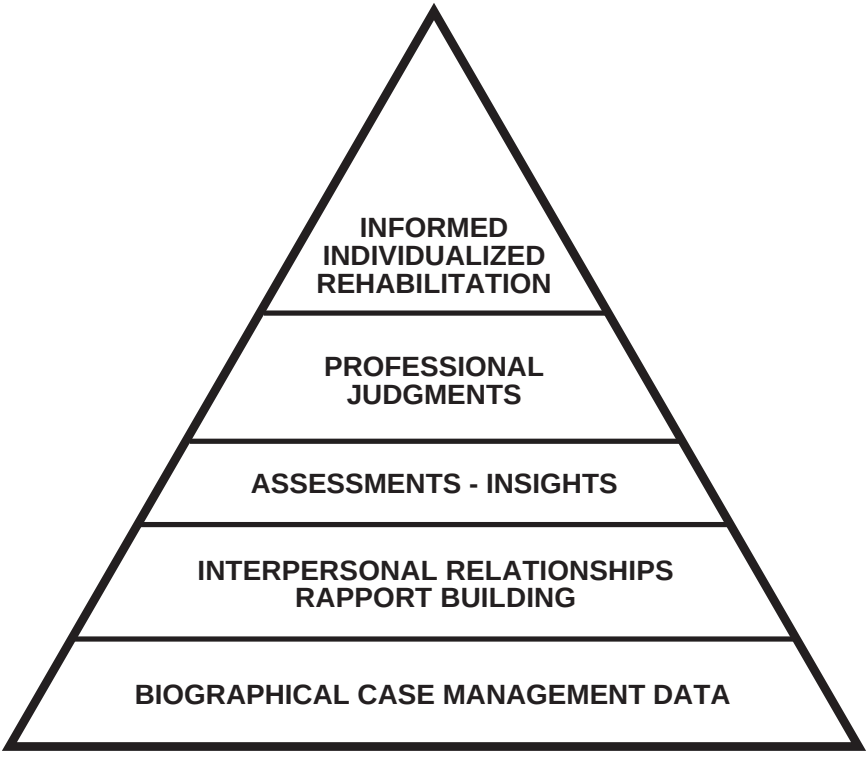

FIGURE 1.1 A Hierarchical Arrangement of Conceptual Aspects of the Caseload Management Process

Merging Counseling and Managerial Concepts and Skills

In the field of vocational rehabilitation, a professional must perform balanced, dual roles involving both typical counselor functions and managerial duties. Dualism must give way to interrelatedness with equal commitments for both roles in order for the process to be systematic (a discussion of these roles will be elaborated upon in chapter 2).

Application of Techniques from Intuitive and Researched Methods

This phrase draws from the systematic or model concept just discussed. However, here considerations are given to caseload management as a developing science that must be supported by techniques and methods derived by counselors through personal experiences and from intuitive approaches. These are "researched" and reported in literature, used within practice, and

then refined by counselor practice. This activity places much of the burden of the developing practice of caseload management with practitioners.

Advancing Efficient and Effective Decision Making

This is a goal all rehabilitation professionals strive for, regardless of setting. It is especially the case in the field of rehabilitation where there are rapport-building activities in human services endeavors, as well as management of financial resources to achieve the greatest benefit from constrained budgets in the public sector, and from cost-restrictive insurance-applied rehabilitation programs in the private sector. The efficiency-effectiveness dimensions often are clouded unnecessarily by a continual dilemma that develops over the decision of which to sacrifice when discussing client concerns (i.e., the effectiveness dimension), and monetary, agency accounting-reporting demands (i.e., the efficiency dimension). This has been termed the "serving two masters" dilemma (Cassell & Mulkey, 1985, p. 13). The obvious, but very difficult to achieve, compromise is a balance between the two dimensions. *Efficiency* has a definite place in a management system and is necessary to achieve *effectiveness*. Hence, setting relatively strict schedule limits or conducting interviews in an efficient manner can be done without sacrificing the interpersonal or counseling relationship. It is by this efficient route that effectiveness is often achieved. However, it must be emphasized that efficiency will not always lead to effectiveness.

Functional Control of Self, Client, Setting, and Other Relevant Related Factors

The idea of control pervades the entire definition and is openly stated in its latter part for emphasis. Control is the key ingredient of a caseload management model and will be given extensive attention in later chapters. This component of our definition further extends the above discussion and reinforces the idea that boundaries are confronted consistently by professionals dealing with clients at the point of service delivery. The counselors' personal needs for performing work activities and deriving personal and professional satisfaction from these activities to meet the needs of clients are important considerations in defining caseload management as an entity consisting of a variety of factors. Also, clients' expectations generally exceed agency or company limitations. Control is the act of ensuring that this exceeding of limitations never reaches a critically high or abort level. Or, if limits are exceeded, then alternatives (the control dimension) are enacted that diminish the critical nature of the events. It should be noted that "related factors" are considered in the generic

sense. That is, legislative mandates (e.g., varying the disabilities allowable as eligible for services), employment outlook in varying economic conditions, counselors' drive and motivational strength, professional-ethical forces, need structures of counselors and clients, client personal strengths, drive and energy levels, and community resources are integral parts of this categorization. Culmination of the above noted factors may result in strategies for empowering consumer involvement in maximizing the rehabilitation process.

Anchoring a Proactive and Outcome-Focused Practice

The concepts brought together in this basic definition are given as boundary conditions or guidelines. Functional control, then, provides only a connection to link the concepts coherently. The end result or action step, *a proactive, outcome-focused practice*, still rests with the execution of consistent daily practices and personal conduct that extends beyond self-defeating negative attitudes that can arise.

Conclusion

It should be noted that the authors' definition does not mention numbers of "successful rehabilitations" or "successful case closures" as part of caseload management. Because caseload management is considered a process to achieve these universally stated goals, success is an outcome dimension and generally will follow if the process is managed adequately from the outset.

There are two other issues that require attention when developing definitions. The first is the activity base from which counselors initiate caseload management functions (i.e., a proactive versus a reactive base). The second is the confusion of case management and caseload management as one and the same with identical theoretical underpinnings. These important issues are addressed in the following discussion.

A CONCEPTUAL MODEL OF CASELOAD MANAGEMENT

The practice of caseload management is not devoid of professionalism, nor is there an absence of consistent approaches. Rather, counselors often develop a personal methodology or approach but are unaware of the individual elements of their systems. Many of these counselors are unable to effect change or initiate improvement without this insight or perspective. For experienced counselors and for those who are being initiated to the demands of a caseload, this text attempts to systematize an approach to caseload management. The concepts offer a measure of organization and a professional base to help

counselors develop a personal management style and personal management system.

The conceptualization of caseload management that follows stems from the authors' conclusions that this area is bounded by four essential elements. Figure 1.2 depicts the four essential factors in this framework: (1) Personal Elements, (2) Data Elements, (3) Client Elements, and (4) Rehabilitation Organization Elements.

Each of these elements exerts a specific influence or force on the caseload management process. The methodology for coping with these factors is usually specific to the particular area of influence, and thus a separate knowledge base is required for each area. However, because these elements do not exist in isolation from one another, the interaction among them establishes the fact that knowledge about or experience gained from each element is usually synergistic with the others.

Clearly, it is this synergism that constitutes *caseload management*. These elements must be viewed and studied individually before they can be properly

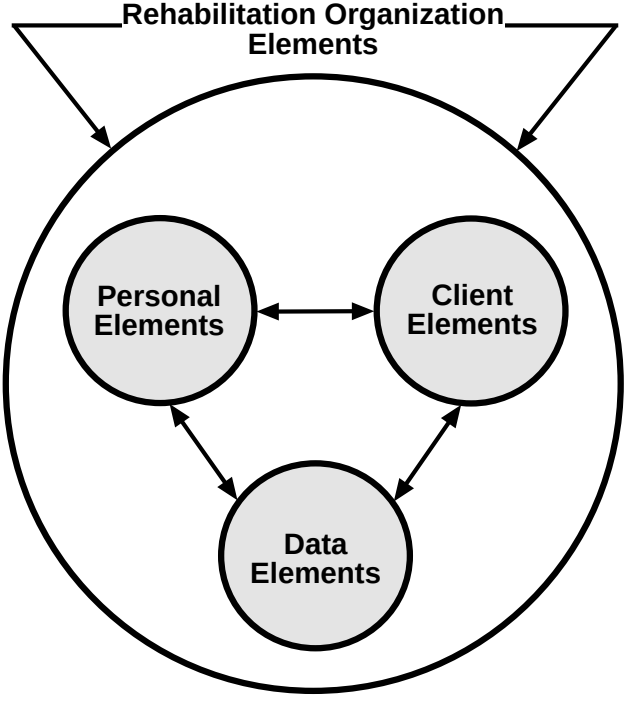

FIGURE 1.2 The Essential Elements of a Caseload Management Model

incorporated into a personalized management system. However, this text will concern itself with those two areas over which the counselor can exert the greatest control and can have the most immediate impact: Personal Elements and Data Elements. Client Elements, of course, can be influenced greatly by a counselor's action (or inaction). The influence is more indirect, and sufficient literature has been developed to treat these elements. The subsequent discussion will present a brief overview of all four elements.

The management of a caseload is dependent first and foremost on the personal characteristics of the counselor. In order to manage a rehabilitation process, the counselor must first understand and be in control of aspects of managing him- or herself in the most effective manner possible. Hence, it is necessary for counselors to be as fully aware as possible of their internal dynamics: attitudes, beliefs, motivations, perceptions, decision-making skills, and general psychological make-up.

Personal Elements have a wide range of components that require the caseload manager to exercise some measure of control. Control is defined very broadly and is not restricted to direct manipulation of overt actions. Basically, knowledge is control. To acquire an awareness or knowledge base in a particular area is to establish for oneself a measure of control. To lack information and knowledge in a specific personal area and to be forced to draw upon this area for interaction with external processes (persons and procedures) is to suffer the consequence of having these external processes control the caseload manager.

The authors believe that four content areas offer a framework for developing Personal Elements in a management process. These four areas are (1) learning the basics of management for counselors, (2) becoming aware of the specifics for establishing control, (3) developing an effective decision-making base, and (4) gaining effective management of time. These basics of management are an important area of consideration as counselors do not often think of themselves as managers, or at least they most often prefer not to do so (Rubin & Emener, 1979).

Personal Elements

One can never really *act* like a caseload manager unless one first begins to *think* like a caseload manager. When the basic information of a management framework is owned by the counselor, the "thinking process" has begun and future constructive action is then dependent upon the use to which the counselor puts the information gained.

Once the basics of a management model have been incorporated into a counselor's generic modus operandi, refinements of the basics are then possible. The caseload manager is now ready to focus directly upon the key management function: *control*. Without a firm level of control—at least personal control if not the difficult-to-achieve structural or organizational control—effective caseload management will always be elusive, or achieved at very dramatic personal costs to counselors. Thus, "stress" (Brill, 1995; Miller & Roberts, 1979; Selye, 1978), "role strain" (Rubin & Emener, 1979; Vash, 2001; Woodside & McClam, 2003), and "counselor burn-out" (Emener, 1978; Faubion, Palmer, & Andrew, 2001; Olkun, 1999) all become relevant issues for practicing counselors.

Decision making, of course, is the pivotal point upon which the caseload management process balances. Decision making is a personal process and requires an individualized approach to make the process valid. However, if the basics for understanding this process and for objectifying it are learned well, decision making becomes more than just an intuitive endeavor (see chapter 4).

Effective decision making, however, will depend upon how well the counselor has developed the control function. When the counselor firmly believes a state of overall control is possible and consistently executes control, then the most formidable barrier to decision making has been removed. Thus, we see how the acquisition of a true management style is highly dependent on a process arrangement or sequential building of one set of activities upon others.

Finally, the mortar for building any management program is the effective use of time. The counselor's consistency in managing a caseload will depend upon whether he or she uses a systematic approach to managing time. By relying on personalized principles and concepts for a complete understanding of time management, the counselor is in control of the flow of day-to-day management activities. Conceptualizing time management as a dual arrangement (i.e., a quantitative base and an intuitive base) with methodology and techniques specific to each leads to a comprehensive picture. Caseload managers must learn to manage their time by becoming aware of the specific manner in which they allot time to various activities (i.e., determining which activities are effective and which are time wasters). Also, caseload managers must sometimes manage time from an intuitive base that does not require the gathering of facts, figures, and other data. Instead, they must be spontaneous and ready to respond from internal processes that guide them through those time traps and time robbers that threaten effective time utilization.

These four areas are not all inclusive for establishing what counselors should understand about the Personal Elements of caseload management. They are the minimally necessary aspects. The information gained in this area should stimulate a thinking process that will allow the manager role to become cognitively and emotionally palatable. Although these are the minimally necessary aspects for control of Personal Elements, the incorporation of the principles learned in a counselor's total approach to the job is not minimal in terms of impact on performance and, thus, client services. These four areas also serve as the core for dealing effectively with the three remaining caseload management elements (i.e., Data Elements, Client Elements, and Organization or Agency Elements) as they exert their influences on counselor practice.

Data Elements

Managers of caseloads most often perceive Caseload Data Elements as the only area toward which to direct management efforts. Counselors who attend training sessions conducted by the authors come with the idea that they will be dealing only with data, including computerized lists, the basic classification system, case movement, and case recording. As one can see from what has already been stated, Data Elements are not the only area requiring the application of a managerial approach. Caseload data points do, however, constitute a significant portion of counselors' areas of responsibility in rehabilitation settings, and must be managed, unless one would have them exert such an influence that the data begin to manage the counselor.

Part II of this text will be devoted primarily to aspects of getting this element of caseload management under counselor control. The areas emphasized will be (1) understanding the basic classification system, (2) managing case flow, and (3) essentials of case recording and documentation.

The monitoring, assessment, and managing of client movement through any process requires a systematic structure. In the rehabilitation field, individuals with disabilities who seek services in private and public rehabilitation organizations automatically become part of pre-established monitoring systems. Therefore, professional caseload managers who work within these organizations or those who work in association with them must have sufficient knowledge of the classification system private and public rehabilitation organizations employ. This system gives counselors the expertise required for moving clients through this monitoring system, and it gives counselors in the public sector and case managers in the private sector, who work with these agencies, an understanding of their terminology and nomenclature.

Caseloads in public rehabilitation are systematized. The classification system itself is somewhat static. When the different zones accumulate numbers representing clients and when these clients move within the classification system, then a more dynamic case flow process is created. If effectiveness and efficiency are to be achieved within this caseload management framework, the counselor cannot move clients aimlessly through the system. Instead, priorities for action must be established and methods applied for assessment of actions that go beyond defined parameters. Next, the measure of control required to cope with changing pressure points must be initiated. This cannot be accomplished without structuring a management approach to caseload data.

With the establishment of a consistent, stable system for classifying cases and monitoring their movement comes an almost monumental amount of data, figures, and facts. If one is to manage in this area, one must exert control over the massive flow of data. The usual tendency would be merely to report the information according to the requirements of those asking for it and stop there. However, if caseload managers can establish a methodology for tracking the flow of cases from input to output stages, efforts to control the Data Elements will be successful.

Accountability has always been a professional issue, whatever the field in which an individual performs. It can be as nebulous as personally derived accountability or as formal as an official audit. In vocational rehabilitation agencies, accountability stems from personal and external sources. External sources include those emanating from federal policy and regulations derived from congressional legislation and appropriate consumer groups. In the private sector, litigation factors and cost containment are among the taskmasters overseeing accountability issues. For these reasons, case recording and documentation are vital aspects of caseload management (see chapter 8). A caseload manager should have the knowledge and skills required in these two areas to facilitate gaining of control over Data Elements.

Client Elements

The characteristics of empowered clients exert a definite influence on caseload management and thus constitute a significant element. These characteristics are not much different categorically from those involved in the Personal Element. That is, clients' attitudes, affect, motivations, beliefs, perceptions, social factors, resilience, and general psychological make-up are integral parts of caseload management. DeLoach and Greer (1979) note concern for accurate predictors to distinguish eventually successful clients from those

who are not rehabilitated. This has been a research concern for two decades. DeLoach and Greer determined that the personality variables of self-esteem, self-acceptance, attitudes, and expectations correlated with client rehabilitation success.

Counselors in the private sector must deal directly with Client Elements from a management stance more than counselors in the public sector. The client characteristics of major concern emerge from five potential problem areas described by Kreider (1983): physical, emotional, financial, vocational, and motivational. The problems all concern balancing the injured or disabled client's welfare with cost-containment restrictions posed by the contracting organization.

Client Elements are less directly affected by a managing practice than are the other three elements. That is, the execution of the action is incumbent on the client. This influence felt by the counselor on caseload management is controlled from a counseling or therapeutic approach. The techniques and methodologies relied on are complex and require extensive and appropriate integration into informed action plans. Rehabilitation counselors currently receive sufficient training and usually acquire the basic skills necessary to deal with Client Elements of a caseload at a relatively early stage in their professional education. This area is fortunate to have a plethora of information available from various sources with a variety of different models or approaches from which to choose. Hence, the significance of this element is duly noted and the counselor can go to these previously developed sources if a higher level of expertise is a personal or professional goal.

Rehabilitation Organization Elements

The final element of this conceptualization of caseload management has its roots in the organization or agency's structural and procedural processes. The influence is related to the guidelines, policies, federal government demands, changing emphases or priorities in serving different groups of disabled people, and changing priorities in general. The control the caseload manager has in this area is minimal. However, Figure 1.2 depicts this element as providing the medium wherein the other three elements operate, interact, and gain their longevity.

Ideally, counselors will have input into the growth and development of the rehabilitation organization element through individual goal-setting exercises for output or production levels expected from a caseload, good record keeping or reporting practices, and the cooperative, participatory teamwork philosophy they bring to the job. Although counselors have input into this

element, higher-level administrative processes are in control wherein checks and corrective balances are achieved through a system over which the counselor has only minimal control. Thus, no specific approach or elaborations on techniques for managing in this area are included here. The counselor's intuitive skills and the knowledge gained throughout this text should be available, however, when the counselor encounters situations calling for these skills. The skills are generalized to all four of the basic elements of caseload management. Although counselors' conceptualizations of caseload management are bounded necessarily by these four areas, basic action (or inaction) orientation affects any form of practice. An action orientation for managing a caseload sets forth the preliminary condition for viewing any conceptualization of caseload management as falling into one of two summarizing classifications: reactive and proactive. Usually, one can predict the kinds of caseload management activities that counselors will engage in by their tendencies to place themselves into either part of this dichotomy.

Counselors who are aware of a tendency to consistently place themselves in one of these classifications will be in a position to lay one or more building blocks upon their efforts to construct a personalized style of managing. They will be aware of which actions to reinforce and which maladaptive behaviors to extinguish. The following discussion will concentrate on understanding what these orientations entail.

Reactive Approach

As the term implies, reactive orientations stem from a stimulus-observe-act model, which means the individual consistently fails to plan immediate coping strategies for most approaching events (see Figure 1.3). Instead, the counselor maintains a waiting posture and problem areas predictably build up to a point where some corrective action is required. The counselor takes no real preventive actions. From this stance, only minimal management practices can occur. A struggle merely to stay even or not to get far behind is predominant; this struggle cannot be termed management, but rather a struggle for survival.

FIGURE 1.3 The Stimulus-Observe-Act Model

For discussion purposes, the following definition illustrates a reactive orientation: *Caseload management is a composite of duties and responsibilities directed toward relieving pressures from personal-professional domains, client domains, and agency reporting-case recording domains.*

The elements of a definition of the type above depict the counselor as a troubleshooter or a brushfire fighter. The counselor waits for pressures to occur before initiating action, thus taking a crisis orientation to caseload management. Procrastination is a characteristic aspect, as evidenced by the "relieving pressures" activities that come about from a wait-and-see posture, thereby permitting a problem to become a crisis.

No descriptions of action for preventative management are built into the definition. Counselors or case managers who adopt this position consistently view their approach as that of a problem solver, deriving a great deal of reinforcement from this type of activity. The danger, of course, is that quite unknowingly counselors will at times create problems in order to demonstrate their skill at solving them because with the solution comes the traditional "atta-girl" or "atta-boy." Caseload management professionals consequently go about setting conditions to achieve as many "atta" awards from supervisors and agencies as possible. Other than this demonstration, no real personal control is built into a definition of this type.

The guiding objective in reactive practices is to stay even with the game. Thus, caseload management becomes something that happens to the counselor. To restate the old adage of whether the dog wags the tail or the tail wags the dog, the caseload wags the counselor.

Proactive Approach

In contrast to the reactive approach, a proactive stance operates on an anticipate-act-assess-act-evaluate mode (see Figure 1.4). Here an anticipate-act cycle replaces the stimulus variable of the reactive orientation. The "act" responses following the "assessment" mode represent the caseload manager's efforts to refine decisions and to act on those variables that could not be anticipated. This means that the counselor is now taking some action prior to a caseload management event reaching crisis or problem potential. It does not mean that problems will never occur and that no crises will ever be encountered. Rather, a proactive orientation lays the foundation for controlling situations by initiating some form of action that will continually lead one toward established goals instead of relying on urgency as a motivator that will incessantly shove one unceremoniously toward those goals. Consistency, of course, is the key concept because realistically one cannot always anticipate and plan for future

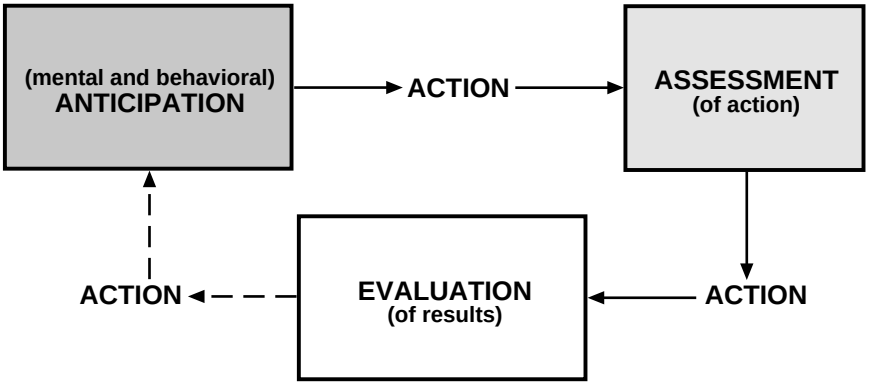

FIGURE 1.4 The Proactive Anticipation Cycle

actions. A reactive type of orientation might be the only response to certain situations. However, the proactive counselor will not rely on this orientation for any extended period of time.

The following statement is a definition of a proactive orientation. *Caseload management is an organized system of techniques or methods to effectively and efficiently control anticipated personal, client, caseload, and setting demands on one's skills and resources and to react through immediate action steps to control unanticipated demands.*

Inherent in this definition is the concept of a counselor as an individual who initiates or develops action steps to thwart agents that would disrupt a flow process in caseload management. Counselors or case managers operating from this orientation are not "holding tight." Involvement in higher risk-taking activities can be predicted, as opposed to the low-risk-taking approach characterizing the reactive stance. The proactive definition depicts the counselor as a *problem preventer*. The problem-prevention stance demands strong personal characteristics of counselors as these activities most often do not come to the attention of the supervisor or others who could offer proper reward. Caseload managers operating from this base perceive reinforcement as derived from intrinsic personal sources, thus opting *not* to seek supervisory, agency, or other extrinsic rewards. Control occupies a central place in a proactive definition. Managers take the initiative in all phases of caseload management. These individuals make caseload management happen; therefore, they wag the caseload.

Proactive Versus Reactive

Proactive and reactive stances abound among counselors in the field. Unfortunately, the latter variety is more abundant than the former. The definitions

reported earlier were judged also on the basis of their *proactive* or *reactive* posture. The information shown in Table 1.1 was used as a foundation for making comparisons. If a definition basically revealed a striving for control, avoiding possible pitfalls, or projecting an anticipatory approach to caseload management, the definition fell within the proactive area.

Reactive definitions reflect a procrastinating nature. A person may recognize that a problem arises and only then take some action. No preventative or anticipatory action is initiated. Another facet is the attempt of those guided by these definitions to equalize their efforts to all concerns without differentiating the degree and complexity of the demands of a situation or event.

Data not meeting the proactive or reactive protocols were defined as noncommittal. Noncommittal definitions are those responses following the stem, "Caseload management is . . ." taken by counselors who demonstrate a lack of a proactive or reactive position on the issue of control. The definitions used by these counselors lead them to avoid any real statement of anticipatory actions. The noncommittal category also includes those definitions that are too brief and so lacking in content as to suggest that these counselors either have no knowledge base upon which to conceptualize caseload management or prefer to remain in limbo and not commit themselves to a definite stance. As the average years of experience in this group was approximately three, the lack of a knowledge base seems unlikely. However, owing to the past nature of caseload management as a less than fully conceptualized entity, the knowledge base quite possibly is fragmented and as such could contribute to this stagnating, noncommittal attitude.

In addition to the earlier definitions, which could be included in one of the categories just described, other examples of actual definitions falling within these groupings are given below.

TABLE 1.1
Approaches to Caseload Management

Proactive	Reactive
1. Problem preventer.	1. Primarily a problem solver, brushfire fighter, crisis oriented, a procrastinator.
2. Seeks intrinsic reinforcers.	2. Seeks extrinsic reinforcers.
3. Risk taker.	3. Low-risk taker.
4. Personal control.	4. No personal control built in.
5. "Wags" the caseload.	5. Caseload "wags" counselor.

Proactive Definitions
"Caseload management is . . ."

- a process whereby the caseload manager effectively controls and maintains the caseload at a maximum efficiency to obtain the maximum results.
- the prompt and adequate movement of all applicants for vocational rehabilitation services from an active status to case closure, without allowing delay of movement due to lack of decisions, paperwork, or other factors counselors can control.

Reactive Definitions
"Caseload management is . . ."

- the ability to keep the flow of work moving with as few snags as possible.
- the ability to be aware of casework flow and to spot any problem areas and be able to correct them.

Noncommittal Definitions
"Caseload management is . . ."

- the orderly and timely movement of the rehabilitation process.
- performing the duties involved in vocational rehabilitation programs in order to provide services necessary to rehabilitate individuals with disabilities.

The results from the analysis of the 98 definitions examined revealed that 26% were proactive, whereas 30% were reactive. The implication for the field is that presently the majority of vocational rehabilitation counselors are laboring under a reactive stance. Seventy-four percent of counselors in this study find caseload management an area that must be tolerated but not identified with, or more than likely an area that elicits their scorn. The cause–effect relationships are not clear. However, inappropriate organization reward systems for effective caseload management, confusing guidelines, unrealistic objectives, and other situational and individual elements are but a few symptoms that contribute to a reactive stance or merely a noncommittal one.

The implications for counselor and supervisory actions are clear. If a counselor is relying more heavily on one of these positions as a basic

modus operandi, appropriate actions must be taken. That is, from a reactive position both supervisor and counselor must interact to move closer to resolving the negative aspects that arise. In contrast, mature counselors who operate from a proactive stance are usually already aware of their actions. Thus, the responsibility is primarily for supervisors to be aware of those proactive behaviors and properly to reward and reinforce these responses in their staff.

BENEFITS OF IMPROVED CASELOAD MANAGEMENT PRACTICES

The benefits for initiating a structured, ordered approach to caseload management come from a variety of sources. These outcomes assist in answering the question, "Why change or improve caseload management practices?" The five areas discussed below represent only a few of the many benefits that accrue from the enactment of a true management approach.

Increased Efficiency

A succinct definition for efficiency is, simply, doing things right. Consistent correct outcomes can come about only within a well-defined system of checks and balances, monitoring and evaluating stepwise actions. In their mention of realizable rewards, the study group of the Third Institute on Rehabilitation Services (Muthard, 1965) identified several products of improved caseload management, one of which is efficiency. Caseload management was seen as "measurable in terms of increased efficiency; that is, improving the ratio of output to input" (p. 1). To be efficient, rehabilitation professionals must recognize and understand the characteristics and trends of their operating system and how each of these must be integrated into service delivery (Havranek, 1995; Riggar & Maki, 1997; Rubin & Rubin, 1988). To a large degree, these characteristics define the unique skills, competencies, and knowledge bases that counselors and case managers must utilize in order to be efficient throughout their practices (Hursch, 1995). Almost any professional is motivated to seek methods for satisfying the economy-of-effort principle. An improved caseload management system provides a means for achieving greater production with at least the same effort, if not with less effort. Woven properly into counselors' styles for action, increased efficiency will not mean a sacrifice in the therapeutic relationships with clientele. Rather, overall competence is more readily obtainable.

Increased Effectiveness

A succinct definition of effectiveness is doing the right thing. Thus, with ongoing correct and consistent actions (efficiency), the caseload manager must decide which prioritized action to take next. These actions evolve into management skills.

The effective use of management skills when working with multiple rehabilitation services has several advantages. First, it allows the counselor to become aware of a vast array of rehabilitation services within the community. "The case manager can concentrate on providing only those services for which he or she is trained while linking the client to the services of other professionals" (Woodside & McClam, 2003, p. 212). Second, not only do effective caseload management practices increase the efficiency of counselors, but they also increase the impact on the broader goal of assisting in the self-actualization and self-sustenance of individuals with disabilities. The study group mentioned above also spoke further to the point of improved caseload management as impacting counselor function. "*Another facet of this would be increasing the effectiveness of the counselor as counselor. That is, if the rehabilitation counselor is relieved of clerical and other routine tasks, whenever feasible, [the counselor] will have more time to engage in counseling*" (Muthard, 1965, p. 1).

Finally, caseload managers must become aware of the difference between tasks that fall within an operating category (i.e., tasks others should be performing or tasks that do not require the counselor's level of skill training) and those that fall within a managing category (i.e., tasks requiring the specialized skills and knowledge of the counselor). Then, understanding the necessity to delegate those operating tasks, where feasible, must follow.

It is not ironic that through a management approach the counseling role is enhanced, and that this role establishes greater gains in authority and prominence for the counselor. The irony is the disbelieving attitudinal posture of many counselors who find it difficult to mesh a seeming dichotomy (i.e., counselor versus manager roles) into a unity. This conflict of deferring commitment to one role while attempting to be effective at the other has robbed many counselors of effective performance.

Standards and Limitations

With a functioning caseload management system comes the opportunity to set standards and limits within which one will manage a process. Such standards offer goals to be attained and, at the same time, set boundaries for reality testing. The benefits should be a decrease in anxieties that, in the past, arose from the perception of a seemingly limitless set of variables to

control. Further, a measure of reward is acquired when the individual performs within the standards established and begins to control those variables that can be controlled. The limits against which counselors will test themselves will emanate from personal and organization-established standards. The managing efforts directed toward operating within personally set limits, when these limits are maturely and wisely established, will provide a self-reinforcement program that is nonexistent in some agencies. Therefore, the overall effect will be a more relaxed approach to the job and a more enjoyable working environment.

Increased Professionalism

Logically, the next benefit for improved caseload management to follow from the above discussion is that not only will it allow counselors to better utilize their professional skills, but improved practices will also add to their self-perception as competent professionals (Muthard, 1965; Rubin & Roessler, 2001). If indeed counselors are managing appropriately and meeting personal expectations by fulfilling the job functions for which they were trained, professionalism is a realizable goal. However, if counselors continue to flaunt the counselor role and show disdain for activities that are significantly managerial, then anxieties and frustrations will stunt any image counselors have of themselves as professionals.

Stress Reduction and Job Satisfaction

One of the most important roles for caseload managers is the coordination of services. "Because in-house services are limited by the agency's mission, resources, and eligibility criteria—as well as by its employees' roles functions and expertise—arrangements must be made to match client needs with outside resources" (Woodside & McClam, 2003, p. 211). Therefore, a final benefit to be mentioned, as a reason for improved caseload management, is one that contributes not only to counselor well-being, but also to the stability of the organization. With increased management skills practitioners develop the ability to utilize important information regarding the availability of rehabilitation services (Bishop & Degeneffe, 2003). This benefit arises from the conclusion that improved counselors' caseload management practices will allow for more productive provision, coordination, and delivery of services in rehabilitation settings. Thus, practices build on the counselor or case manager's knowledge about availability of services and the skills to put these services to use.

Counselors who practice effective management skills are more effective professionals and work to ensure client-informed choice and self-

determination. However, improved counselors' caseload management practices, and thus more favorable perceptions of themselves as professionals, is "linked to the old problem of retaining and recruiting trained professional staff" (Muthard, 1965, p.1). Although there are numerous reasons for counselors leaving their positions in both the public and private sectors, from the authors' perspective, many of those can be linked to disillusionment with the field of vocational rehabilitation as a panacea for fulfilling the professional aims of counseling persons with disabilities toward greater self-actualization (Cassell & Mulkey, 1985). Rapid staff turnover is another significant problem impacting all aspects of rehabilitation organizations and their services. "Staff turnover is influenced by many factors and the associated high monetary and service-related costs are significant concerns for community based rehabilitation programs" (Mallik & Lemaire, 2003, p.25). Previous literature has noted four reasons for employee departure. They are (1) lack of opportunity for advancement, (2) little job satisfaction, (3) stress and burnout, and (4) personality differences with management/supervision (Brill, 1995; Mallik & Lemaire, 2003; Riggar, Hansen, & Crimando, 1987; Woodside & McClam, 2003).

As consumers of rehabilitation services are responsible for directing the development of their plans and services, they are more involved than ever before in the decision-making processes regarding service delivery (Bishop & Degeneffe, 2003). Therefore, they must realize that rehabilitation professionals do not just help people through the rehabilitation process. Instead, counselors seek to empower individuals in the management of their rehabilitation processes, and they work to ensure client-informed choice and self-determination (Bishop & Degeneffe, 2003; Cassell & Mulkey, 1985).

The management base and philosophy support and augment the counseling function. Muthard (1965) has suggested that counselors discharged only approximately 25% of their time in what can be termed the counseling function, while the remaining 75% was allotted to other supporting functions. The "other supporting functions" fall within the purview of the role of the counselor as a manager. Thus, we can see evidence of the extent to which the counselor is actually involved in managerial efforts. From 1965 until today, it has become apparent that counselor functions have basically remained the same. Therefore, with full acceptance of manager orientation as a reality and the imbuing of it with a personal bias for constructive action, the profession will develop with greater solidarity, exhibit less contradiction, resolve many contrasting philosophical issues, and, in the end, establish firmer job stability and personal satisfaction for counselors.

CASELOAD MANAGEMENT: ART OR SCIENCE?

To conclude this chapter's attempt to define what does and what does not define caseload management, consideration should be given to the whether caseload management is art or science. The field of private or insurance rehabilitation has only recently formalized practice tenets and guidelines.

In the past, attempts at fully describing caseload management have defied definition to the point that one could conclude at times that it does not exist as a scientific entity. Very little research has contributed to a scientific base. The questions that arise are (1) What gives this universally espoused term a basis for existence?, and (2) If caseload management exists, who or what gives it continuity and definition?

A plausible explanation is that the acts and practices of professionals in the field culminate in a gestalt that is then labeled caseload management. With the individual parts and processes identified and isolated, they subsequently combine to produce "caseload management." However, these parts and processes cannot be totaled in any simple form. Thus, at the moment, one can only conclude with partial certainty that caseload management exists as an art emerging from cogent practices of many proficient professionals performing from individualized management styles.

This conclusion immediately provokes a critical inquiry. How does the field achieve transfer of knowledge and skills among all its practitioners? The answer lies with the identification and collection of the salient features of the art that are exhibited consistently by *successful* counselors or case managers. The next step is teaching these salient features to the motivated learner who will then become a knowledgeable and skilled practitioner. The point to be developed in this text is that the art can be embellished or added to through an organized, structured information base. A more complete understanding of the parts and the processes of caseload management can be gained to give it order, consistency, and transference for increased learning by professionals and ongoing achievement of professional development as well as improved service delivery systems.

SUMMARY

This chapter has developed a rationale and overview that set the stage for content specifics to follow. It was noted that the competency upon which professionalism can evolve must come from the integration of a manager philosophy with a counselor philosophy. The benefits that can be gained from working toward improved caseload management were presented. These five areas were discussed: (1) increased efficiency, (2) effectiveness, (3) limits

testing, (4) professionalism, and (5) job satisfaction. A conceptualization of caseload management was introduced. The chief components of this framework were organized around four essential elements of caseload management: (1) Personal Elements, (2) Data Elements, (3) Client Elements, and (4) Rehabilitation Organization Elements. The purpose of the present text is to develop in detail the first two of these elements. Finally, the question of whether caseload management is art or science was posed. The conclusion is that the science of caseload management must be considered a functional developmental process to interface with the art. As such, the rehabilitation professional must continue to be an integral, contributing part of defining "Caseload management is. . . ."

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CHAPTER 2

A Management Model for Rehabilitation Counselors

THE MANAGEMENT MODEL

Abraham Maslow, in his well-known conceptualization of the hierarchy of human needs, stated that one fundamental group of needs stimulates behaviors that satisfy a need for order, stability, and structure (Glass, 1991). To be at their highest level of functioning and achieve the greatest output counselors must fulfill the requirements of these basic conditions before the emergence of needs in the relatedness, self-esteem, and self-actualization areas. That is, if an individual is to make maximum movement toward functioning as an effective counselor with the proper credentials to maintain a professional profile, that individual must deal systematically with the establishment of the required order, stability, and structure. These systematic attempts, of course, can only originate from the acquisition and application of a management philosophy or program that has the variety and depth to meet the complex demands of public and private rehabilitation organizations. Rehabilitation counselors often come to the field well versed in several counseling models but ill-prepared to confront an entire process of multifarious variables and contingencies that must be managed, controlled, or otherwise kept within some realistic boundaries.

Counselors frequently fail to think of themselves as managers. The rationale is, "I am a counselor. Why do I need to know management?" Reeves (1994) points out that there are managers without titles. Reeves states, "You may not think of what you do as 'managing,' but if you are working through other people to achieve a purpose or goal, you are managing" (p. 4).

Ultimately, professionals in the field of administering and delivering services to individuals with disabilities must confront the realization that the management process at all levels of the organizational structure is paramount

for effective and efficient program success. Without question, administrative and supervisory personnel operate from a management base and thus are relatively comfortable with their role structure. Their array of activities can be ordered into recognized patterns of duties and responsibilities that permit relatively conflict-free roles. The role of counselor in a vocational rehabilitation agency, however, is rarely conceptualized or experienced as a gestalt of commonly accepted and agreed-upon activities. The preponderance of literature on the coordinator versus counselor controversy and other elaborate works that describe what a counselor in the rehabilitation field does give credence to this observation. The conclusion to be drawn is that no systematic model currently exists for describing or explaining the array of activities engaged in by counselors. When no consistent, interdependent behavioral guideposts are available, confused and frustrated performance can be the result.

This chapter is devoted to the development of the basics of a management model that will give practitioners a foundation for understanding the relationship between their role as counselor and their role as manager in a rehabilitation setting. Such a model provides a basis for meshing these seemingly unrelated roles into a personalized counselor management model. This blending, however, depends on an application phase that cannot be taught easily but that most readily evolves from some already established solid base. Thus, although this chapter provides a broad cognitive base, some additional components such as personal motivation or drive must be present in sufficient quantity to give impetus to the information gained. The model presented in this chapter is organized around three conceptual areas: (1) Base Concepts, (2) Process Concepts, and (3) Structure Concepts (see Figure 2.1).

Base Concepts are static aspects that form the building blocks and the basic support that give the model stability. For example, boundary definitions must be available that provide an understanding of the distinction between the role a counselor performs in a rehabilitation setting and the functions or activities required of the counselor. Distinctions are made among those aspects of counselors' activities that give order and clarity to the job because only then will proper affective and cognitive goal-directed behaviors arise. Thus, a resolution of conflicting expectations (from the role base) will allow performance to initiate from the proper skill area (i.e., the function base).

Process Concepts are the dynamic aspects of a management program. They are concerned with the outcomes obtained from effectively combining technical skills (e.g., filling out forms and following procedures) with human relations skills (e.g., counseling). These enable the process to move from beginning to end stages with a minimum of progress-thwarting barriers. The focus of this segment of the model is on the global skills of a caseload

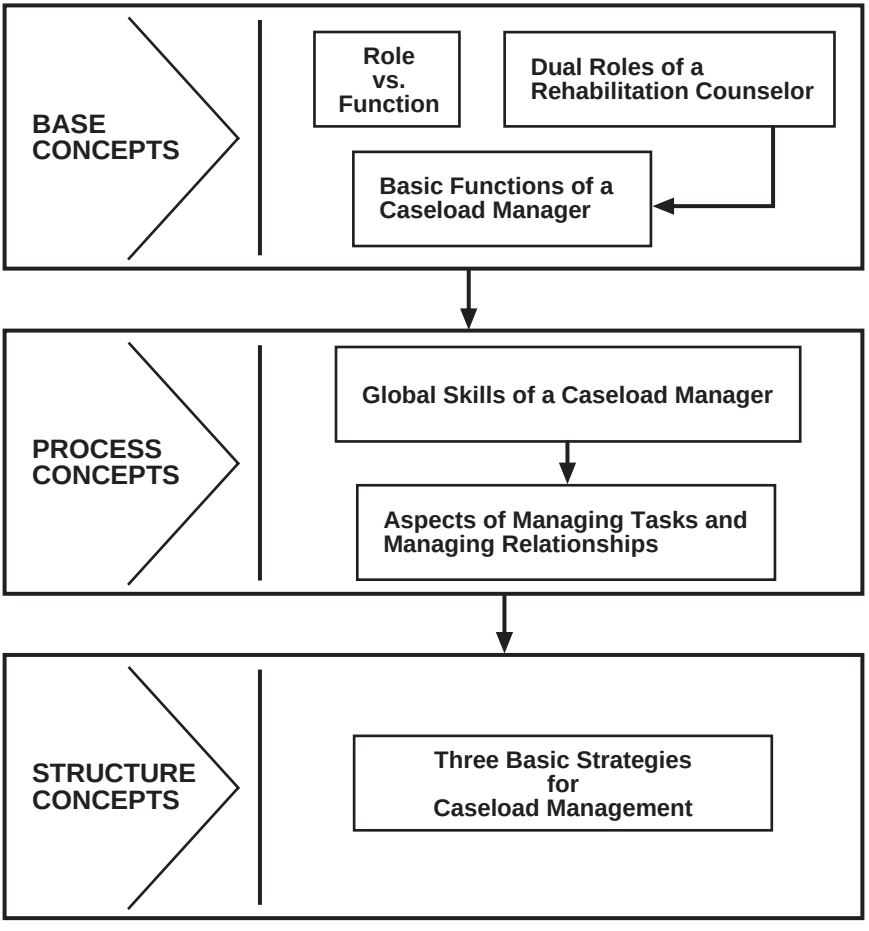

FIGURE 2.1 The Major Components of the Cassell-Mulkey Rehabilitation Counselor Management Model (1985)

manager and on how to interface the management of the mutually interacting task and the relationships are the two crucial areas for any manager in a human services organization to consider.

Finally, with Structure Concepts, the last necessary component of the management model is in place. The first two components are the fabric for developing a management ideology but this collection of concepts and principles must have a background or structure whereby the fabric can be woven into some unified whole. Thus, Structure Concepts focus on strategies on which caseload management practices are usually based. Practices stem from one of three basic strategies or a combination of strategies.

ROLES VERSUS FUNCTIONS

Basic to any management model is the understanding of the distinctions between roles and functions. In practice, confusions between them are likely to distort the entire performance schema; therefore, clarification must lead the way for counselors to establish higher-level individual commitments to their job activities and lay a firm groundwork for a control or management position.

Roles

The definition of a role is arrived at by using three rudimentary terms or concepts: (1) title descriptors, (2) implied expected behavior patterns, and (3) status within a group. Roles are depicted in operation manuals and other agency documents that outline duties and responsibilities to be performed. Roles also evolve out of an implied structure through expected behavior patterns and status within groups. Implied expected behavior patterns are created over time through the reinforcement of certain patterns of performance. For example, some rehabilitation counselors are reinforced for their continued involvement in community development programs for individuals with disabilities. Status in a group also determines roles when, for example, the general characteristics of an individual make that person stand out as a leader. The three terms discussed here are used singularly or in combination, but all three form a broad base for understanding the role of an individual. As seen below, the field of rehabilitation is not always clear in the distinctions made among these terms and thus conditions are set for ready-made contradictions and role stress that can frustrate efforts directed toward managing for appropriate outcomes.

Outlined responsibilities often take the form of job descriptions or listings of conceptual activities encompassing a variety of duties and acts. The authority to carry out these activities is the key to establishing consistently accepted role responsibilities among counselors. In the rehabilitation field, if a significant level of authority is not afforded to those counselors who have the maturity to accept it, role responsibilities will be incomplete. Likewise, if appropriate authority is present and the counselor lacks the initiative or sufficient leadership qualities to use it, role demands and outcome expectations will be in conflict. Only when adequate responsibilities are outlined and significant authority allowed can counselor-managers justifiably be held accountable for the roles expected of them. Finally, the authors contend that counselors in diverse areas of rehabilitation have evolved to the place where they must now perform not one but two roles, each with specific functions,

duties, and responsibilities. The dual roles expected of counselors in rehabilitation are discussed later.

Functions

Definitions offered for a function show it to be a significant part of the description for a role. In management terminology, functions are defined in terms of the tasks, the acts, or the operations expected of and performed by an individual (Hannagan, 2002; Introna, 1997). Functions then give definition to roles and not vice versa. That is, for any particular role an individual fulfills within an organization, there exist descriptions of the functions that constitute that role. However, a list of scattered functions lacks the completeness and boundary-setting qualities of a well-defined role. Likewise, just as a caseload manager has a role to fulfill by the performance of certain functions, so do clients or receivers of services have the responsibilities inherent in fulfilling their roles and functions within a rehabilitation process.

The traditional functions required of managers in many settings can also be used to define the role of the counselor-manager in rehabilitation. These management functions are described later, along with some of the typical functions performed by counselors. The descriptions of counselor functions presented here are intended only to give the reader an idea of the array of activities stemming from the counselor role. The list is not intended to be exhaustive; further elaborations on counselor functions can be obtained from other classic works, which give their primary attention to this task (i.e., McGowan & Porter, 1967; Muthard & Salomone, 1969).

In the field of rehabilitation, expected duties or functions required of counselors are far from cut and dried. However, careful scrutiny of the expectations and cogent categorizing of the functions required gives rise to our conclusion that counselors working in multiple vocational rehabilitation settings must perform the dual roles of counselor and manager. As seen below, the statement of the expectancy of a dual role position does not constitute a dualism or a paradox. Rather, we are espousing a viable harmony to account for the expected and necessary duties or functions presently being performed by individuals in these rehabilitation settings.

DUAL ROLES OF THE REHABILITATION COUNSELOR

Rehabilitation literature has long debated the two primary roles required of counselors (Cassell & Mulkey, 1985; Henke, Connolly & Cox, 1975; Patterson, 1957; Riggar & Maki, 2004). Arguments have focused on whether these

service providers are counselors, coordinators, or some combination of the two. The incompleteness of the argument has continued the controversy into the present day so that conceptual awareness and performance commitments have significant barriers to overcome, thereby causing efficiency to deteriorate. This incompleteness stems more from basic conceptual flaws in the arguments than mere semantic differences. When combined, the elements of a *counselor framework* constitute a larger whole. However, it is important that this framework reflect the coordinator function as only one component of a more significant, encompassing management process, which involves several other functions. Counselors practicing in rehabilitation agency settings will rely on the coordination function for effective performance; however, an individual who is a coordinator will not necessarily be a counselor.

Coordinating, of course, is one of the five major functions that must be performed by managers regardless of setting. However, the implication and underlying message are the expositions one is accustomed to reading is that counselors are not capable of the entire management process, only the one function (coordination) or the one role (counselor). Here we can visualize the discrepancy and conflict arising from the confusion of elevating a function to a role. In the rehabilitation field, the result is usually personal commitment of the practitioner to the higher status *counselor role* but indifference to the *coordinator function*. The ability of counselors to perform the manager role should not be considered the critical issue here; rather the lack of opportunity and properly established reward systems are more significant barriers that need to be considered if the seemingly dichotomous roles are to merge into one unified role for efficient performance. The position taken here is that, indeed, two primary roles are required of rehabilitation counselors (see Figure 2.2).

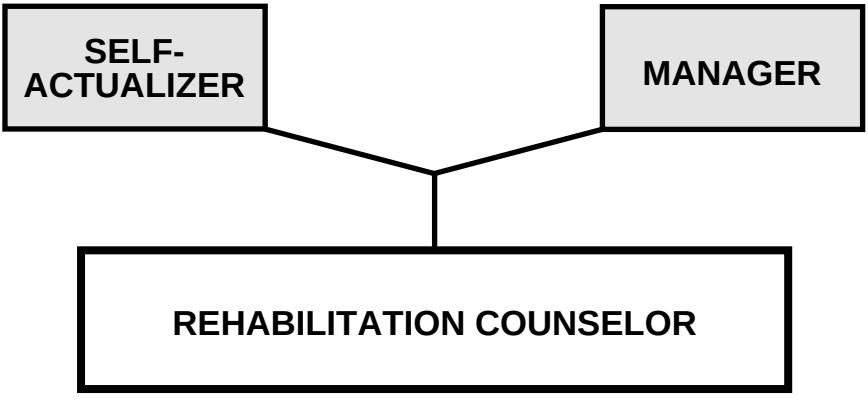

FIGURE 2.2 Dual Roles of Rehabilitation Counselors in Vocational Rehabilitation Settings

One role is the counselor's commonly accepted position, the role of a *self-actualizer*. A self-actualizer is an individual who accepts the responsibility to be part of a process that allows people's potential to reach the highest attainable level (i.e., potential within clients, within peers, within subordinates, and within the counselors themselves).

The remaining role is that of a *manager* in this process. Self-actualization does not simply emerge from the manager. It is a process that changes and evolves over time. Therefore, administration of a definite process or sequence of events and activities, through the manager role, permits access to the self-actualization level. These two roles will be discussed below with the greater emphasis given to the components of the manager role.

Self-Actualizer Roles

The public agency rehabilitation counselor must function as a significant other to allow the client to achieve a self-actualizing level of functioning, that is, the achievement of the highest level of functioning of which that individual is capable. However, the self-actualization process in the private rehabilitation sector reflects a level of functioning that is a state of employability for the individual as near as possible to the preinjury level of employment. Counselors in this case appear to follow a return-to-prior-functioning-level philosophy for working with their clients with disabilities. Matkin (1983a) notes that

> Although the public vocational rehabilitation system seeks to maximize a disabled client's potential, the philosophy of worker's compensation (i.e., private sector rehabilitation) is to restore the individual to the preinjury level of employment or, if that is not possible, to a state of employability as near as possible to that level existing prior to the occupational injury. [p. 237]

This argument is not, in and of itself, a negation of the self-actualization philosophy. With these cautions in mind, the following discussion elaborates on this self-actualization process.

The "self" described in this case is discussed in the generic sense. Thus, the actualizing of a self can occur at the provider or counselor level as well as at the client level. The term *self-actualizer* is chosen as descriptive of the needs and goals of the counseling process and thus conceptualizes the role more clearly than the more often used term *counselor*. As a self-actualizer, the rehabilitation professional can perform responsibilities well recognized as proper activities for such an individual—interview, establish positive rapport settings, counsel for problem identification-problem abatement, offer occupa-

tional information, assist in goal selection and guidance toward goals, and assist in preparation for work adjustment and work stabilization, to name only a few. Several authors have made lists of numerous characteristic responsibilities and duties performed by counselors (e.g., Bellini & Rumrill, 2000; Blake & Mouton, 1985; McGowan & Porter, 1967; Van Voorhis, Braswell, & Lester, 2000). With the exception of only a few, these lists contain only counselor or self-actualizer functions.

The self-actualizer role is well documented in the literature as a primary role and counselors are extensively trained to perform this role. Universally, rehabilitation counselor education training programs establish curricula heavily imbued with counseling theory, counseling practicum, and internships in counseling with clients. Also, programs sponsored by state agencies and continuing education training programs select classic models such as Carkhuff, Perls, and Rogerian, or some other counseling model to prepare their counselors (Carkhuff, 1969; Carkhuff & Pierce, 1975; Cohen & Cohen, 1999; Okun, 1999; Perls, 1969, 1973; Rogers, 1951, 1961; Seligman, 2002; Thomas, 2000). At the conclusion of such training, the rehabilitation counselor usually has an adequate base for establishing the self-actualizer role.

The self-actualizer role also offers a means for visible and immediate gratification that in the past has caused this role to be valued above the manager's role. With the self-actualizer role, the counselor can establish conditions to attain rewards and experience fulfillment in the absence of an organizational reward system. The counselor in this instance is in control of personal reinforcers, and draws from these reinforcers to make further commitments to the self-actualizer role.

Manager Roles

In contrast to the self-actualizer role, the manager role in the past has not been a well-recognized or well-documented area in the public sector. Few articles are written on the managerial aspects of counseling in the rehabilitation area, few academic courses incorporate principles of management for counselors, and little experience is afforded in training for managing a caseload. Thus, the foundation for establishing the manager role has not emerged fully in public rehabilitation.

The manager role also suffers a low status position because the activities often are not conspicuous, and opportunities for immediate gratification are not readily available. The manager-role activities are not rewarded by agency systems, and intrinsic reinforcement processes require a mature counselor to garner adequate reinforcement to continue proficient performance.

Because private sector rehabilitation is frequently viewed as a business (Matkin, 1985), the manager role takes on a relatively different emphasis. Research depicts the roles and functions of the private sector rehabilitation professional (Buys, 1993; Habeck & Munrowd, 1987; Mullahy, 2004; Shrey, 1995a; Shrey, 1995b). These bodies of work revealed five major task categories:

1. Planning and coordinating client services.
2. Business and office management.
3. Job development and placement.
4. Diagnostic assessment.
5. Other professional activities.

Role Integration

The self-actualizer and manager roles have been discussed as two separate entities or dichotomous roles, but in actuality they are interlinked and interdependent. Figure 2.3 depicts the hypothesized relationship between the two. Whatever the setting, little of either major role is excluded as an integral part of effective counselor performance.

For discussion purposes separateness is maintained, but counselors viewing the relationship of the manager and self-actualizer roles as they are depicted in Figure 2.2 will have conflict in committing themselves to both roles. A oneness must be maintained in responding to the requirements of both role areas. The familiarity in the field with the term *counselor* compels the authors to draw upon it with great frequency throughout this text; therefore, we will use the terms *self-actualizer*, *manager*, and *counselor* interchangeably. However, this does not mean that we have abandoned our earlier reservations about conceptualizing the person as performing counselor activities only; these still stand. On the contrary, quite often the individual's lack of an adequate knowledge base or adequate awareness prevents full acceptance

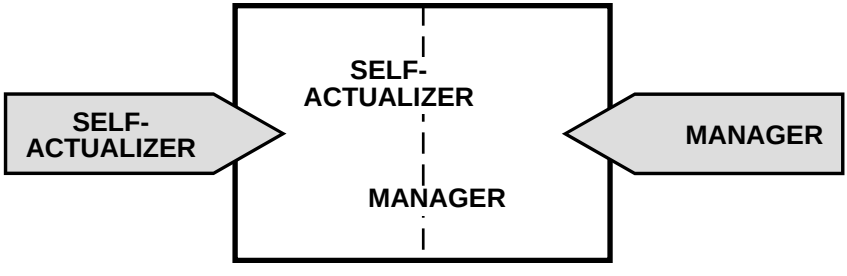

FIGURE 2.3 Interfaced Self-Actualizer and Manager Roles

of manager-role activities. This situation may occur because counselors are unaware of the functions to which they must commit themselves in an orderly manner. Acceptance of manager-role activities will be facilitated when counselors recognize this limitation. In fact, rehabilitation professionals are currently fulfilling many managerial functions, and the only missing ingredient for effectiveness is often a lack of a systematic, organized format from which to operate.

BASIC CLUSTERS OF MANAGERS

Authorities in the management field have identified basic functions required of managers regardless of the setting in which they operate. The number of functions described by writers often varies but most can be subsumed under the five basic skill clusters listed in Table 2.l, which for our purposes now become the basic functions of caseload managers. As the discussion below indicates, the counselor-manager in rehabilitation draws from these functions in varying degrees. Effective individuals who actually manage their caseloads intuitively draw from these five functions. If the counselor-manager can lift the functions out of partial obscurity to a personal awareness level, the gains for improvement in the caseload management process are obvious.

Skill Clusters

Skill clusters are patterns of actions that revolve around central themes or axes. A skill is a learned ability for doing an activity in a competent manner. Often,

TABLE 2.1
Basic Manager Functions in Caseload Management

Traditional Managerial Functions	Typical Corresponding Caseload Management Functions
Planning	Establishes set and setting for interpersonal communications to occur.
Organizing	Initiates and facilitates interpersonal communication process with clients and staff.
Coordinating	Serves as adjunctive link to physical, social, and emotional rehabilitation regimes.
Directing	Executes an interpersonal-vocational problems identification process.
Controlling	Guides goal-setting activities and necessary corrective action phases within an individualized rehabilitation program structure. Objectifies Individualized Plan for Employment.

the execution of one skill relies on another prerequisite skill. Thus, skills often occur in clusters, each one relating to another (Cassell & Mulkey, 2004). Each cluster gathers together sets of specific actions that the caseload manager uses for consistency of personal practice and for fulfilling organization standards. For caseload managers, as reflected in Table 2.1, there are five major skill clusters: *planning*, *organizing*, *coordinating*, *directing* and *controlling*.

Planning

Planning is a key function in the management process. It assists the counselor in guarding against the influences that interfere with the daily tasks that produce desired management outcomes (Cassell & Mulkey, 2004). Webber (1975) declares that the rationale for planning "is not to show how precisely we can predict the future, but rather to uncover the things we must do today in order to have a future" (p. 268). Being in charge of the future (in a management sense) begins with good planning skills today.

"Planning is intrasystemic, which means that planning develops its own internal system properties. Planning must be approached in a systematic way" (Cassell & Mulkey, 2004, p. 258). Planning long has been seen as a basic strategy for managers. More recently, the focus has begun to narrow to strategic planning (Cook & Fritts, 1994; Introna, 1997; Luther, 1995; Sahlin-Andersson & Engwall, 2002), which places emphasis on planning as a critical and essential component of the management process. According to Webber (1975), dreams and visions are of importance in the planning process. Therefore, "a sense of the present developmental phase of the caseload, and where one should be with it, is a part of strategic planning" (Cassell & Mulkey, 2004, p. 259). Ackoff (1970) further extends this perspective by the contention that planning is anticipatory decision making. Although planning is projected, the strategic planning process is applicable not only at the macro level, but on the individual level as well. Cassell & Mulkey (2004) reflect on the steps projected for the individual level:

1. a personal vision,
2. writing down assumptions that shape a caseload,
3. from the assumptions listing, stating the issues facing a caseload and the desired objectives,
4. developing measures for each objective, and
5. choosing strategies that will satisfy each objective.

Finally, systematic planning requires that a common purpose exist among all of the manager functions to be accomplished in the process of

caseload management. All of these activities are interlinked by issues affecting performance and outcome. First, planning has an influence on the morale of both the counselor and the client. It is for this reason that planning is intrinsically linked with goal-setting activities. Although it does not eliminate the unmotivated client syndrome, a first step is taken to deal with the problem. Second, inherent in the above statement is that planning affects productivity on a personal level. Well-constructed planning forecasts the degree to which the counselor, the client, and the agency as a whole accomplish tasks. Third, planning is essentially a problem-prevention activity and thus is an integral function in a proactive counselor's repertoire. Without adequate planning, rehabilitation professionals direct attention to planning as the one goal, when in fact, "it is a common direction in which the caseload manager, the client, and the program are moving" (Cassell & Mulkey, 2004, p. 259). Planning is the conscious selection of successive plans, one building upon the other, and the creation of successful and informed outcomes.

Organizing

The cluster of skills involved in organizing initiates a true action function, and focuses on the establishment of the next priority that will engage the caseload manager. Although planning is a somewhat passive mentalor largely non-observable activity, organizing involves actively bringing resources together. Such resources include people, financial resources, placement sources, and equipment to establish the most beneficial pattern for attaining established goals. At this level the rehabilitation professional functions analogously to a "managerial architect." That is, the manager directs efforts toward laying the foundation for integrating people variables with all the intricacies of financial and budgetary demands and other hardware elements. At the same time, the manager attempts to arrive at a coordinated balance of people and supportive variables that will stand the test of time.

Organizing is a priority and can be viewed as having two prime response-demand areas that elicit action from counselors: (1) structural demands and (2) humanistic demands. *Structural demand areas require* a rehabilitation professional to

1. clarify responsibilities with the rehabilitation supervisor and other professionals in the rehabilitation unit.
2. clarify with clients who the responsible parties are for particular aspects of the rehabilitation program or plan.

3. deal with centralization versus decentralization of authority in a rehabilitation unit. That is, does the maturity level of the counselor and the latitude given by the supervisor match? Often, the counselor's "track record" is the determining factor.
4. determine the span of control, or establish the conditions or limits over which a counselor may effect control. For example, there is a limit to the number of clients a counselor can manage effectively.
5. establish standards, boundaries, or goals against which one can structure action steps.

Humanistic factors come to bear on the organizing functions when we realize what part the following elements play:

1. Mental set or attitudinal factors can create chaos with this function if adequate preparation does not precede action.
2. Motivation is an important consideration in organizing if we realize that the absence of motivation sets the conditions for procrastination and thus ill-defined organizational attempts.
3. Centralization versus decentralization becomes a central issue here as well. The counselor who effectively manages a caseload will learn the practicality of decentralizing control to clients when working jointly toward rehabilitation goals.
4. Finally, organization always precedes commitment to action. Organizing is the first personal contact with any initial steps toward program implementation. If the act of organizing is not followed by sequenced steps, guilt and personal condemning behaviors will likely result.

After correctly identifying the organizational cluster of skills, it is important to note the simple conceptual steps for organizing. According to Cassell & Mulkey (1985, p. 49), these steps include

1. *Sizing:* Analogous to the preparation of a wall for its wallpapering, this step requires the counselor to set the conditions for organizing activities to occur. Involved is the collection and integration of all relevant data into a framework that at this stage does not pass judgment on the information units gathered.
2. *Patterning:* Patterning or "chunking" is the process that cohesively brings together related elements and rejects other elements until they are similarly patterned.

3. *Selective Ordering:* Now, the process or organizing begins to take form. Chunked elements begin to demonstrate attached values that mentally prioritize them for the action phase that follows. With a definite structure for ordering, the initiation of actions becomes less formidable and procrastination is thwarted.
4. *Switching:* Finally, analogous to the railway mechanism whereby movement along a set path can be redirected, organizing must also have a mental mechanism. Switching redirects the ordered chunks to the sizing phase for processing through the other steps in order to remain continually organized and thus avoid dead-ending behaviors. One is always in the process of organizing. One is never in actuality organized.

Coordinating

The coordinating function has long been recognized as a major counselor responsibility. Many authorities have attempted to assign coordination as the only function of a counselor, whereas others have attempted a compromise position centering on a balance between coordination and counseling. However, our earlier discussions on roles and functions have eliminated this controversy. If debate were necessary, then the reader should now be able to make a point for a "counselor-planner" controversy or a "counselor-organizer" controversy. However, in the past, the extensive emphasis in the literature and discussions in the field have put the coordinating function on center stage for so long that the reader may find it difficult to grasp the significance of the remaining functions necessary for effective management of caseload responsibilities.

The major emphasis in the coordinating area is the responsibility of linking together the requirements of many divergent systems. Counselor-managers must function as buffers between the demands of the case management system for moving cases through the system and the demands of the service delivery system of training facilities, placement sources, and so on. They must also function as buffers between client system variables such as client restoration needs, motivation, and skill levels. In the public sector, a counselor-manager must be an intermediary between state-federal mandates and the limitations of available services. In comparison, private-sector practitioners must be intermediaries between insurance companies, attorneys, worker's compensation boards, and client needs as they relate to the restrictions placed on rehabilitation service strategies.

C. H. Patterson (1957) first posed the question that rehabilitation professionals have long pondered, whether they are counselors or coordinators.

Patterson reflected solely on the skill clusters in the area of counseling. Therefore, "those educators and trainers who followed this lead (event to the present day) disparage management functions, when in fact, these are crucial to the counselor-manager equation" (Cassell & Mulkey, 2004, p. 260). However, without either, the equation deteriorates and the rehabilitation professional becomes lost in the myriad of caseload management priorities.

The skills necessary for being an effective coordinator include the ability to recognize and access community resources. That is, the professional must be knowledgeable and alert to the rehabilitation entities that will be most cost effective when trying to meet the objectives for the program strategies on the caseload. Coordination challenges the rehabilitation professional to become a link between client needs and the wide range of possible services available to meet those needs. Therefore, the rehabilitation practitioner must develop the comprehensive skills that will enhance performance and personal functioning, and contribute to power communications (Cassell & Mulkey, 2004).

Directing

Directing involves putting into action the preparations made during the previous functions. Once again, the synergy aspects of skills clusters are evident; planning plus organizing allows the rehabilitation professional to make and enforce decisions. Therefore, directing provides the action from which each of the previous skills will operate. In its less obvious form, directing is closely allied with coordinating and becomes the end result of a coordinating-directing cycle (see Figure 2.4).

Other rubrics that fall into the directing category are sometimes elevated to separate functions. The most commonly listed activities are (1) motivat-

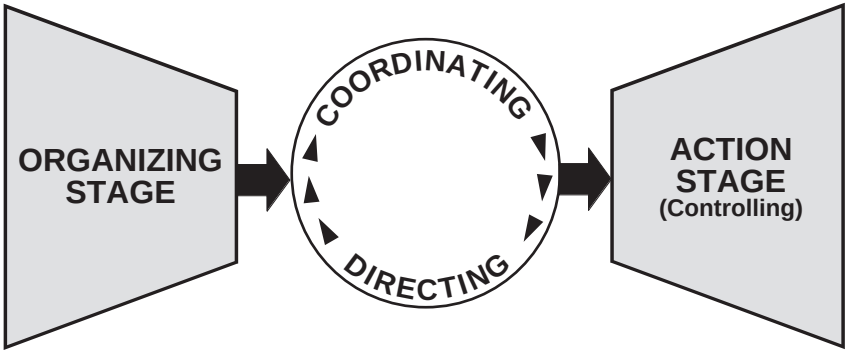

FIGURE 2.4 The Coordinating-Directing Cycle

ing, (2) communicating, (3) leading, (4 guiding, and (5) executing. A more parsimonious conceptualization of the activities and duties of the counselor-manager is satisfied if we consider these activities as key elements under a directing function.

Rehabilitation counselors preparing themselves for effective caseload management will do well to become fully aware of the directing function, even though at the outset their involvement may appear minimal. Directing has basic elements that must be understood, and the act of directing a natural process will allow a counselor-manager style or relatively consistent approach to evolve (Cassell & Mulkey, 1985). Directing is probably the weakest of the skill clusters. "Logically, this is evident because directing skills, endowed with pointing, steering, leading, instructing, regulating, and administering behaviors, are perceived as an antagonist to counseling orientations, imbued with helping, supporting, and empathic behaviors" (Cassell & Mulkey, 2004, p. 262). This statement is sometimes misunderstood as a "hard-hearted," non-empathetic approach to working with c1ients. But such is not the case at all. The point is that clients, as a rule, are indeed placed in a subordinate role by virtue of their call for assistance and lack of personal resources to achieve a higher status. Therefore, clients look to counselors for guidance, to be led toward goals. However, sometimes professionals who are heavily weighted by a pure counselor orientation overlook the subtle power of directing a client to become empowered. Thus, counselors who display a command of situations and exude an aura of solidarity in their approach to clients obviously will have clients who will begin to model these behaviors for their own positive outcomes.

A second element that builds on the first is the motivation of clients and staff members for whom the counselor is responsible. Here, directing or leading entails issuing responses to clients that give them the personal motivation to achieve expectations. Several research studies have addressed the importance of teaching the manager the effective guiding of clients' initiative (Oncken & Wass, 1974; Parker, 2002; Seitel, 1984). The rehabilitation professional is encouraged to learn to transfer the initiative to clients, thereby allowing them to make informed choices. There are five levels of client initiative (Cassell & Mulkey, 2004; Oncken & Wass, 1974; Parker, 2002):

1. waiting to be told what to do,
2. asking what the next thing to be done is,
3. recommending a course of action, and then taking some form of action,

4. actually taking action on one's own but reporting immediately to the caseload manager that the initiative has been taken, and
5. acting on one's own behalf and only reporting on a routine basis.

A final element of directing is maintaining a disciplined approach to managing self and others. The counselor-manager must respond appropriately with correct reinforcers to continue or stretch beneficial behavior streams and modify unwanted behavior patterns by redirecting them. Directing will emerge naturally as a relatively stable style or pattern of responding to clients and others who are responsible to the counselor-manager. These styles are intrinsically linked, of course, to personal attitude, structure, motivational base, and one's value system. Styles for directing are grouped into four categories (Cassell & Mulkey, 1985; Hersey & Blanchard, 1972). The caseload manager should be aware of the factors making up these four categories. Through introspection, counselors will come to recognize which style they display. According to Cassell & Mulkey (1985), these four styles of directing include

1. *Dictatorial directing*: Here the counselor achieves results through intimidation and fear. Criticism and negativism are the counselor's tools for attempting to relate with clients, colleagues, and subordinates. The dictatorial approach can appear in a blatant form but most often its powerful effects show up in more subtle ways such as inappropriate humor, sarcasm, put-downs, and the like. This approach will often get quick, but only short-term, improvement in performance in the desired direction.
2. *Benevolent autocratic directing*: Here the counselor-manager presents a very forceful yet benevolent approach to guiding clients through the rehabilitation process, and clients are willing to allow themselves to be dictated to because of the nurturing atmosphere. However, dependency sets in and client movement is nil when the counselor is not present to direct such movement consistently. Most clients will allow themselves to be guided readily by this type of directing, which further worsens the problem.
3. *Democratic directing*: This type of directing is participatory and involves clients and counselors alike. Clients become involved at the outset in establishing individualized written rehabilitation programs, decision making in career choice and job selection, general organization, and movement toward goals. Motivation and morale are high

and intrinsic rewards are plentiful. Usually, this is the most acceptable of the four styles presented.

4. *Laissez-faire directing*: This is not actually a form of directing as no leading is offered. Clients and others responsible to the counselor must generate their own goals, initiate movement, and presumably sustain it. All too often, this style is adopted by default because of the counselors' own career choices, overcommitments, pressures from high caseloads, and the like.

These four styles establish a base for understanding the many facets of directing. A danger here, however, is that the four styles portray the counselor-manager as having rigid approaches to caseload management, which may not be the case. That is, the counselor could be put into an "either-or" mold, when, in fact, each style may come into play under particular sets of circumstances. Again, the purpose here is to broaden understanding of the directing function. In order to realize fully what is involved in approaches for managing the complexities of caseloads, a more lengthy treatment of styles is included later in this chapter.

Finally, directing involves numerous patterns. These include effective communication, appropriate leadership, and motivating clients. Directing is a style that can be learned. However, it often requires the rehabilitation professional to shift paradigms from a pure counseling orientation to instructing and channeling constructive actions on the part of the client (Cassell & Mulkey, 2004). For it is by this shift that clients are permitted to experience "the rewarding opportunity of establishing internal control over their own processes, thereby enhancing stable, lasting rehabilitation results" (Cassell & Mulkey, 2004, p. 263).

Controlling

Controlling is the last of the skill clusters that direct the previous skills within operational boundaries. In this model of management, the controlling function forms a base or central position that has a significant impact on each of the other four functions. Controlling is drawn out as a separate entity in the paradigm, but this aspect of managing interweaves the previous skill clusters and pulls them into a system of codependent patterns of choice making, action initiating, and results assessing, and ensures consistent repetitions of the cycle (Cassell & Mulkey, 2004). Figure 2.5 depicts the relationship that all of the functions have to one another. Controlling appears as a separate but

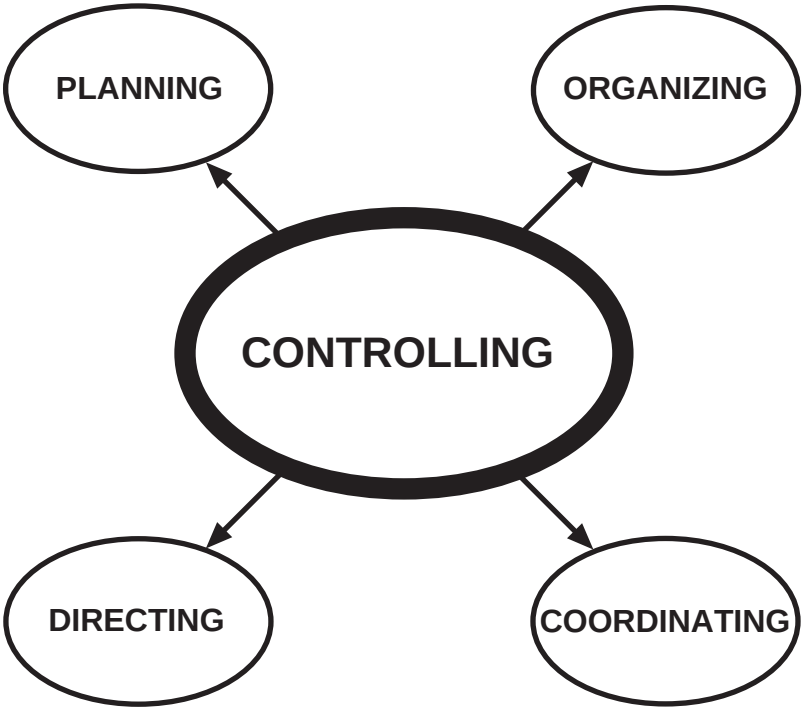

FIGURE 2.5 The Five Essential Functions of Management

interlinked function. As an essential component of this management model, controlling is involved in all the activities counselors perform.

When considering organizing, coordinating, and directing, the rehabilitation professional again is focusing on control elements. Thus, control pervades the entire gamut of activities performed in managing a caseload, and requires separate attention in this model of management. Chapter 3 is devoted to issues and concepts surrounding the establishment of control in caseload management, and the majority of our discussion on this key element will be deferred until then.

Although these five functions of managers are given separate treatment, each skill cluster activity, as mentioned earlier, has links with the others, and rarely does any one stand alone. One activity may come to be the function of the moment, but the manager must draw from all the remaining functions to execute, in a coordinated and systematic manner, the tasks involved in the caseload management process.

It has been stated previously that caseload management is the key to effectiveness (Cassell & Mulkey, 1985; Henke, Connolly, & Cox, 1975). In order to acquire this easily stated but difficult-to-achieve effectiveness, a mature rehabilitation professional must be able to take all the elements of a caseload management process and form them into an operative gestalt. Control is a strong variable that many rehabilitation professionals believe is out of their parameter of practice. Therefore, it is only after the self-actualized manager has internalized or owned these components that effectiveness may result. In the final analysis, the key to effectiveness becomes (1) the attitudinal-motivational level of counselors, (2) the style with which they approach caseload management demands, and, in general, and (3) their willingness and ability to accept and employ equally both the self-actualizer and manager roles.

A counselor can be an *efficient* caseload manager without being an *effective* one. Excessive energies directed at short-term goals and easy to achieve outcomes with low value for more encompassing, longer-range goals will never guarantee the effective practice of caseload management. On the other hand, counselors who demonstrate a great deal of efficiency are often accused by peers of being ineffective, because in their conceptualization of the process, both role functions cannot occupy the same professional work space simultaneously. The erroneous reasoning here is that a concern for client welfare is sacrificed in order to deal with other caseload management concerns. The error is tipping a hypothetical concern scale (see Figure 2.6), which leans more toward the self-actualizer role, thus, creating an imbalance. However, it is important to note that counselors cannot be effective without being efficient, and that can only occur if they accept programmatic goals and client concerns as equal responsibilities.

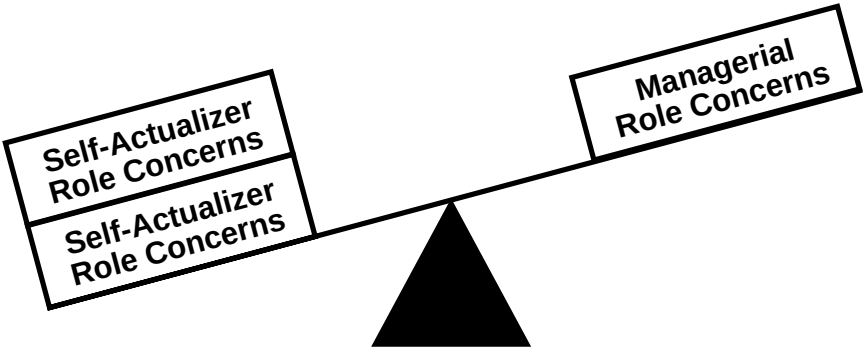

FIGURE 2.6 A Caseload Management-Concerns Scale

SKILLS OF A CASELOAD MANAGER

It should be clear by now that caseload management is a *process* founded on principles encapsulated within the complete roles, functions, and responsibilities of counselors. The concepts described above must be established firmly as a counselor's own personalized base before the process concepts become viable alternatives. Thus, the process concepts are needed to bring this management model into a state of maturity.

The birth of a process (through Base Concepts) provides a partially completed model of management that must be molded by skill patterns in order to achieve, in the end, the status of a system. The skills to address the management of a process should not be so refined or specific as to address a multitude of discrete actions. This enumeration of every skill to match small units of action would not be descriptive of a model, but rather would resemble a programmed learning situation. Instead, for a conceptual model, the skills should be global in nature to address the groups of actions required. Thus, within each group of actions there can be specialized skills developed to provide the basis for daily functioning on the job.

By way of a working definition, clusters of skill patterns are collections of overt action sequences or organized passive response patterns that bring process elements and expected outcomes together at the appropriate time (see Figure 2.7). Skills are intermediate links that bridge or close an "expectation–results gap." That is, such mental activities as perceptual awareness, foresight, and insight can only set the stage for what the counselor would hope to see happen (Cassell & Mulkey, 1985). This, of course, can leave the counselor at a considerable distance from the goal of realistic outcomes. Positive and consistent outcomes can be achieved only when certain skill patterns are acquired that keep a multitude of variables within manageable limits. For example, let us say that an expected outcome is career planning with clients. In this instance, process variables might be agency or organizational requirements to get clients through a successful vocational program to gainful employment. Therefore, skill patterns would include, for example, the activities of (1) assessing functional limitations of clients, (2) selecting, administering, and interpreting vocational testing-screening with clients, (3) reconciling medical facts of client conditions with client motivation and job-market availability, (4) conducting employer-employment negotiations, (5) choosing and carrying through the appropriate counseling approach required for a specific client, and (6) organizing these various components into a conceptual, functional program in which all parts fit together in a coordinated manner (Cassell & Mulkey, 1985). By concentrating on separate skill patterns, we have a means for taking a complex array of everyday demands, and,

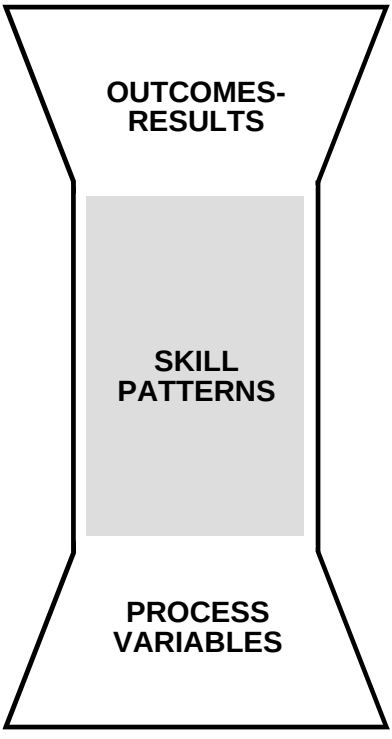

FIGURE 2.7 The Function of Skill Patterns in a Caseload Management System

by acting on management-type responses, we can more accurately match expectation with desired outcome.

Skill patterns may be acquired through combining experience and task-relevant education and training programs. However, to understand more fully what one must acquire, we need to look briefly at the basic groupings of skill patterns. Overall, the effective caseload manager should possess sufficient levels of four encompassing skill patterns—Technical Skills, Human Skills, Conceptual Skills, and Implementation Skills. These skills are described in the following discussions.

Technical Skills

Technical Skills are established, sequenced, directive patterns that allow one to affect one's immediate environment by drawing from acquired past knowledge, methods, and techniques (Cassell & Mulkey, 1985). Technical Skills include, for example, the methods and techniques for counseling

and for processing cases through an organized system, the use of mandatory guidelines and policies of the organization for which one works, and the finding of appropriate vocational positions and assisting in the placement of clients. These concrete skill patterns are oriented toward getting the actual job done (achieving goals and production outcomes) with the activities required for one's professional specialty, which in this case is the rehabilitation of people. Technical Skills are also the support mechanisms that extend to the Human and Conceptual Skills. The continued application of these skills is influenced positively or negatively by the discovery of new, more efficient means of manipulating elements in one's environment; by obsolete skills in the face of rapid change; by legislative mandates; and by rule or guideline changes.

Interpersonal Skills

Interpersonal Skills are established, sequenced, relational patterns giving one the ability to relate with others, and, in general, to work for fulfillment of personal, client, and agency or company objectives. These skills exhibit a concern for the welfare of people rather than for the system or larger processes of which the clients are a part. Counselors should possess adequate skill in this area to enable them to work through potentially thwarting barriers that can prevent them from knowing the people with whom they work. Interpersonal Skills allow counselors to be fully aware of the complexities engendered by feelings, for example, the differences among empathy, sympathy, and unconditional positive regard, while also motivating and encouraging others (ten Have, ten Have, & Stevens, 2003). Counselors with good Interpersonal Skills must be able to create a setting in which true two-way communication occurs, and they must know when to allow latitude in freedom of expression, as well as when it is appropriate to dominate or lead for therapeutic purposes.

Interpersonal Skills are a given for the self-actualizer-manager in rehabilitation, but they are not inherent or automatic. Whereas Technical Skills can reach a high state of completeness or efficiency and can be relied upon for action over time without a great deal of maintenance, Interpersonal Skills cannot. These Skills patterns must be constantly rehearsed, examined, updated, and elaborated upon. Interpersonal Skills patterns never "arrive" or reach a state of completeness; they are always in a state of change. The continuance of these skills at high levels is often hampered by the counselor's personal frustrations, internal conflicts, and confused values system, all of which must be corrected before higher skill levels can be attained.

Conceptual Skills

Conceptual Skills, as applied to caseload managers, are established, sequenced, mental patterns giving one the ability to understand the total working of an organization or a process (Cassell & Mulkey, 1985). It is the ability, for example, to visualize where individual goals and objectives fit into the larger whole. It is the ability to select quickly the significant indicators for success with clients, as well as pinpointing early where problems or obstructions are likely to occur. It is the ability to grasp the gestalt firmly and quickly.

Conceptual Skills include the ability to gather information about and from clients through case data, interviewing, and counseling, and then to put the information into a balanced perspective and to select a direction toward which the process must move in order to achieve a state of rehabilitation with a client. Conceptual Skills involve the ability to "put it all together," to sense correct action paths in the face of conflicting objectives, to work within a "big picture" perspective, and to operate effectively from an intuitive base. It is the total understanding of how all components fit together to ensure client welfare (Introna, 1997).

Skill patterns falling into this area are difficult to acquire if the counselor does not come to the job with already-established generalization abilities. The ability to hold a great number of factors constant while attempting to fit them into a workable whole for each client in a variety of settings is difficult to train for if the counselor has not already developed this ability early in life. However, to enhance skill levels, the counselor must learn to control time pressures, conquer the fear of failure, and cease trying to be all things to all people. In other words, excessive internally created pressure will almost always thwart the development of Conceptual Skills patterns (Cassell & Mulkey, 1985).

The growth of these skills is either enhanced or hampered by the counselor's extent of information gathering, e the ability to be future-oriented in one's perspective, and the ability to maintain a healthy, creative working relationship with data, people, and things.

Implementation Skills

Katz (1974) suggests that all effective managers require a functional level of competence in multiple areas of skills (Technical, Conceptual, and Interpersonal), but his model falls short. These skill patterns lack force, dynamism, or a base for movement. Thus, our conclusion is that due consideration must be given to Implementation Skills.

We have seen that Conceptual Skills provide a perceptual base or establish proper functional boundaries. Technical Skills become a foundation for action by providing specialized response modes, and Interpersonal Skills assist in establishing a medium for the latter two skills to occur or interact. However, some personal force or driving mechanisms are needed to gather these skills into a gestalt for a successfully managed program. Implementation Skills provide those mechanisms for action. They involve such elements as personal motivation, personal energy levels, individual commitments, professional commitments, acting on established priority systems, and the attitude posture of the counselor. A certain amount of skill is required to select the proper reinforcers, to maintain one's motivations at a high level, to develop the assertive force required to make one's personal energy levels work for rather than against one, to develop techniques for overcoming complacency and procrastination, and to continually replace tendencies for inaction with the impetus to act (Cassell & Mulkey, 1985).

Few counselors recognize the importance of the above statements and this discussion. Few recognize that the act of implementation actually consists of learned skill patterns. Many counselors sit placidly waiting for some external energy source or some act of providence to bring about implementation of client and agency goals. With counselors' awareness of implementation as a skill process containing components that must be learned, rehearsed, and practiced, this process should become more frequent and should result in higher quality program success for counselors, clients, and both the public and private rehabilitation structure.

STYLES OF ADMINISTERING A CASELOAD

Counselors can, indeed, acquire the skill patterns discussed above, but they often need some starting point from which a system of responses can be built. Earlier it was suggested that anxiety is a major barrier to acting skillfully, and it is known that ambiguity replaced by structure is a major way to combat anxiety. Another rubric for structure is the model concept. Thus, if the counselor can develop an adequate model that allows gains to be made in acquiring the skill patterns described above, reinforcing structure will have replaced ambiguity as a base on which to build a system or counseling approach. The model to be described below will provide information in the area of Technical Skills by suggesting how one deals with the management of tasks or activities of a technical nature, and information on Interpersonal Skills by suggesting how one deals with relationships or the people factor. As these two areas are discussed jointly, and discussion also involves how

they interact with one another, we have an instance of how we develop our Conceptual Skills as well, because we are getting the "big picture," not just parts and process. Thus, one's ability to manage the entire caseload can be given a significant boost over mere trial and error as a management approach.

In a continuing effort to provide the rehabilitation counselor with an adequate awareness of those various elements necessary for constructing and administering a personal management model, we will now concentrate on the second phase of our Process Concepts: Managing Tasks, Managing Relationships (see Figure 2.1). This phase involves equally significant, dichotomous areas of responsibility under which all functions performed by counselors can be subsumed. We are focusing on the interaction between managing tasks and managing relationships, and we want to learn the conditions under which counselors will centralize their efforts in these two areas for maximum effect through full utilization of their management abilities.

As the administrator of a caseload, a counselor is always responsible for activities linked with task and relationship variables. In Table 2.2 one can examine examples of what sets these areas apart as distinct management concerns. If the administrator of a caseload is not fully aware that these dichotomous areas exist and that appropriate timing for adopting an appropriate style of administrative action is required, then the administrator cannot hope to be an effective or efficient caseload manager.

This brings up an important observation concerning the interrelationships among counselor variables, client variables, and the particular situations under which counselors and clients operate. The observation is that the effective administration (EA) of a caseload is a function of counselor (CO), client (CL), and situation variables (S):

$$EA = f\,(CO, CL, S).$$

Effective administration will be a function of all *three* of these sets of variables *all the time*. The effective counselor then must take into account responses to such guiding questions as (1) What are the prevailing needs of the client? (2) What are my biases, attitudes? (3) What pressures or forces are there in the situation under which my behavior and the client's behavior are operating (e.g., the family's involvement, resources presently available, attitudes toward a certain disability group in the work force)? Thus, the counselor must develop a style of administration that will be maximally effective to control the three variables as they interact.

TABLE 2.2
A Comparison of Task and Relationship Styles

Task Styles	Relationship Styles
Global Behaviors	**Global Behaviors**
• Sets conditions for accomplishing goals through priority- and objective-setting exercises.	• Maintains clients as a group within cohesive limits.
• Has a concern for production, output, and end results.	• Demonstrates a high concern for people variables—their feelings, attitudes, and anxieties.
• Works primarily with policy concerns and agency procedures for getting the job done.	• Sets pleasant conditions for therapeutic interactions to occur.
	• Provides the appropriate socioemotional support to clients when situational demands are high.
Discrete Behaviors	**Discrete Behaviors**
• Constructs Individualized Plans for Employment.	• Helps clients evaluate their strengths and weaknesses for solving personal-familial-situational problems.
• Moves cases from status to status appropriately.	• Initiates self-direction and independence in clients.
• Sets time frame for goal accomplishment for self and client.	• Helps keep clients self-motivated at appropriate levels through positive urging and encouragement.
• Keeps clients moving sequentially forward toward work goals.	• Allows clients the opportunity to get the most from their potential.
• Sets vocational objectives with clients and assists with placement activities as required.	• Makes clients feel comfortable and secure in interview and counseling settings and sessions.
• Gathers psychological and medical data for casework purposes.	• Keeps interactions with peers and supervisors at a facilitative level where personal communication can readily occur.
• Interprets psychological and vocational results with clients.	• Helps clients gain insight into their adaptive behavior patterns and causes for emotional upheaval.

The following discussion will examine the process of selecting a response style for daily situations that takes into account the interaction between task-oriented and relationship concerns. Background information will provide the reader with past and present perspectives on the development of styles of

administration. Then, an explanation of the four basic administrator styles will be presented that will make the counselor aware of the most appropriate style to select for the demands of the particular situation.

The concept of developing adaptive styles for administering a caseload is not new. The reader may consult Fielder (1958, 1961, 1967), and Stogdill (1956). Hersey and Blanchard (1972), Cassell & Mulkey, (1985), Glass (1991), and ten Have, ten Have, & Stevens (2003) provide more elaborate discussions on the development of styles. However, their discussions will be couched in terms of styles of leadership. We see the discussions on administration and leadership as emanating from the same base; thus there are no conceptual or real deviations of any consequence. That is, the counselor must fulfill a leadership function when dealing with the responsibilities of guiding clients toward rehabilitation goals, developing resources for restoration and placing clients in adequate community living environments, and dealing with supervisors, peers, and other organization structures. We strongly urge readers to assess their style of leadership. The Hersey and Blanchard (1972, 1974) inventory is especially recommended. It is available and easily understood. Much of the discussion to follow is centered upon their work.

Task Response Style

Developmentally speaking, the earliest administrator styles arose from an organization base. That is to say, the end toward which an administrator worked was to fulfill the organization's needs or demands. This technological approach viewed humanistic elements as subordinate to fulfilling policy and guideline demands. However, administrators of caseloads who operate from a strictly task-oriented base might be seen as consistently coercing clients into conforming to the demands and needs of the organization, and the counselor would probably not adjust the structure to accommodate the needs of clients. Through this administrator orientation, interpersonal relationships would tend to be held to a minimum, the majority of efforts would be directed toward coordinating services, and thus a task focus would take center stage. In the rehabilitation field, some evidence of this evolving style is gained from the role fulfilled by service delivery personnel in the early stages of the rehabilitation movement. In the 1920s this service delivery person was known as a rehabilitation agent rather than by the current title, rehabilitation counselor or rehabilitationist. As an agent, this individual was an instrument of the organization, an agency official who attempted to operate within the boundaries set by the organization's policies and procedures. Thus, many early management styles were essentially concerns for task or structure elements.

Human/Interpersonal Response Style

With the appearance of the work of Elton Mayo (1933), the trend in the management area turned toward interpersonal relations concerns in industry and elsewhere. Slowly, acceptance was gained for the idea that if the rehabilitation organization is to make significant gains one must deal with the real power base that emanates from interpersonal relationships or the reciprocal sharing of social-emotional support among clients and counselors, counselors with one another, and counselors with supervisors. The human relations style of administration emphasized cooperative goal setting and cooperative, coordinated efforts between client and counselor for goal attainment with the added ingredient of setting the stage for personal growth and development of clients by the removal of personally thwarting concerns. In the human relations orientation, the needs of the individuals being served were primary concerns, not the needs of the service organization.

Continuum Versus Separate Axes

Thus, with the advent of the human relations movement the opposing stem for a continuum was formed (see Figure 2.8). Administrator styles took a position at one or the other of these opposing poles, depending on whether their behavior was demonstrative of a task orientation or a relationship orientation. Behaviors of leaders falling on this continuum were seen by some (e.g., Blake & Mouton, 1985; Glass, 1991; Hannagan, 2002; Tannenbaum & Schmidt, 1958) to range from authoritarian styles (task orientation) to democratic styles (relationship orientation). At one extreme of this continuum, authoritarian behaviors call for the manager to simply make decisions and announce them to the appropriate person. However, at the opposite end, democratic manager behaviors call for larger degrees of freedom of choice for individuals operating within those limits initially defined by the structure. Again, Table 2.2 suggests some of the behavioral components at the extremes of this continuum.

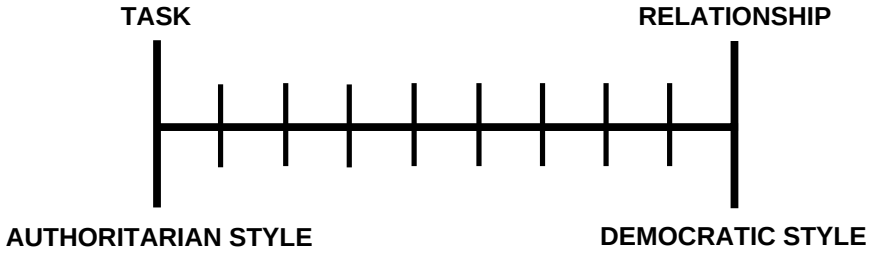

FIGURE 2.8 Continuum of Contrasting Administrator Behaviors

For example, a task behavior is to interpret evaluations with clients, whereas a relationship behavior focuses on the client's insights and adaptive behaviors suggested by the evaluations. Controversy raged for a considerable period over the most useful style that an administrator should have for the greatest control and for the most productive outcomes (Cassell & Mulkey, 1985). Some writers favored a democratic style as the sole approach. Others supported an authoritarian role as the only way to achieve adequate outcomes. Few supported a middle ground or compromise between these two poles.

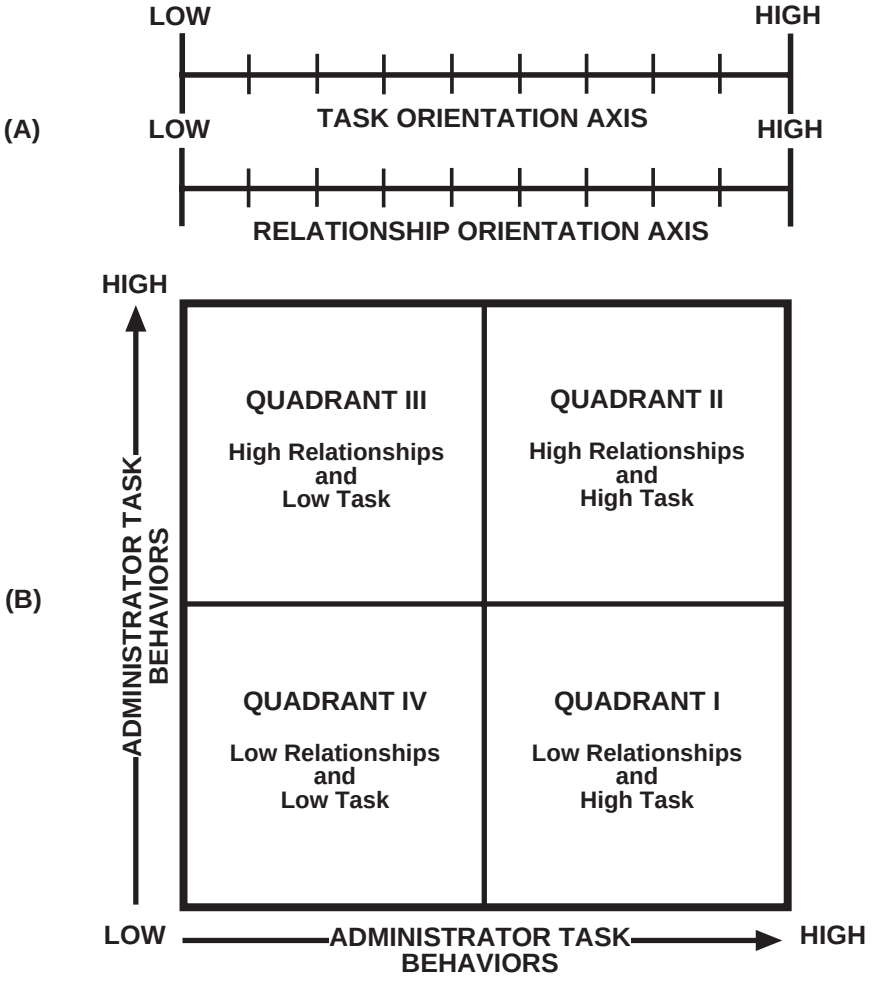

FIGURE 2.9 The Four Basic Administrator Styles for Managing Task and Relationship Elements of the Caseload Management Process

The next significant development in the quest for understanding what administrator styles or behaviors are most adaptive and productive began with what Hersey and Blanchard (1972) term the "Ohio State leadership studies." From actual observations, Ohio State University researchers attempted to demonstrate how administrators accomplish the duties and responsibilities required of them (Stogdill & Coons, 1957). These researchers retitled the task and relationship dimensions as Initiating Structure and Consideration, respectively. These terms were chosen to describe administrator behaviors as either a directive approach, focusing on the particulars of guiding the worker or client to accomplish specified tasks, or a relationship approach, taking into account such behaviors as respect, warmth, genuineness, and empathy when interacting with workers or clients.

The most significant contribution from these studies, however, is the realization that administrator styles are too complex to simply arrive at a single continuum. Instead, these styles were seen as falling on two separate axes (see Figure 2.9, part A). By placing these two separate axes in interaction we can arrive at Figure 2.9, part B, which shows four quadrants with various combinations of a task style and a relationship style.

Other researchers saw the value in this quadrant arrangement and drew upon this concept to describe manager behaviors. Blake and Mouton (1964, 1978, 1985) originated the well-known Managerial Grid, which is depicted in Figure 2.10. They viewed an administrator as having a low to high degree

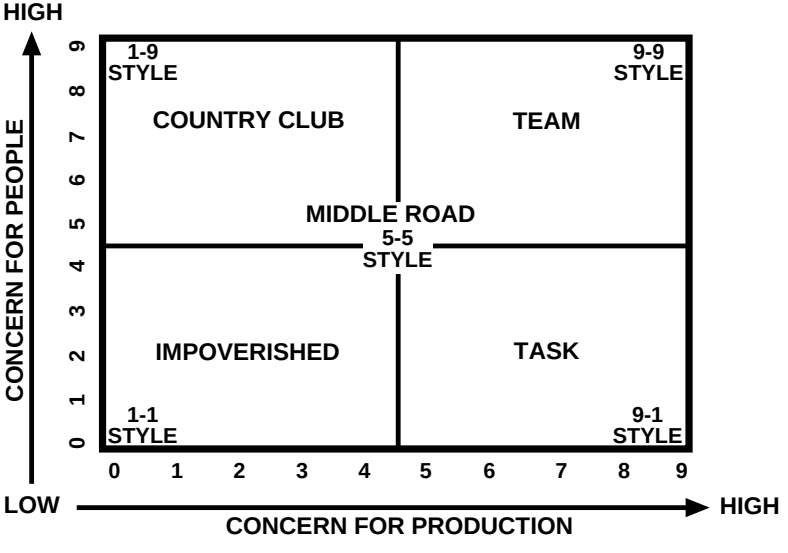

FIGURE 2.10 The Blake and Mouton Managerial Grid of Leadership Styles

of concern (one to nine) for production or a low to high degree of concern (one to nine) for people. Thus, when these two dimensions were placed onto a grid arrangement (see Figure 2.10), the styles shown become the five possible orientations that managers can adopt.

The Best Style

All of the positions on styles described above consistently moved in the direction of the erroneous conclusion that there exists one best style for an administrator. That is, for example, the relationship or democratic style is considered to be a best style; high structure and high consideration is thought to be the best style; a 9-9 is the best style; and the high task, high relationship orientation is considered the best style. Conversely, the low task-low relationship, low structure-low consideration, the authoritarian orientation, and 1-1 styles were evaluated as negative or always-to-be-avoided styles. However, results derived from these studies consistently contained unexplained outcomes, or outcomes that were explained away as error or of little consequence. The fact remained that in those studies some 1-1 administrators were successful in their settings and some low relationship, low task administrators were successful; whereas on the other hand, some high task-high relationship and 9-9 administrators were unsuccessful in their settings. These findings are, of course, contrary to what is expected from the respective models, but little attempt was usually made to deal with these contradictions other than attempts to explain them as, for example, error variance in the studies. In the final analysis there can be no one ideal style of administratorship to fit all situations. Recall the earlier discussion that focused on the situation as a third interactive component of effective administrator behavior. Thus, the situation cannot be ignored when concentrating on what is required for one to be the effective administrator of a caseload who is attempting to keep the task and the relationship under control. Therefore, the only conclusion that can realistically be drawn is that an administrator of a caseload must be capable of exhibiting a number of styles, depending on the needs and demands of individual situations.

ADAPTIVE ADMINISTRATOR BEHAVIOR

A caseload manager must be able to assess a situation correctly and to respond with the appropriate style. Thus, with some clients a 9-1 style is appropriate, whereas with other clients a 9-9 or even a 1-1 style can be appropriate. In order that a counselor be equipped with the insight and background to acquire expertise in diagnosing situations and responding adaptively to the

demands that arise, two concept areas must be explained: Maturity Level and Adaptation Cycle. (Note: In Hersey & Blanchard's work, adaptation cycle is known as "life cycle theory," and much of the following discussion emerges from their concepts.) These two new concepts and their interaction with task or structure and relationship variables will be discussed below.

Maturity Level

In an Adaptation Cycle conceptualization, the level of maturity of a client or person coming under the responsibility of a caseload manager plays a significant role in the behavior of that administrator. That is, as the maturity levels of clients increase, less task or structure emphasis is needed while the relationship dimension simultaneously becomes increasingly necessary until a high level of maturity is reached. This interaction is depicted in Figure 2.11.

As Figure 2.11 points out, at low levels of client maturity the emphasis on task variables is high whereas there is a much lower emphasis on the relationship. Also, as the maturity levels of clients go up there is less emphasis on the task dimension but the relationship dimension gains in relative importance. However, after reaching a midstage level of maturity, between immaturity and functioning maturity, even the emphasis on the relationship

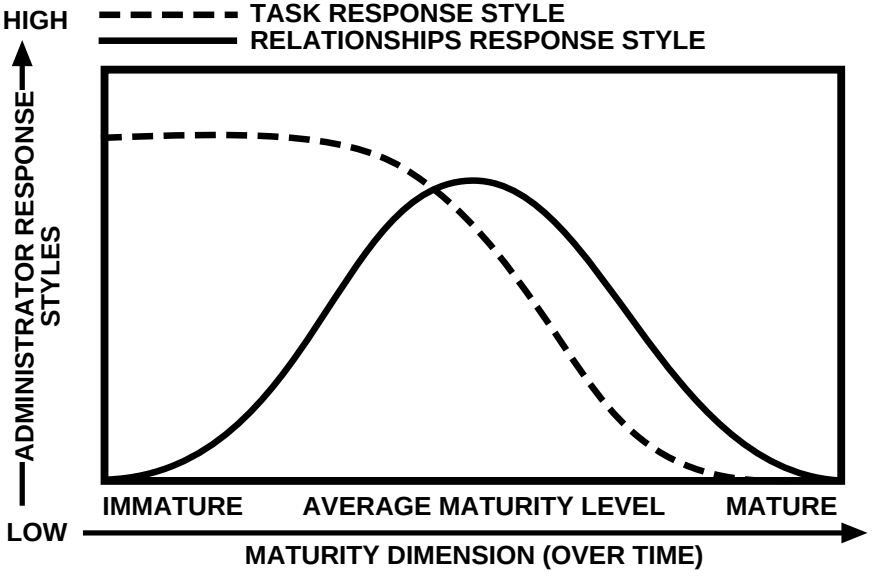

FIGURE 2.11 Interaction Between Administrator Response Styles and Client's Maturity Levels

dimension loses its prominence as a significant force in the interactions. The client is gaining in autonomy and the therapeutic relationship is no longer an urgent requirement. For the purposes of this Adaptation Cycle explanation, maturity is defined by Hersey and Blanchard (1972) as follows: (1) achievement-motivation of clients, (2) the ability and willingness to own one's behavior and take responsibility for it, and (3) the education and experience one has accumulated that is relevant to the task or goal to be accomplished. Thus, age is not considered a relevant issue; maturity is considered to develop along psychological dimensions, not along a chronological continuum.

Adaptation Cycle

Let us look at the conceptualization of the Adaptation Cycle, or Life Cycle Theory (Hersey & Blanchard, 1972) and see how the maturity level of the client, the task or structure factors, and the concern for relationships all interact to provide an effective administrator model for the caseload manager.

Figure 2.12 shows an integrated model with the complete Adaptation Cycle, the task dimension and relationship dimension, and the maturity–

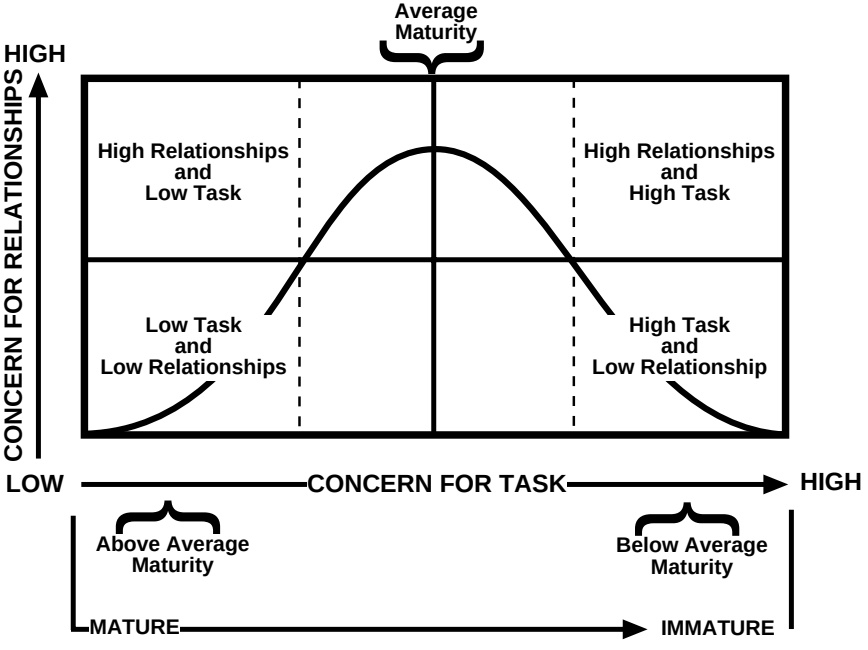

FIGURE 2.12 The Adaptation Cycle Showing the Relationship Between Maturity Levels and Concern for Task and Relationship Variables

immaturity dimension included. The Adaptation Cycle suggests that as client behaviors move from immaturity to maturity the administrator or caseload manager's correct response style should move from

1. High Structure-Low Relationship Counselor Behavior,
to
2. High Structure-High Relationship Counselor Behavior,
to
3. High Relationship-Low Structure Counselor Behavior,
to
4. Low Structure-Low Relationship Counselor Behavior.

Let us then go step by step through this model with an example in order to come to a complete understanding of its workings and usefulness for the counselor.

Look first at Quadrant I (high task-low relationship, or 9-1 style, Figure 2.13). This figure reveals, first, that in this quadrant client behaviors are within

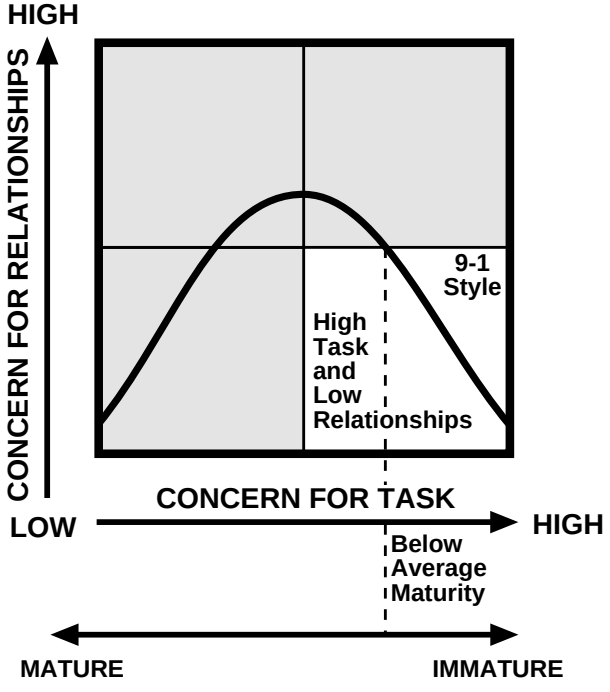

FIGURE 2.13 Quadrant I of the Basic Administrator Styles and the First Segment of the Adaptation Cycle

the immaturity area and, second, the counselor must respond with high task-low relationship behaviors in order to be maximally effective and to satisfy the client's needs. Let us assume we are accepting a new referral and we are interviewing the person, discussing policy, procedures, regulations, diagnostic examinations needed, and future goals and plans. In short, we are emphasizing task behaviors and giving structure to the unaware individual. We are saying we have observed that this client has deficiencies in achievement-motivation, ability and willingness to take on responsibilities, and task-relevant education (these are aspects of the maturity definition discussed earlier). The counselor, then, responds with high structure and low relationship. Notice we say low, rather than no, concern for giving socioemotional (relationship) support at this time.

Let us suppose that the client is showing progress, that is, movement toward a higher maturity level is evidenced. The client has made gains in the three areas defining maturity and is now at a midstage maturity level. On the mature-immature dimension the client can no longer be described as immature, but the client also is not showing enough autonomy to be placed in a mature stage:hence the designation midstage maturity. At this point the Adaptation Cycle has moved to Quadrant II (see Figure 2.14);

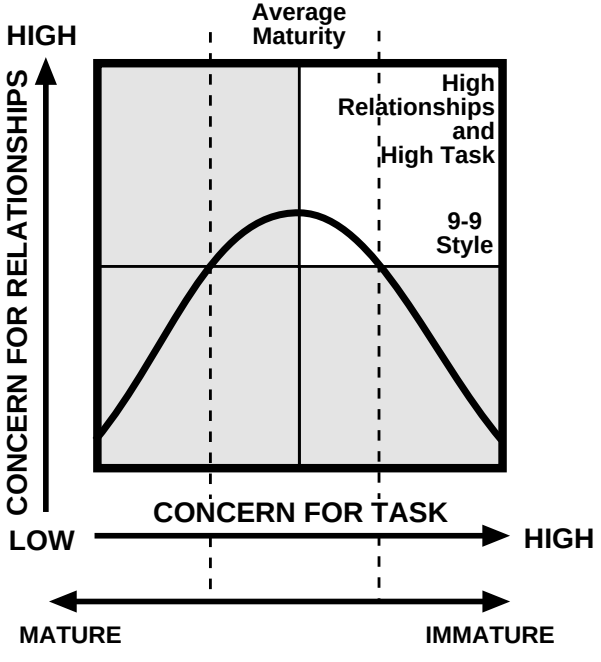

FIGURE 2.14 Quadrant II of the Basic Administrator Styles for Managing Tasks and Relationship Elements of the Caseload Management Process

the high task and high relationship quadrant. At this time the counselor's orientation should be to continue to emphasize structure or task elements, but now the timing is appropriate for increasing socioemotional support. Relationship factors are now of high concern for the client. If the counselor had provided too much relationship before the client had gained in maturity, this counselor's behavior quite likely could be viewed as too lenient and permissive. Thus, the client could grow in dependence on this counselor's willingness to subvert structure or task elements for a friendly, "feeling good," "ego massaging" environment.

If the client continues to show good midstage maturity level behaviors, Quadrant III (high relationship-low task) can become appropriate when the client appears ready to accept these kinds of counselor responses. Figure 2.15 shows that we have now moved to include Quadrant III. Here the counselor's style is to continue to provide socioemotional support but at this time there is a marked decrease in the emphasis on structure or task elements. Now, the client is assuming more and more self-control in the rehabilitation program. The client's self-direction and internal control are providing self-initiated goal

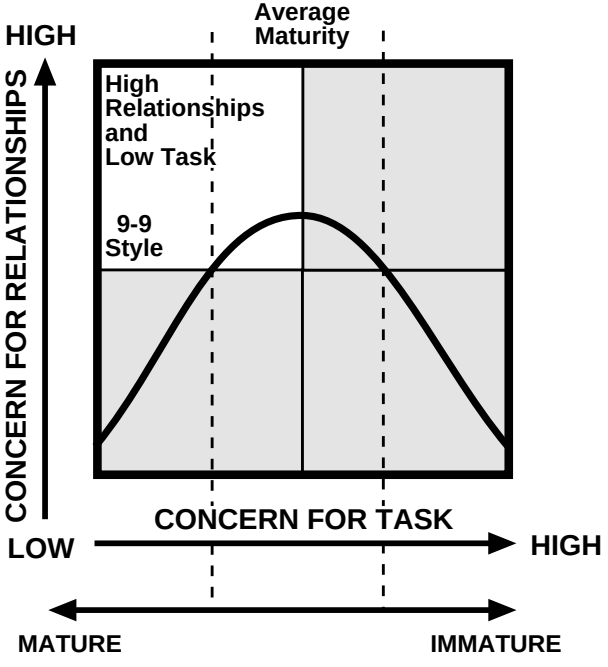

FIGURE 2.15 Quadrant III of the Basic Administrator Styles for Managing Tasks and Relationship Elements of the Caseload Management Process

setting and motivation to achieve these goals. The counselor continues to be available to provide support and positive affect when needed.

Finally, we come to Quadrant IV, low task-low relationship (see Figure 2.16). We are now at the highest level of maturity; the client is functioning quite adequately in the areas defining maturity level and requires little socio-emotional support and little task emphasis. The client is rehabilitated, for the most part, and the case is near closure. As Figures 2.13–2.16 demonstrate, with immature clients Quadrant I behaviors are most adapting. Clients at a midstage maturity level require Quadrants II and III. Finally, clients of adequate maturity need only Quadrant IV counselor responses.

Now, we must consider the reason the Adaptation Cycle includes the cycle concept. Suppose at this point (Quadrant IV, low task-low relationship) a crisis arises and the client's maturity level wanes (e.g., achievement-motivation declines or willingness to accept responsibility decreases). According to Hersey and Blanchard, the next activity to occur in the Adaptation Cycle model is that the counselor's style of responding moves with the client back to Quadrant III.

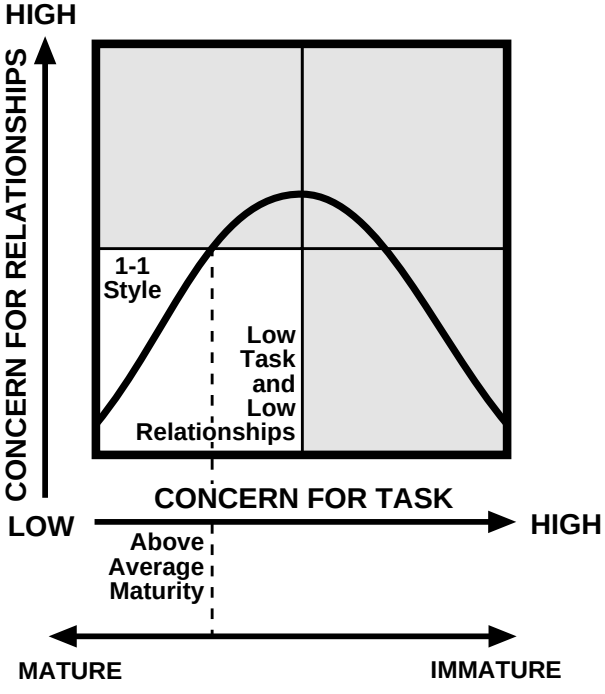

FIGURE 2.16 Quadrant IV of the Basic Administrator Styles for Managing Tasks and Relationship Elements of the Caseload Management Process

Again, the counselor begins to respond with increased socioemotional support and does not yet emphasize structure elements with the client. To do so at this point would lower still further the client's maturity level and limit progress. If the crisis deepens and the client's ability to adapt slide further down the scale, it is appropriate to impose structure on the client , that is, there should be a more definitive emphasis on the client's task elements because the client at this time is not in a position to effect structural or task variables. However, the counselor provides the same level of socioemotional support as that previously given while directing him- or herself to respond from the guidelines of Quadrant III. In some cases it may even be necessary to reduce these relationship behaviors to a very low level and focus primarily on task specifics. By reversing the sliding trend clients have worked themselves into, the counselor provides a base upon which to begin upward adapting once more.

From the above discussion one can readily see the cyclical effect coming into play. Adaptations do not necessarily progress in a straight line toward a desired goal. At times adaptations must be made to situations with nonreinforcing or negative overtones, and we see that a practice of switching from quadrant to quadrant is not only possible but very likely. Also, the speed at which counselors and clients adapt to the requirements of quadrants can vary a great deal. Some clients mature more quickly than others; some counselors have a greater propensity for accurately diagnosing and acting on their environment, whereas others arrive at this stage more slowly after acquiring a knowledge base upon which awareness is built.

Counselors' styles of responding will then depend on the *situational* demands, not on some preconceived, ideal style. An administrator of a caseload must therefore have an adaptive range of styles ready to respond to changing environments. This range of styles requires a great deal of personal and professional growth. The counselor must develop flexibility and be perceptive to the needs of the situation. The effective caseload manager must take into account the interaction between task or structure elements and relationship elements of the job. Counselors must develop the diagnostic ability to recognize the maturity level of the client and to respond appropriately with the most adaptive style required by the situation. Truly, effective administratorship of a caseload is a function of the counselor, the client, and the situation: all threeall the time (Cassell & Mulkey, 1985).

THREE BASIC STRATEGIES FOR CASELOAD MANAGEMENT

The caseload management process cannot operate within a vacuum. Numerous processes and structures will affect management practices. This brings us

TABLE 2.3
Three Basic Approaches to Caseload Management

	Process Model	Marketing Model	Accounting Model
Focus	Production	Consumption	Controllership
Product	Vocational Rehabilitation Services	Client	Dollar Savings
Customer	Consumer Service	Employer	VR Agency
Casefinding	Referral Sources	Job Capability	Economy of Effort $
Organizational Goals	Predicting Input	Predicting Job Market	Accounting Techniques
Effectiveness	Quality of the Process	Employment	Accountability Cost–Benefit $ Saved

to the final phase of the caseload management model described in this chapter, which is Structure Concepts (see Figure 2.1). As their common beginning Structure Concepts share the insight that the caseload management process can be affected by current trends and the higher-order socioeconomic philosophies of those individuals and elements invested with position and structure power (Cassell & Mulkey, 1985). Just as the organization and management of a business must have basic orientations and responses to particular socioeconomic pressures, so must organizations and management within professional rehabilitation settings. Particular aspects of caseload management are affected by three basic strategies or models that have emerged within industry. These models are (1) the Process Model, (2) the Marketing Model, and (3) the Accounting Model (Muthard, 1965). These distinct models from industry have implications for understanding outcomes in the field of rehabilitation. They are professed to be the models for achieving optimal effectiveness in multiple organizations and business settings. Our concern is not to select the best or worst of these models, but instead to explore the various elements of each and allow situational dictates or management philosophies to select the structure to be applied. Table 2.3 depicts the three strategic approaches to caseload management and the essential components of each for comparison among them.

Process Model

The Process Model in industry is likened to the often quoted "rehabilitation process." This model has historical lineage, coming into vogue in the early 1950s when production in all phases of the economy was at a high level.

The entire economic structure was operating from a scarcity basis, where the supply and demand balance was tipped toward demand. The essential components of this model are discussed below.

Focus

Counselor-managers who operate primarily from a Process Model have production or rehabilitation outcomes as their central concern. The emphasis is on the internal workings of the system. This system must be monitored and improved in order to ensure that optimal quantities such as numbers of successful rehabilitation closures (i.e., 26), people moved through the system in a specific amount of time (a public rehabilitation sector focus), and clients who return to their level of functioning prior to their injury (a private rehabilitation sector focus), will exist at appropriate end stages.

Product

Because the Process Model is production oriented, it must have a product that will ensure its continued longevity. The product here is vocational rehabilitation services. Energies are directed toward providing or making available services that are "sellable" or that will be in demand for its target customers or client populations.

Customer

The customer for this model is the individual with a disability or other conditions resulting in an impediment to employment. The Process Model then is client oriented to the extent that it readies its product (vocational rehabilitation services) to meet a client demand market. Thus, a humanistic approach is not sacrificed despite the fact that the model is focused on its own internal processes.

Casefinding

As the name implies, the function of casefinding is to keep the process supplied with the necessary elements to ensure adequate operations for that particular model. In the Process Model, the counselor-manager is concerned with making certain the process is adequately supplied with cases or clients to ensure adequate flow from the input to output stages. The counselor-manager's tasks are to increase referral sources and modify existing strategies for referral acquisition. One method is to advocate for passage of congressional expansion of eligibility criteria legislation allowing entrance of other disability

groups into the process. These may include individuals who are in culturally disadvantaged groups, persons with behavioral disorders, and those who are considered most significantly disabled. By these means the process continues to keep its system well supplied with users of its product or services. By these casefinding activities, the Process Model assures that its services continue to be in demand.

Organizational Goals

Operation from the Process Model necessitates following organizational objectives directed toward predicting the input into the model. By keeping in mind the flow and quantity of people through the process, counselors can exert greater control over the output. This is a logical aspect of this process, as production is the focus of this model.

Effectiveness

Judgment of the level of success attained by the Process Model is based on quality control while the process is in action. Effectiveness is judged in terms of how well the counselor has set adequate criteria for success, and how well the counselor has selected clientele who will meet these expectations or exceed them in a positive direction. Setting limitations in this model is not especially concerned with the final outcome, but instead is focused on effective and efficient rehabilitation services delivery.

Public-sector rehabilitation professionals are required by law to give service provision a high priority. Thus, they have a high concern for success variables relating to the quality of services administered throughout the rehabilitation process. Although private-sector rehabilitation counselors also have an interest in the quality of services extended to persons with disabilities, their business orientation necessitates a higher concern for outcomes. Success has a great deal to do with programmatic issues relating to cost-reduction programs, referral source requests, and expeditious rehabilitation regimens.

In summary, counselor-managers operating from this model are concerned with the production of services for their clients and/or clients with disabilities. Major efforts are exerted to keep the system supplied with clients in order to justify the existence of the established products (services). Judgments of the effectiveness of the model are process based, not outcome based, and placement of the client into a vocational setting is not of primary concern. This does not mean the Process Model sets aside this aspect of the rehabilitation process. On the contrary, placements take care of themselves,

as the model can only operate in an economy of scarcity in which demand for products is high and unemployment is low.

Caseload Data Indicators

By observing certain caseload data elements, we can find evidence that counselors are adopting one of these three models. The extent to which various indicators and combinations of data are present will help the counselor identify what particular model is in use if indeed the counselor does not already know. Clark and Wells (1980) give examples of elements indicative of a Process Model counselor. Some of these examples include

1. excessively large backlog of referrals,
2. consistently high acceptance rate,
3. concentration of cases in physical-restoration classification,
4. dearth of clients in training,
5. rapid movement and processing of cases through the caseflow system,
6. mounting numbers of unsuccessful cases, and
7. low levels of extended evaluation/trial work and waiting for employment.

Of course, the presence of one or two of these indicators in isolation should not be taken as concrete evidence that a Process Model is in use. Rather, several of these elements in interaction with one another will be required to make that assessment.

Marketing Model

In contrast to the Process Model, the Marketing Model arose out of the needs and pressures of an economy and philosophy characterized by surplus. This model came into vogue in industry and likewise in rehabilitation in the 1960s when the supply and demand scale was tipped toward excess supply and unemployment was high.

Focus

The Marketing Model is oriented toward the employer or the job market. The counselor-manager operating from a Marketing Model base will be concerned with external aspects such as job-market trends, employer attitudes, and the matching of client skills to particular job demands. A visible shift is made from concerns about production to consumption. Therefore, the Marketing Model is considered to be a model of consumption.

Product

In contrast to the Process Model where the client was the customer, the Marketing Model has the client as its product. Clients are viewed as having particular skills or characteristics that will make them marketable to employers who have the opportunity to choose from several candidates for job openings.

Customer

The customer is the employer. The product of the Marketing Model must now be tailored to fit the demands of the potential employer. The model's efforts are directed toward readying a client to "sell in the job marketplace."

Casefinding

In order to keep the Marketing Model supplied with materials that ensure its longevity, emphasis is placed on job feasibility, which is based on current job market trends or, again, on finding clients who can fit into particular work positions. Casefinding is enhanced by recent developments in rehabilitation in the areas of job analysis, job development, job modification, and reengineering. These efforts remove structural and attitudinal barriers, thus permitting engagement in higher-level competition with non-disabled persons.

Organizational Goals

Objectives guiding behavior in this model center around prediction of the extent to which the product will be absorbed into the job market. The process is given cursory consideration with greater emphasis on goals directed toward predicting the output. The primary danger is that humanistic concerns may be put aside easily or may be sacrificed in the battle to satisfy demanding entities external to the rehabilitation process.

Effectiveness

Effectiveness is based on the quantity of successful placements. The Marketing Model is a placement model. It must be understood that the process is not ignored in this model. Indeed, controls and boundaries or criteria limits must be adhered to in order to produce an adequate product at the output stage.

Public rehabilitation counselors have recently begun to give the Marketing Model a prominent place in their caseload management philosophy and practice. For example, in 1983, the Federal government, awarded a national

grant to train counselors in applying marketing strategies to public-sector job placement efforts. However, the private-sector professional's primary concern is predicting a client's absorption into the job market. Several authors (Hursch, 1995; Matkin, 1985; Mullahy, 2004; Organist, 1979) have offered the following hierarchy suggesting the ranked predictors for successful rehabilitation:

1. same job, same employer;
2. modified job, same employer;
3. different job,capitalizing on transferable skills, same employer;
4. same or modified job, different employer;
5. different job using transferable skills, different employer;
6. formal training leading to a change of occupation, same or different employer;
7. self-employment.

In summary, those rehabilitation professionals operating from the Marketing Model attempt to produce a particular clientele for a job market that is experiencing a surplus of applicants. Therefore, the counselor-manager must be equipped with an increased knowledge base and expertise in analyzing and predicting job-market trends or feasibly modifying the job environment to allow clients to "sell" themselves (Cassell & Mulkey, 1985; Fabian, Luecking & Tilson, 1994; ten Have, ten Have, & Stevens, 2003).

Caseload Data Indicators

Clark and Wells (1980) suggest examples of caseload data elements that may assist in diagnosing a Marketing Model. These examples include

1. acceptance rates that are lower than usual for the caseload,
2. large numbers in extended employment/trial work and training,
3. tendency to do more vocational testing in the evaluation stage,
4. excessively high rates of successful rehabilitations,
5. tendency to have a smaller caseload, and
6. cases remaining in various zones for prolonged periods of time.

The cautions stated for the Process Model hold for this model as well. That is, it is an accumulation of the above factors and possibly others that tip the balance toward the Marketing Model as the one given major emphasis by a counselor.

Accounting Model

This model arose out of the need to establish control and efficient planning functions.

Focus

The focal concern is control, or getting the complicated rehabilitation process to operate as efficiently and economically as possible.

Product

This model's product is financial, and it includes other material savings or gain. Rehabilitation professionals, supervisors, and administrators operating from this model will address the dollar savings that the vocational rehabilitation program is making in exchange for their investment.

Customer

If the product is dollar savings then rehabilitation professionals are the customers. That is, the vocational rehabilitation agencies will benefit from controlling and planning that eliminate waste and excess expense.

Casefinding

Casefinding involves efforts to support the accounting structure with added resources. These resources stem from third-party funds, community resources, and economy of effort.

Organization Goals

This model sets its objective to arrive at the most efficient accounting techniques possible. Program efforts are directed toward sacrificing convenience for worthwhile austerity.

Effectiveness

Effectiveness is judged on the basis of accountability formulae, cost–benefit ratios, and dollars saved (i.e., the tangibles). To the extent that financial books balance and the planning function has achieved its purpose, the model is satisfied.

Caseload Data Indicators

The elements of a caseload that reveal an Accounting Model as the base from which particular counselors operate include

1. low cost programs,
2. fast moving client programs, and
3. descriptive language that speaks to monetary issues and subordinates people issues.

In summary, the Accounting Model attempts to yield a product for the benefit of its internal needs. Characteristics of a client-centered system receive lower priority in relation to organizational goals. This is not to say the Accounting Model has no place in the rehabilitation process. Indeed, aspects of this model are productive for a caseload manager in both private and public rehabilitation. In public rehabilitation settings, priority selection processes force counselors to maintain caseloads that have higher levels of individuals who are considered most significantly disabled. Therefore, when focusing on issues related to cost containment, this model is productive for rehabilitation counselors as well as agencies. The implementation of the components of this model benefits rehabilitation professionals by eliminating waste and ensuring lower-cost programs. In private settings, this model is productive for companies when focusing on service-delivery priorities. It is within this rehabilitation setting that employers and insurance carriers can seek speedy closure through a job placement or monetary settlement (Cassell & Mulkey, 1985; Diamond & Petkas, 1979; Lynch & Martin, 1982; Mullahy, 2004; ten Have, ten Have, & Stevens, 2003).

SUMMARY

Leadership in multiple settings and agencies needs to keep abreast of key management models. Leaders, managers, and rehabilitation professionals have often operated in opposition to one another. Counselors frequently work differently than the administration expects and than the model administration follows, thus, creating many problems and conflicting expectations for caseload managers. For example, federal- and state-level administrative personnel within a state agency might begin with an Accounting Model as their major approach. The Accounting Model is emphasized by necessity as priorities are focused on keeping rehabilitation programs solvent. By the time one reaches the level of a district supervisor or regional director in a rehabilitation

agency, the Marketing Model possibly achieves greater emphasis, with all of its variables coming into prominence. Again, this is a reasonable expectation as supervisors must respond to hierarchical pressures to focus on outcomes or output. Finally, when one reaches the service-delivery level, the Process Model becomes a primary emphasis. Counselors who are at this point most often tend to be concerned with services and their customers or clients. It can easily be seen, then, that a basis for internal conflict exists. The counselor thinks in terms of planning to serve clients, whereas the administrator focuses on saving money and cutting costs. Thus, philosophical and administrative orientations are seemingly in conflict. But, in the final analysis, all are responding to the necessities required by their position and they will usually defend the values system from which they operate. At cost is that differing perceptions introduce conflict into the organization's structure. The result becomes segmenting and cleaving into "we–they" groups. Therefore, it is important to have open and continuous communication within the organizational structure and within the rehabilitation field.

The potential for conflict among practitioners in the private sector arises from the "two masters" controversy posed by Matkin (1983a), who states, "Perhaps central to the issue of conflicting interests in the private rehabilitation sector is the question, 'Who is the client?'" (p. 245). Is the person with the injury the client, or is the referring insurance carrier the client? Matkin noted:

> When the quality of services rendered is viewed solely as a function of costs to the funding source, billable time to the employing rehabilitation company (the Accounting Model), and/or maximization of vocational potential beyond the preinjury level by the client's attorney (the Process Model), the rehabilitation practitioner may be faced with attempting to serve competing philosophical and professional demands. [p. 245]

Another area that exemplifies the transition from one model to another is that of serving individuals with the most significant disabilities. Emphasis in the public rehabilitation field has gone through sequential steps, beginning with the Process Model and moving into the Marketing Model. At the outset, in serving individuals with significant disabilities, concerns were directed toward readying quality services that could meet this clientele's needs. This, of course, is the Process Model. Currently, the rehabilitation field is beginning to enter into the Marketing Model in serving individuals with significant disabilities, as evidenced by emphasis on job analysis, job development, job modification and reengineering, as well as other means that would modify the

job market to allow fuller integration of this population (Wehman, Brooke, & Inge, 2001).

With an awareness of the particular model base from which counselors or other individuals are operating, rehabilitation professionals are provided with some predictive powers concerning expected behavior patterns and/or outcomes. Knowing the basic model others use to orient themselves to rehabilitation assists in the recognition of the pressures and the value systems under which those individuals operate. This knowledge prepares professionals in the field of rehabilitation to occupy a position that allows them to convince peers, supervisors, and others of the value of the basic positions from which the particular counselor is operating. In the final analysis, knowing the orientation of significant others is a prerequisite in any management endeavor at any level of operation, whether it be caseload management or organizational management.

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CHAPTER 3

Establishing Effective Control in the Caseload Management Process

CONTROL AS A KEY MANAGEMENT FUNCTION

The essence of achieving a functional level of operations within any established system is the effective conceptualization and implementation of a personal control concept. Control can be defined as a "systematic steering towards a defined final state or goal" (Introna, 1997, p. 114). Control implies insight into the current point or state; a defined ultimate point, state or; and the ability to steer through the system throughout periods of transition (Cassell & Mulkey, 1985, 2004; Cassell, Mulkey, & Engen, 1997; Introna, 1997). This is true whether a system involves managing an insurance case to a prompt rehabilitation, managing case movement, or dealing with elements of the rehabilitation organizational structure.

As stated in chapter 2, the five basic functions in a management approach are all linked and provide continuity through the control function. Because the development of a professional orientation for rehabilitation counselors necessitates the knowledge and application of a management base for all activities and duties, control becomes a crucial element contributing to overall effectiveness.

"The best rehabilitation procedures contribute enormously toward bringing into focus the possibilities of coping with difficulties" (Wright, 1983, p. 65). Therefore control is a prominent element in conducting client counseling sessions. A counselor must use the control base from which the client is operating (i.e., based on internal, personal dynamics or coming from powerful others or another external source). Reinforcements are then applied to the client's coping efforts in order for that client to make further gains in personal control.

Control is a prominent element for every counselor as the realistic appraisal of controllable and noncontrollable events is essential for personal disci-

pline. Control is significant for a sense of power in the position, for developing self-confidence, for thwarting frustrations, conflicts, and wasted efforts, or just adjusting to a burnout syndrome. "A system can be effectively controlled without detailed understanding of the processes within the system. The controller of the system must, however, have a clear understanding of the behavior of the system, i.e., what output will result from the given input" (Introna, 1997, p. 114). Therefore, control is fundamental to the way the counselor sets and meets production standards, achieves smooth movement of clients through a rehabilitation process, and, in general, keeps within manageable limits those organizational demands that impinge constantly on one's job. For example, self-discipline is a valued attribute for the caseload manager in private rehabilitation as control is localized within the individual practitioner. Many of these practitioners operate on an independent basis in the field with only infrequent contact with central office personnel (Shrey & Lacerte, 1995). The need to set priorities, establish limits, and manage various client- and organizational-related elements within acceptable limits therefore evokes control-related responses. Although many counselors in public rehabilitation agencies voice pessimism over their control position, control is exemplified through their professional decision-making activities (Crimando, 2004). Certain parameters for these practitioners are established by federal mandates and state policies—for example, eligibility determination—but decisions as to case movement, placement activities, and the like all operate through a control concept.

Thus, as a powerful concept for performing, control pervades almost everything a counselor does. It must be understood, and techniques or methods must be established for making it as basic to the counselor's practice as are, for example, counseling or placement techniques. This chapter offers initial steps toward that end.

The authors conceptualize control into two essential areas: Elements of Personal Control and Elements of Structural Control. The first part of this chapter will focus on the identification of the counselor's base for personal control and on significant factors for formalizing a model for effective functioning. The second concentration will be on the identification and awareness of elements to put structural control into perspective as a contribution to the caseload manager's overall developing system.

ELEMENTS OF PERSONAL CONTROL

Personal control is a key ingredient in the rehabilitation paradigm. "If skill clusters are the mechanical works of an entity termed professional practice, then personal control is the fuel needed to drive the entity" (Cassell, Mulkey,

& Engen, 1997, p. 231). Control here is meant to be "the awareness or proper assessment of the base for one's present behavior level and the correction of recognized deviations in performance that create personal and caseload management problems prior to these problems reaching a crisis level" (Cassell & Mulkey, 1985, p. 89). Whereas control occurs in the larger context of difficult-to-handle demands, requirements, restrictions, and standard setting (which can be termed structural control), there are personal aspects of control, those intrapersonal processes that allow practitioners to take charge of situations that normally would override their best-bet actions, that is, actions that would produce the desired outcome to benefit the client (Cassell, Mulkey, & Engen, 1997). Therefore, the awareness and assessment of one's own position in relation to a concept of control is at least a starting point for establishing effective control. If counselors are unable to state objectively the base from which their actions emanate, then at the very outset they are in a position of low control.

Locus of Control

There are several conceptualizations of personal control. The focus chosen for our purposes emphasizes personal control as given by internal versus external control orientations (Rotter, 1966, 1975). Rotter termed this *locus of control* and since its first appearance, research has continued to the present (e.g., Key, 2002; Livneh, 2000; Strauser, Kleim, & Ketz, 2002). This extensively researched area provides a broad-based set of concepts from which the caseload manager can operate, is understood easily, and is likely to be generalizable to rehabilitation practitioners. Rotter (1954, 1966, 1975) has stated that the locus of control for an individual lies within an external or an internal frame of reference, depending on the perceived origin of the reinforcers that influence the behavior. "In general, the perception that one's own behavior produces the majority of outcomes experienced defines an internal control expectancy" (Cassell, Mulkey, & Engen, 1997, p. 231). That is, if counselors perceive rewards following the performance of an act or sequence of acts as coming about as a result of what they (the counselors) have done to produce those rewards, then these events are perceived as controllable. However, "the belief that outcomes and happenings are not the result of one's own actions leads to expectancies that one has little effect on those outcomes" (Cassell, Mulkey, & Engen, 1997, p. 231). That is, if counselors perceive the rewards following the performance of an act or sequence of acts as coming about because of luck, chance, or fate, then they typically do not perceive the events as being under their control.

For example, let us suppose a counselor has placed a client in employment and this counselor concludes that successful placement came about primarily as a result of the counselor's own actions and those of the client. That is, in addition to the client having sufficient interest in the job and the skill level to function in it, the counselor believes performing the following counselor actions produced the result: (1) accurate diagnosing of the client's problem area and remediation of the deficits, (2) accurate assessment of the client's vocational potential and skill level, (3) sufficient knowledge of the job market, and (4) contacts made with employers and public relations established. The counselor is likely to repeat this same sequence of activities and have the necessary personal energy and/or motivation to carry through with the difficult stages required to arrive at this end result. Thus, we have the basis for concluding that this counselor is operating from an internal locus of control base.

In contrast, suppose we have a counselor who has placed a client in employment and who has the following impressions of the results: "I surely was fortunate to get that placement. I seem to be having a fair run of luck lately. It's lucky we have a few employers who are nice to individuals with disabilities and give them jobs; hope I'm lucky enough to find a few other placements for other clients." Clearly, the counselor is operating from an external locus of control base. This counselor does not think personal actions directly correspond with outcomes, and thus probably will not view the process of placing clients as controllable. Some people have personal command of most of their activities whereas others allow external sources to have a greater influence and impact on them. For example, some counselors do not let time, excessive casework, and excessive client demands control them (an internal orientation). Other counselors frantically scamper about trying to be all things to all people with the result that little is accomplished in the long run because someone or something is always making demands or usurping their priorities.

Again, if one depends on an outside source of reinforcement for the impact of goal-directed behavior, that person is externally oriented. Typically, externally controlled counselors do not believe they are having significant impact on the results or outcomes of the caseload management process. These individuals tend to attribute outcomes to luck or chance. The person with an external orientation is likely to experience greater confusion over which priorities to act on, will procrastinate on making choices, will not take risks, can be manipulated by assertive or aggressive others, and is unable to establish systematic caseload management (Cassell & Mulkey, 2004; Cassell, Mulkey, & Engen, 1997). They allow their reinforcers to be handled by others and other factors outside of themselves. Depending on luck as they do, these

individuals tend to wait until favorable conditions line up again before they can duplicate past results. This, of course, contributes to lowered production. Table 3.1 presents a few of the research findings that further describe this external orientation.

As a rule, internally controlled people are autonomous. The person with an internal orientation is more able to take charge, take risks, manage time appropriately, respond assertively, apply self-motivation and rewards for outcomes, and command the events that occur within the caseload management process. The internally controlled person gains intrinsic or internal rewards for performance without relying on the "atta-boys," "atta-girls" or other forms of reinforcement from external sources. These people see themselves and their own behavior as the key to having the greatest impact on the results obtained. Table 3.1 also gives further summary research findings that are descriptive of an internal locus of control.

In summary, internally controlled people know more about what is important to them, seem more eager to gain information that will increase their

TABLE 3.1
Comparison of the Internal and External Locus of Control

Internal Controllers	External Controllers
1. Can delay their need for reinforcement.	1. Require immediate gratification, are impulsive.
2. Place great deal of value on time and manage it accordingly.	2. Tend to procrastinate, put things off. They thwart effective use of time.
3. Alertly read to take action to confront problems and difficulties. Dwell less on deficits and faults when doing problem analysis and problem solving.	3. Tend toward inaction because they tend to have fear of failure more than they have hope for success.
4. Are risk-takers.	4. Are not risk-takers. Tend to play it safe and keep involvement down.
5. Cautious about data and general information they accept from others, and make more use of information they are aware of.	5. Accept information at face value; make less use of information.
6. Do preliminary steps for data gathering.	6. Engage less in preliminary data gathering.
7. Are resistant to pressures from external sources to direct their behavior.	7. Responsive to the influence of prestigious sources.
8. Expend deliberation time on decision making and on tasks demanding skill.	8. Expend deliberation time on chance-determined tasks.

probability for success, manage time wisely, take appropriate risks backed by a good information base, and are decidedly more deliberate in skill tasks when control is possible. Externally controlled individuals seem more involved in chance tasks, are more impulsive, require immediate gratification, tend toward procrastination, and spend time and effort on decisions that seem of little concern to the more internally controlled individual.

Locus of Control in Rehabilitation

In order for the caseload manager to have a functional knowledge base in this area of internal versus external locus of control, he or she must review the application of the area to the field of rehabilitation. The information below is a brief introduction to the research that has been accomplished in which the focus has been persons with disabilities or counselors in the rehabilitation field:

1. For individuals with disabilities, internal or external locus of control can determine attitudes and behaviors (Lipp, Kolstoe, James, & Randall, 1968; Roy & MacKay, 2002).
2. Psychological adjustment to a spinal cord injury is largely devoted to correlates of adjustment, notably personality factors and locus of control (Thompson, Krause, & Henry, 2003).
3. Rehabilitation counselors should consider the locus of control of their clients when formulating rehabilitation plans (Niles & Harris-Bowlsbey, 2002; Walls & Miller, 1970).
4. Locus of control orientation is useful in predicting the accurate perception of personal health status and the appropriate time for returning to work for individuals who have disabilities (Green, 2004).
5. In a study of learning disabilities, Skinner (2003) states that "many (adults with learning disabilities) may need assistance in developing adequate coping strategies and to develop realistic self-awareness. Identification of locus of control can be a first step in such development" (p. 31).
6. Finally, research findings indicate that rehabilitation outcomes may be improved significantly if clients' control orientations could move from an external to a more internal locus (Wehman, 2001).

Locus of control, then, is an important variable for counselors to consider when administering the responsibilities of a caseload. This variable, of course, cannot be relied upon as a single predictor of client behaviors,

but when used in conjunction with other diagnostic tools it can be of great value.

A Counseling Framework for Locus of Control

The basic concepts derived from the locus of control area offer a "mini-counseling" framework. According to Cassell and Mulkey (1985), a counseling process that uses this approach, would require four basic steps:

Step 1. Assess the Client's Locus of Control Orientation

This assessment can be done with or without the application of the Rotter I-E Scale. With a short course of self-education and training the counselor should find it relatively easy to establish with confidence the locus of control of the client. Observations of a client's verbal and nonverbal behavior that signifies a giving up of control to luck or chance to "them" and "they" can be significant indicators of external locus of control. A sufficient observation period is needed in order to have confidence in the assessment of an internal versus an external position. If the Rotter scale is used, the counselor should still gather observation data to confirm the assessment done with the instrument.

Step 2. Promote Behavior Recognition

The second step establishes a process for promoting clients' recognition, at their level of understanding, of how they are giving up control if the locus of control is external; or for promoting the positive recognition of the internal orientation if the client operates basically from that base and builds on that orientation.

Step 3. Accountability Counseling

The third step consists of introducing the client to the concept of personal ownership of the behaviors recognized in Step 2. This means, of course, that counseling strategies must be directed toward abstracting self-esteem elements from client behavior that produce negative results. The client is now ready to accept the responsibility for these negative outcomes. Clients must come to understand that they should not deprecate their self-worth because of negative outcomes, that the negative products come about as a result of their actions, and that their new actions can produce positive outcomes. If clients accept responsibility for negative results, they can also accept personal self-reward for producing positive outcomes, thereby moving in the direction of internal control. Once these prerequisite conditions have been

accomplished the transition can begin from the external locus of control framework to the internal position.

Step 4. Guide Preference Commitments

This final step involves the coordinated weighting of the alternatives available to clients and then establishing a proactive stance to allow them the opportunity to make the process happen. Clients must be guided to understand (for ownership purposes and for permitting the internal orientation to flourish) that the preferences for action to which they will commit themselves stem primarily from their own personal base.

Organization versus Personal Control

In the administration of the rehabilitation process, caseload managers probably have the *least* control over the following elements: legislative and judicial actions, budgetary aspects, geographic region elements (e.g., paucity of referral and placement sources), economic trends that put higher costs on prime services and appliances for individuals with disabilities, Worker's Compensation Board decisions, and the setting of some office and field standards for counselor practices (Cassell & Mulkey, 1985). These are factors that the internally controlled individual cannot influence to any great extent. These factors have the greatest opportunity of controlling the caseload manager. Because counselor behaviors directed toward these factors will likely as not be perceived as under the counselor's control, the payoff expectancies for involvement in them will be minimal. However, the control that is possible comes about when the demands from these areas are integrated with other activities in the management process and then tolerating or adapting to their seeming inevitability is accepted.

In contrast, control is *possible* when dealing with such elements as caseload size and projected numbers of persons to be rehabilitated (some practicing counselors in rehabilitation agencies would question this, but control *is* possible), time structure, amount of paperwork (debatable but controllable in the final analysis), referral acquisition-retention (i.e., where source paucity is not the issue), and the case flow and case movement of clients through the rehabilitation pipeline (Cassell & Mulkey, 1985). These factors most likely would come under the control of a caseload manager, with the more internally controlled individual having greater effect on these areas than the externally controlled individual.

Internally controlled counselors would, of course, be aware of the extent and kind of control they are exerting. Thus, they would have a much

greater opportunity to understand for themselves the effect they are having in managing the wide gamut of caseload elements. Those who argue most fervently that the issues just listed are not under the control of counselors are likely to be externally controlled individuals themselves. Therefore, they stand the chance of losing the opportunity to gain a measure of strength from the realization of the control the counselor is effecting at the moment. If these counselors would scrutinize their activities more carefully, it would be clear that they are having *some* impact on these factors. They are exerting a certain amount of control, but they are failing to give themselves valuable self-reinforcers by refusing to perceive any extent of control.

Admonitions

To fully comprehend the usefulness and the appropriateness of the locus of control area, the counselor must be aware of the limitations of the Rotter scale. Noting that the I-E Scale offers only a broad, generalized expectancy for prediction purposes, Rotter (1975) cautions that "some measure of a very broad generalized expectancy allows prediction in a large number of different situations, but at a low level" (p. 57). Attempting to use this instrument as the sole basis for predictions should be avoided. The I-E Scale, along with other supporting data, allows predictions at higher levels.

Another admonition is to resist the tendency to conceptualize results from the I-E Scale in a "good me-bad me" framework. Rotter (1975) notes that there is no evidence to conclude that all characteristics of internals are good and those of externals are bad. This, of course, gets into the area of making value judgments such as, for example, concluding that internals are high achievers and that it is bad therefore to be an external, who is a low achiever. There may very well be barriers and problems associated with an external orientation with which one must cope, but value judgments should not be attached.

There are demonstrated differences in the behaviors of people who differ in their internal and external locus of control orientations. However, caution is urged regarding attempts to conclude that there are two different personality types described. There is no evidence for a typology whereby a person can be classified in an internal or an external category. There is, however, a continuum on which an individual may be placed according to internality or externality (see Figure 3.1). That is to say, individuals possess varying degrees of internality or externality, and anyone can s move toward one pole or the other. A consistent orientation occurs when behavior stemming from one of these expectation poles becomes dominant.

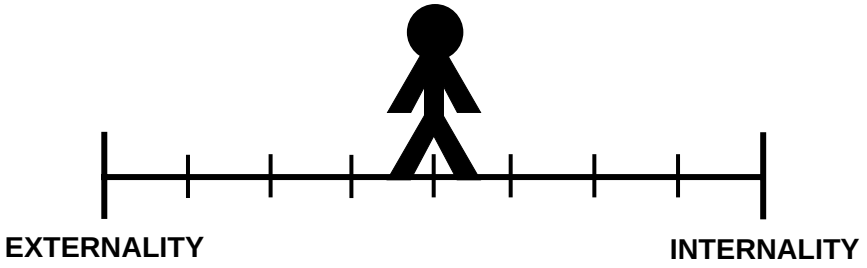


FIGURE 3.1 Depiction of Locus of Control as a Continuum

PRIME FACTORS FOR ESTABLISHING CONTROL

Research has shown that one's orientation to control can be altered (Corey & Corey, 1997; Dua, 1970; Introna, 1997; Rubin & Rubin, 1988; Van Voorhis, Braswell, & Lester, 2000). An individual counselor or client whose locus of control stems from an external orientation can move along the continuum depicted in Figure 3.1 toward the internal orientation through a process of self-awareness and constructive, practiced action. It is also possible that an individual who is localized on the internal control scale can maintain that present level of control, if so desired, or can even gain a higher level or firmer base for internal control.

Counselors can train themselves consistently to establish control over or be more in command of the caseload management process. This development begins with an awareness of the factors that influence effective control. Cassell and Mulkey (1985) identify five Prime Factors that are involved in developing or establishing personal control. These Prime Factors represent only a few of the many areas in which individuals interact that can rob them of effective control. When studied and incorporated into the counselor's remaining repertoire of response patterns and techniques, they form a base for gaining and/or keeping control. These five factors are presented in Figure 3.2.

Perception

Perception ranks highest in importance among the five Prime Factors for establishing control. This factor can work to the counselor's disadvantage and exert great control over the individual's behaviors. Without the counselor's awareness, it can control much of his or her behavior and therefore must be managed appropriately.

In the process of perception, information about external events is collected in a cumulative manner until a basis for interpretation of future events is established. This basis for interpretation can come from numerous points of

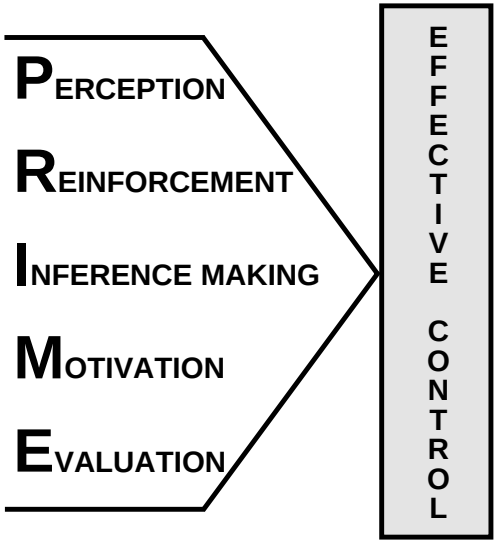


FIGURE 3.2 The PRIME Factors for Effective Control

origin. The significant point of origin results from the cumulative experiences of the counselor, which have established such personal factors as attitudinal posture, emotions, and values. As a counselor's experience base grows, the consistent development of reactions to terms, concepts, ideas, organizational policies, philosophical bents (e.g., relying solely on counselor duties as the basis for professionalism), and the like tend to form a foundation for perceptions. If these perceptual sets develop in an unguarded manner or are allowed merely to evolve spontaneously without the counselor's becoming actively involved in their development, the potential for loss of a measure of control in thecaseload management process is increased. The die is cast for the emergence of *compelling perceptions* to control the counselor's functioning.

The process of perception then tends to establish a prearranged or preorganized system in which to fit information. This means that when usually neutral stimuli or events confront the counselor, the reaction is to put structure or meaning to these events as one perceives them. The value in this arrangement for functional adaptive behaviors is obvious. However, the danger comes when counselors begin unjustifiably limiting the way they react to stimuli, including reacting uncritically to it. This is the point at which counselors begin to lose control.

The difficulty in gaining control over this area is easy to understand because the act of perception automatically triggers responses without going

through a logical, rational, reasoning process. Therefore, the majority of the time, behavior is controlled by perceptual sets without an awareness that behavior is being influenced.

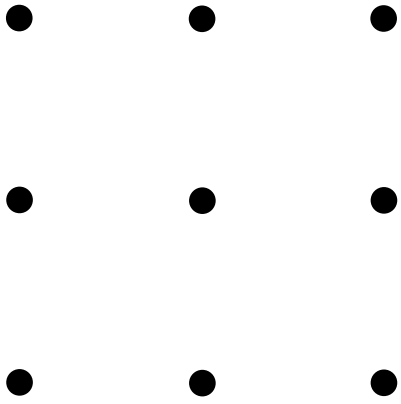
Perception of Significant Disability

The great frequency with which words and concepts are encountered helps create psychological sets and forms counselor perceptions. With greater frequency of contact with terms or concepts, the psychological set to react to them becomes automatic and preprogrammed. The term *significant disability* is a good example. In the past, this term has usually connoted a "nonrehabilitatable" person, or someone who is "*not* feasible" for vocational rehabilitation services. Thus, the compelling perception was to force the counselor to focus on the functional limitations of the person with a significant disability and declare the individual ineligible for services from the rehabilitation system.

However, perceptions are continuing to change. Since the enactment of the 1973 rehabilitation legislation (with subsequent amendments) and the onset of priority categorization in many states, of persons applying for services through state vocational rehabilitation agencies, highest priorities must be given to those considered most significantly disabled. These individuals have not changed drastically over the years in terms of their functional abilities or vocational capacities, but perceptions have changed and continue to evolve over time. Counselors continue to explore empowering strategies for such individuals in the rehabilitation process and are retraining their perceptions or awareness to force themselves to visualize the positive assets that individuals with significant disabilities possess in order to assist such clients in attaining their highest level of functioning. The perceptions of clients at many levels have also begun to change with the implementation of the mandates of the 1998 amendments to the Rehabilitation Act that call for a focus on vocational assets and informed choice.

Perception and Problem Solving

Another example of how control is lost through perception stems from the conclusion that perception or set sometimes blinds the counselor to present realities. This can frustrate problem-solving attempts. As an example, Figure 3.3 depicts a common problem that is influenced by perceptions. This problem graphically illustrates how perceivers can place relatively neutral stimuli into their framework in such a manner as to make them unable to arrive



RULES:

Rule 1. **Connect all of the dots with *four* straight, continous lines. (When a line changes direction that constitutes a new line.)**

Rule 2. **The lines may cross.**

Rule 3. **Do NOT lift your pen from the paper.**

FIGURE 3.3 A Problem-Solving Example

at a solution. In this case, the situation is controlling the perceiver. Look at Figure 3.3 and follow the instructions for attempting to solve it. Attempt the problem several times and then consult with one another for the solution and brief discussion.

In caseload management activities this compelling perception process often comes in just as disguised a form as the example in Figure 3.3. However, if caseload managers have prepared themselves properly for managing through the five essential functions described earlier: planning, organizing, coordinating, directing, and controlling (see Table 2.1) then the frequency with which loss of control in problem solving occurs will be greatly diminished. If a caseload manager's style of operating is based on a proactive stance, the perception problem is further controlled. The proactive stance operates in a problem-prevention way to limit its occurrence. There are at least two areas that serve as examples of the way perception tends to form limits and boundaries: people perception and perceptual limiting.

People Perception

The perception of persons with disabilities or the misperception of their abilities by society and sometimes by counselors is one area in which control can be lost. The following brief exercise should provide insight and awareness into people perception. Complete the Disabilities versus Abilities Perception Checklist before continuing. Then turn to the scoring explanation in the Instructor's Manual, and then return to the discussion below.

Disabilities versus Abilities Perception Checklist

Below are two columns. The first lists various disabling conditions, and the second lists a variety of activities that require the application of some level of skilled ability. On the line beside the conditions listed in the first column, list the numbers of all those activities in the second column that you believe there is *very little likelihood* a person with that disability could engage in. There are no limits as to how many or how few activities you can list for one disability. Activities can be used more than once if desired.

Disabling Conditions	*Activities Requiring Skilled Activity*
_____ Deafness	1. Drive a car
_____ Blindness	2. Fly an airplane
_____ Cerebral palsy	3. Play golf
_____ Spinal cord injury	4. Go to social affairs and dance to music
_____ Epilepsy	5. Operate a personal computer
_____ Double amputee (below knees)	6. Ride a bicycle
	7. Go bowling
	8. Play computerized games
	9. Go water skiing
	10. Play basketball

There are numerous written accounts of individuals with significant disabilities who exceed perceptual limits in their everyday activities. For example, people who are blind play in golf tournaments, individuals who are deaf or hard of hearing attend social affairs where they dance to music, blind individuals or those with low vision ride bicycles, and individuals with paraplegia water ski. The authors personally know a blind person who drives a car (with verbal assistance from a sighted person on "back roads"), and another blind person who flies an airplane (again, with verbal assistance from a sighted pilot). In fact, the authors have personal knowledge of people with

the disabilities cited in the above exercise who have engaged in the activities listed in the right hand column of the exercise.

If individuals with disabilities were prevented from entering into the above social and athletic events as well as other everyday activities, it can be said that perceptions had the effect of limiting reactions to these individuals. Thus, perceptions can control caseload managers' behavior by not allowing individuals with disabilities to realize their full potential.

Perceptual Limiting

Perceptual limiting narrows the focus of the reasoning process. It can interfere with a counselor's development of referral sources. Through a compelling perception process, public-agency counselors can force themselves to perceive that referral sources must be linked with such health-medical sources as hospitals, clinics, social workers, and public health professionals. However, other referral sources can be of use if one can control the situation and transcend the set of purely medically related sources. For example, insurance agents, post office employees (mail carriers on some routes see a large number of individuals and socialize with them to some extent), financial-aid officers in local colleges, taxicab drivers, and state patrol officers are all examples of nonmedically related referral sources that potentially have contact with people with disabilities who require rehabilitation services.

In conclusion, the establishment of control comes about when counselors become aware that they are being boxed in by perceptual set. Counselors must train themselves to revisualize the problem, restructure the situation from different angles, and then take one step beyond the limits of first perceptions. Typical questions one might ask are, "How else can this information or this event be interpreted?" and "Can I go beyond this first impression or boundary that I have artificially established?"

Reinforcement

Reinforcement is another controller of behavior. Counselors need to become aware of the source of reinforcers if they are to be in control of them. From the earlier discussion, we discovered that greater control occurs when the counselor operates from the expectancy that rewards will come about as the result of personal actions (an internal frame of reference) rather than by uncontrollable sources (an external frame of reference).

It is known from research beyond any doubt that behavior can be shaped by reinforcement, and so the gaining of control at this point is of great concern. When a counselor believes that personal actions resulted in

the placement of a client in employment, or that the counselor's behavior led to the development of a good source for placement, then in a sense that counselor has reaped his or her own reward. Counselors operating from this base clearly are in control of their own reinforcers. However, other counselors may take clients through the rehabilitation process and in the final analysis attribute the success to the kindness of an employer, chance factors, or a lucky break (the counselor just happened to have a client with just the right skills for a particular placement), all of which will deny counselors the opportunity to feel that their own behavior or efforts led to this result. A counselor in this instance would tend to overlook the fact that hard work, persistence, and good public relations were significant contributing factors.

The question becomes, "What will happen to counselors' efforts if they are externally controlled?" More than likely, efforts will be experienced as laborious, perceived as nonrewarding, as drudgery, and rewards will come only when the lucky break comes about again. Obviously, the situation is controlling the counselor. However, an internally controlled individual gets self-applied rewards from efforts in good case recording, the client's self-enhancement, getting the client ready for employment, developing the placement source, and adequate assessment of the client's potential for a job. In such instances, counselors function as their own source of reinforcement. Key questions here might be, "Are you, the client, or the agency in control?" and "Where most often do you go for your reinforcement?"

The answers to these questions should never come from outside sources. Many rehabilitation counselors expend great energy through frustrations, feelings of being ignored when successes are accomplished, and seeking positive rewards from the agency. Counselors must realize that these rewards probably will never come. Thus, self-applied reinforcement enhances one's personal control of situations. A guiding principle here is never to let someone else or some external process handle your reinforcers because, then, these external sources are in control.

Inference Making

A third control variable that can influence reactions, and of which the caseload manager must become aware in order to be in firmer control, is the *inference-making process.* This, in the final analysis, becomes the mediation between inferences versus observations.

Inferences depend upon taking in information and processing it through a decision-making or evaluation stage before taking action. On the other

hand, observations are products of personal experience. To observe something, one must see, hear, feel, smell, or taste the data on a firsthand basis. Inferences can only be secondhand at best because they are built upon accumulations of data from various sources that are themselves derived from secondary sources ad infinitum.

The counselor cannot be an effective manager without using both of these strategies. A good part of the time, the counselor is forced to operate from an inference base when facts are not available or direct observations are not possible. A danger does exist, however, when counselors make the mistake of treating inferences as if they were observations and acting accordingly. That is, the counselor makes no attempt to take into account the extent of the risk involved if, indeed, the data are in error. In this instance control is slipping away. When the counselor acts on inferences as if they were facts or true observations, problems ensue.

The Uncritical Inference Test

The Uncritical Inference Test comes from the work of Haney (1971), who has employed the "test" in his training and consultancy activities. Haney states that an observation has three basic criteria. All three must be satisfied or else the conclusion must be that an individual's actions stemming from the data come from an inference base. The three criteria are as follows:

1. Content statements can be made after or during the event but never before the observation (i.e., the Time Element).
2. Content statements must be limited *to only those aspects* one has observed (i.e., the Limitation Element).
3. Content statements are specific to an individual's firsthand observations (i.e., the Source Element).

Examples of instances in which inferences can lead to errors or confusion and thwarted outcomes, if some efforts are not made to evaluate the process, are as follows:

1. Suppose a counselor acts to eliminate a client from consideration for placement in a specific job in which the disability of the client seemingly precludes the client's performance of the job. The Time Element is violated because the counselor has not observed the client working at the job, perhaps through some job modification or reengineering adaptations.

2. Suppose a supervisor observes a counselor conducting a poor counseling session with a client who has cerebral palsy and concludes that the counselor is not able to work with people who have disabilities. The Limitations Element has been violated because the supervisor has observed the counselor working with only one client in one specific disability category.
3. Suppose a counselor is working with a client developing work objectives from a vocational evaluator's reports. The counselor is working from an inferential base because firsthand observation data are not available. This counselor is in violation of the Source Element criterion.

Most information is processed in a form other than observed facts. This cannot be avoided. Therefore, counselors must operate most of the time from an inference base, as the example in number three above shows. As decisions are made, risks must be taken, and the possibility for loss of control is everpresent. Therefore, the counselor needs to cultivate what Haney terms the "Calculated Risk" and totally avoid uncalculated risk taking. Counselors must realize first that they are taking a risk and then that their selected alternative is not within the appropriate decision scheme (see chapter 4); they must realize that the decision may not culminate in success. This stage must be followed by some appraisal of the trade-offs. Naturally, *high cost* decisions (ones with probable effects on clients' lives) must have a higher probability of being correct, and thus as much observation information or near-to-the-event data as possible must be available so that low risks are taken. Low-cost decisions—those relating to situations that are not essentially disruptive to a client's rehabilitation—can withstand error. Possibly, inference-based data with a 10% certainty level might be appropriate, allowing the counselor to engage in higher-priority tasks.

Haney (1971) suggests a checklist of questions to help one distinguish between observations and inference making:

1. How closely involved or personally tied are you to the event? Are you making observational statements before the actual observation itself?
2. Does what you say about the observation pertain to that event or are you slipping back into excessive inference making?
3. When you deal with *important* inferences, do you intuitively assess the probabilities of the certainty of the data in high risk situations?
4. When you interact with your clients, do you remember to label your inferences as such and teach your clients to label their inferences as such and establish appropriate risk levels?

Motivation

This fourth factor in our model builds naturally on the previous three—on perception, on reinforcement, and on inference making. In this factor of control, the concern is with the events that cause people to act, or the stimulus that causes them to set themselves into motion and move toward a goal. Therefore, questions to be asked are, "How does motivation figure in as a factor of control?" "How does motivation control us, or how will the counselor control motivation?"

There are three general summarizing methods for getting individuals to perform. Two of these represent more external control orientations whereas the third is clearly an internal orientation. These methods are discussed below.

Force ("Stick")

To control behavior, this means of motivation relies upon physical punishment in some cases and threat or oral reprimand in others. Control then is exerted through some external fear mechanism.

Counselors, of course, would not use physical abuse on clients, nor is physical abuse used on counselors to get them motivated. However, the berating approach is not beyond some supervisory staff to motivate personnel. Also, the client's perception of the counselor, not as a therapist or helper, but as a powerful authority figure, can be an example of force. This points out the need for striking a coordinated balance between the counselor and the manager roles.

Enticement ("Carrot")

This method motivates counselors and clients to perform their duties or arrive at goals with the promise of a reward for their efforts. Getting the next pay level on schedule or being promised supervisory promotion or involvement in special projects are examples. These two sources for motivation are usually considered the only means for motivating individuals to act. If, however, counselors rely on them and allow clients to operate from one or the other, then behavior will always be tied to external sources. An external process is controlling the reinforcers and only minimal self-enhancement is afforded.

Identification

This form of motivation represents a more internal orientation. Counselors are motivated to perform because their duties and responsibilities on the

job become a part of them. Here, counselors become closely identified with almost all of their responsibilities and duties. Working with clients, understanding rehabilitation as a profession, being a self-actualizer, being a caseload manager, all become a part of one's self-identity and are not perceived as external. Counselors who are in control feel accomplishment and make a genuine contribution to job functions because these functions are identified closely with self-esteem and self-worth. Job functions are a part of these counselors.

Similarly, clients who are guided to accept ownership of the rehabilitation program will also gain more from this internal orientation format. If clients are able to identify a planned service strategy as *their* program, if they take pride in the progress and achievements made in *their* rehabilitation, then they will emerge from this interaction autonomous and empowered. The often-stated "unmotivated client syndrome" is averted.

Clearly, more personal control is established if motivations are based on identification and not the carrot or the stick. Therefore, motivating oneself for effective caseload management will depend a great deal on an attitudinal base. Again, counselors must stop themselves from focusing solely on establishing interpersonal relationships with clients and accept other aspects of managing their caseloads, such as doing case recording, maintaining case flow, and developing referral and placement sources. These activities cannot be things the counselor does *in addition* to counseling; *they are a part of the total functioning required.*

Evaluation

This last factor in our model serves as a means for establishing control as an ongoing process. Change is inevitable. Things and processes are continually in a state of flux; they are dynamic and ever-changing. Therefore, for control purposes counselors must continually assess where they are, where they need to go, and what must be done to get there.

Evaluation takes place at all levels of this model of control. It intertwines among the other four factors and keeps them in proper perspective. Evaluation is an integral part of assessing the boundaries for perceptual limitations and then testing new limits when these boundaries are expanded to accommodate added insights. Evaluation is involved in ascertaining the source of one's reinforcers and selecting those of highest value. Distinguishing between observations and inferences involves evaluation. Finally, determining the process chosen to base action upon and the benefits to enhance personal self-

worth are essential in forming a self-established evaluation system. Only then can control be fully functional and ongoing.

In conclusion, to assist in the recall of these five Prime Factors in establishing personal control—Perception, Reinforcement, Inference Making, Motivation, and Evaluation—note that the first letters spell the word PRIME. These significant factors are useful only if the counselor chooses to make them so. They are not answers by themselves and they cannot be the counselor's final solution to control problems. They are a base from which the counselor can begin to establish effective personal control. However, even though control is established in the personal realm, the counselor still must gain some measure of control over the structural aspects of functioning within the rehabilitation field whether in agencies, facilities, or other settings. The gaining of control over structural aspects is discussed below.

ELEMENTS FOR STRUCTURAL CONTROL

Whereas personal control systems are significant considerations, just as significant are elements for coping with or establishing some form of control over the environment, agency objectives, or other structural components of managing a caseload effectively. Structural control differs from personal control in that here we are talking about control on a larger, more global scale or control concerned with nonperson dimensions. Several researchers (Cassell & Mulkey, 1985; Freemantle, 2002; Marshall & Oliver 1995; Sartain & Baker, 1978) note that there are four essential elements in a control system. These elements are (1) standards for action or action decisions, (2) considerations for application of a performance standard, (3) deviation assessment, and (4) steps for deviation correction.

Standards for Action Decisions

Business-related or personal decision making is all about how to choose. Freemantle (2002) makes the point that increased awareness of choices, combined with a wider range of possibilities from which to choose, equals a higher probability of achieving positive outcomes. Along with personal decision-making processes, standards become concrete control functions when an individual, an organization, or a work unit sets them as limits from which only particular deviations under special conditions are allowable. A standard can be described as an established, mostly stable, minimum or maximum outcome that is required for successful performance (Cassell & Mulkey,

1985). A standard provides a means for comparing one's present ongoing level of behavior with past performance or expected future performance as a guide for necessary actions. Standards should be present at all levels of a caseload management process.

For example, counselors might have among their lists of standards the following:

1. Meet with counselor assistant three times weekly to discuss office procedures and strategies.
2. Do no less than two job analyses in industry a month.
3. Ensure that even and timely flow is maintained in serving clients:
   a. Make decisions on referrals (i.e., accept or close from caseload) no later than three months after referral is received.
   b. Move 80% of clients from IPE formation to rehabilitation closure within eighteen months, twenty-four months at the most (see chapter 6 for explanation of the basic classification system).

Standards must also exist at a personal level for guiding day-to-day activities. For example, counselors might have among their daily standards the following:

1. Use a Daily-To-Do-List for managing activities.
2. Establish a prioritizing system for selecting high to lower value activities, such as the A, B, C Method.
3. Set aside one self-imposed hour daily for planning, organizing, and coordinating.
4. Make all call-backs within 24 hours of their reception.

When we are talking about expectations of others, what our peers or supervisors think about our performance, we are, of course, concerning ourselves with standards. Without standards caseload management would be a chaotic, indecisive battleground for thwarted actions by rehabilitation practitioners.

Standards guide the structural components of our caseload management process. Some are established by legislative mandates whereas others are self-imposed. The nine standards that were set by legislative action gave caseload managers in a public rehabilitation agency guidelines or established criteria for performance against which counselors and the agency could assess effectiveness and guide behaviors. These standards outlined several levels of performance against which counselors could measure how well or how poorly

they were progressing toward goals. The rehabilitation organization itself has also mandated standards for supporting its structure. The manual of policies and procedures, the guidelines for administering services, office or regional rules, and other occasional memoranda from agency directors' offices often constitute standards. Standards also exist in the private rehabilitation sector. Shrey and Lacerte (1995) have noted that private rehabilitation is searching for accountability through program evaluation. They observe that accountability standards take at least two forms: minimal professional competencies and program evaluation of special delivery systems. Matkin (1981) states further that "program evaluation offers a systematic procedure for regularly determining the results achieved by clients (as well as practitioners) following the provision of services and determining the efficiency with which those results are obtained on a regular basis" (p. 66).

Finally, good standards have common characteristics that contribute to their continual use as guides for behavior. Authorities usually state that the effective standard is the one that most often is (1) challenging but within reach without undue, long-term exertion, (2) based on competition within rehabilitation units and among states (i.e., as in the constant reminder to counselors that "our state is the best in _____" or "has the most _____," and (3) perceived as fair to persons responsible for outcomes. Standards must also be clearly comprehensible and quantitatively stated.

CONSIDERATIONS FOR APPLICATION OF A PERFORMANCE STANDARD

The breadth of application of a standard or the extent to which it can be applied for all counselors within both public and private practice depends on six key elements: (1) the equated work task, (2) common-based physical and social environments, (3) extent of work flow, (4) personal output control, (5) action decision-making processes, and (6) an understanding of an approach to the system.

Equated Work Task

The scope of the counselor's tasks is important to determine whether a particular standard should be applied to every counselor in the work setting. The complexity of tasks is also a consideration. For example, in public settings does the caseload contain a high percentage of dental, surgical, physical-restoration cases, or all significantly disabled cases? Careful consideration should be given as to whether some counselors have added

responsibilities and duties that burden the work task and thus require operation under varying standards. Probably the most pervasive forms of frustration and anxiety experienced by professionals in any field stem from attempts to perform efficiently while trying to satisfy impinging standards from a variety of sources. Many of these are counterproductive standards calling for an outlay of a great deal of energy and time in tasks that really do not bring the counselor any closer to meeting overall production goals.

Common-Based Physical and Social Environments

Some commonality should exist among counselors within an organization in the two areas of physical and social environments. This sharing of commonalities ensures that no burnout syndrome will result if one counselor's performance is held equal to a second counselor's output when they operate under different social and physical constraints. For example, counselors who work in an economically depressed geographic area with few placement possibilities should not be forced to operate under the same quantity standard of output as those in an area where resources are more abundant. Likewise, counselors with special caseloads (i.e., containing only one or two specific disability categories) must operate under different standards than those with general caseloads.

Extent of Work Flow

Obviously, a standard specifying the amount or percentage of persons rehabilitated from a particular caseload cannot be applicable if there are not sufficient referral sources s to consistently supply the quantity of necessary applicants. Again, varying standards are applicable.

Personal Output Control

Finally, the breadth of application of standards within a particular rehabilitation unit and among rehabilitation units is dependent on the actual power counselors have to control their own output levels. The above three conditions provide a means for assessing this last factor, but in addition, such characteristics as the authority and responsibility to carry to conclusion the conditions assigned or implied by a standard are essential. Thus, as an example, two counselors in significantly different geographic areas with varying economic and social conditions, with different client populations and different caseload sizes, and supervised differently would not be expected to be held responsible for identical standards of performance.

To the extent that counselors find themselves functioning where all the above conditions are not met, effective control cannot be established. It is important to note that all these conditions must be satisfied because the absence of control over any one condition will affect ultimate control. By initiating personal diagnostic skills, assessing the situation as it presently exists, and taking corrective actions with the full involvement of the supervisory structure, control can still be a reality.

Action Decisions

Action decisions require rehabilitation caseload managers to (1) set objectives, (2) be proactive, and (3) maintain an outcome focus. This process can be visualized through a travel analogy. When one determines the destination of a city to visit (objective), anticipatory action (proactive response) dictates the necessary planning, and keeping on the road in a timely manner leads to completion of the trip (outcome focus). Action decisions provide the means for evaluating competing demands (desired side roads or stops) and potential alternatives (change in directions or cities), to assure effective results.

An ever-increasing emphasis is being placed on assisting the rehabilitation professional to make decisions on the basis of accurate information and agency standards (Cassell & Mulkey, 1985, 2004; Lauver & Harvey, 1997). Compromise is an important concept for understanding the selection of decision variables. "Caseload managers must represent a philosophy or viewpoint that integrates and separates decision variables that influence the outcome or focus. Thus, the decision approach used by any caseload manager determines the adequacy of case-by-case movement" (Cassell & Mulkey, 2004, p. 267).

According to Cassell and Mulkey (1997, 2004) it is important initially to set obtainable objectives based on rehabilitation standards. These objectives must be *Specific, Measurable, Achievable, Relevant*, and *Time-specific*. Thus, the acronym *SMART* can also translate into structural events for all participants who will be affected by the decision. Objectives and intentions must not be determined as equal to one another. It is critical that achievable objectives be established in the initial planning stages. Remember, before event outcomes can reach fruition, action decisions must be selected that are based on personal and agency standards. There will always be some level of uncertainty, but the effective caseload manager will act on the best possible information that may yield desired and appropriate outcomes.

Systems Approach

Without an adopted or self-constructed system of operations, effective practices will never evolve. "All successful caseload managers employ a system or series of interconnected subsystems on which to base action and practice (Cassell & Mulkey, 2004, p. 269). A systems frame is the only approach that will sustain a caseload manager in the face of multiple standards and demands.

In a diversified environment, which often cannot be controlled or managed, rehabilitation professionals cannot survive without a modus operandi emanating from a systems perspective—"by the seat of the pants" perspective (Cassell & Mulkey, 2004, p. 270). Caseload management is asynchronous with a politically mandated rehabilitation environment. Demands on the rehabilitation manager are multifarious and competing. For example, the rehabilitation organization has goals, objectives, and standards to be served and the client populations have advocate forces to question the efficacy of professional decision making (Cassell & Mulkey, 2004). Also, adjunctive groups and organizations, which clients apply to and/or hire, contend for the caseload manager's action decisions. All of this suggests that priority setting and action initiation can come only from some systematic weighing and sometimes juggling of competing standards and demands. If there were only one guiding principle of an effective caseload manager, Cassell and Mulkey (2004) state that it would be that "the rehabilitation professional must operate from a self-constructed system of operations . . . based on the parameters of the organizational standards, policies and procedures" (p. 270). There is no alternative to survival in an environment in which quantity of demands significantly outweighs quality responses. "For CLM and case management practices, consistency and effectiveness are synonymous with system ideology" (Cassell & Mulkey, 2004, p. 270).

DEVIATION ASSESSMENT

Following the establishment of action and systems standards, a second essential element for structural control must emerge, including an assessment of deviations from the control. The assessment of structural control sets the stage for corrective actions and must therefore lay a good base for this important next stage. Deviation measurements have two characteristics pertinent for counselor consideration: establishment of strategic measurement points and sensitive limits testing. Counselors must create strategic measurement points throughout the caseload management process in order to assess deviations before a full-blown crisis emerges. Strategically placed measurement

points assist in fulfilling the objectives of each standard and keep them within manageable limits. Thus, we can add to a proactive counselor's repertoire for problem prevention.

Some variation is expected in all counselor activities, and so a certain amount of variation tolerance can prevent wasted efforts in continually correcting deviations that are not large enough to warrant action steps. A mature counselor who has set standards adequately and has a self-initiated measurement system will have a means for assessing the magnitude of deviations and will be able to make decisions on the extent of actions to be taken, if any. The process of making these decisions will be elaborated upon in chapter 4.

DEVIATION CORRECTION

When standards or guides for behavior are set and a monitoring or assessment system is relied upon for information gathering and feedback, the obvious next managing objective must be corrective actions for the deviations. The corrective actions work to stabilize one's management system and provide the control needed to continue to manage.

This final element for structural control logically follows the previous two: the interrelationships can be visualized easily with the awareness that actions present here are analogous to action steps tied into a thermostatic system for corrective actions, as opposed to a thermometer-type control. In thermometer-type measurement control systems, a passive monitoring setup merely reflects a condition; no internal corrective actions are built in. For example, a printout of a caseload or an enumeration of a caseload from month to month merely states a condition and reflects no action to be taken.

However, with thermostatic controls the measurement control functions are built in. Indicative of a proactive stance, as limits are exceeded, prearranged automatic action stages are initiated before crises or "compelled actions" occur. An everyday example is the thermostatic control in many home heating systems in which exceeding a preset limit will initiate a corrective action:turning on or turning off the heating system.

The effective caseload manager should plan for alternatives and build in thermostatic controls for caseload management activities. An example of a thermostatic control is a counselor file system, numbered or color coded by individual case, which indicates when a change is needed for a client, and whether that change necessitates mandatory or crisis-oriented actions.

Finally, corrective actions often require the effective caseload manager to reevaluate actions already taken or needed in the remaining four functions of the managerial system described earlier: the planning, organizing, directing,

and coordinating functions. For structural control the manager-counselor must not only be aware of these more administrative or tangible elements requiring action, but also must consider where the personal control elements fit. Thus, as has been emphasized numerous times, a gestalt or "big picture" is finally achieved with the interlinking or coordinated establishment of these two control areas.

SUMMARY

This chapter dealt extensively with aspects of control in a caseload management process. The four essential elements of caseload management discussed in chapter 1 demonstrated that personal elements must be given a great deal of consideration for effective outcomes in the rehabilitation process. Elements for personal control within this process were discussed and a concept for personal control was addressed. The concept of control that has been offered as a base for understanding and dealing with this area was Rotter's conceptualization of locus of control. The value this concept holds for the rehabilitation field was discussed. The PRIME factors for establishing control were presented. These factors include (1) Perception, (2) Reinforcement, (3) Inference Making, (4) Motivation, and (5) Evaluation. Elements of control were discussed to introduce the caseload manager to the kinds of issues that will be encountered with personal and system approaches to action decisions once field practices begin. Standards for action and a discussion of deviation assessment concluded the chapter.

Finally, it must be recognized that control occupies a central position in a management system. The caseload manager should realize at the outset of initiating professional practices in rehabilitation that without consideration given to the control function, all efforts in the caseload management process generally come to be exercises in futility.

CHAPTER 4

Elements of Effective Decision Making

RELEVANCE OF DECISION MAKING

By the very nature of their position-defined responsibilities in public and private settings, rehabilitation professionals are required to provide timely and coordinated services to numerous individuals simultaneously. In order to carry out the duties of their positions effectively, they must be able to address rehabilitation needs, recognize appropriate services, offer these services, and then perform those actions that are necessary to deliver the proposed individualized plan. Although the ability to recognize individual needs and service availability underlies the knowledge base of rehabilitation counseling, the actual provision of services to individuals demands that counselors exhibit high-level decision-making abilities. In fact, the study group that composed the Third Institute on Rehabilitation Services (Muthard, 1965) regarded the ability of rehabilitation counselors to make decisions "as a critical variable in effective caseload management" (p. 13).

Rehabilitation counselors cannot perform their service-delivery duties unless they are capable of making decisions. Although caseload managers should not make hasty and impulsive decisions based on incomplete or inadequate information, they must be willing and able to make decisions from ambiguous or inconclusive data. In other words, rehabilitation counselors cannot delay service provision until each inconsistency is resolved or until the data conclusively support their decisions. A delay in decision making often works against the timely delivery of services and therefore detracts from responsible, cost-effective rehabilitation practice. It must be remembered that in not making a decision the counselor actually is deciding against service delivery at that time.

Rehabilitation counselors do not have a choice about whether to make decisions. By virtue of their caseload management duties and their responsibilities for a rehabilitation process, counselors are decision makers. The decisions made or not made play an integral part in determining the caseload manager's overall effectiveness in the service-delivery process. Decision approaches may be labeled as active (thinking, planning, doing) or inactive (doing little or nothing). Thus, the case manager's approach to decision making determines whether case movement does or does not occur. For this reason, how well rehabilitation counselors are able to apply their knowledge in serving individuals with disabilities depends on how well they make active decisions and perform related actions. Therefore, in addition to acquiring a knowledge base, rehabilitation counselors must develop a structure for the organizing and planning stages of their management activities. That structure will then enable them to make sense of the many variables associated with the delivery of individualized services in a variety of complex situations. This chapter describes decision-making concepts and useful decision-making models, and presents a model for decision making in rehabilitation. These parameters provide counselors with preliminary tools to ensure that the rehabilitation process is indeed progressing toward defined goals.

A DECISION-MAKING STRUCTURE

ABC Decision Patterns

The paragon of rehabilitation decisions has a fundamental structure consisting of three basic components: Apex Decisions, Base Decisions, and Consequential Decisions. These components are the foundation of what the authors term the ABC Decision Patterns for caseload managers (see Figure 4.1). The identified patterns offer a logical conceptualization of the decisions required for successful performance as a rehabilitation counselor-manager. Clearly, decision making or assisting clients to make decisions about such things as evaluation procedures, vocational goals, return to work, eligibility, or appropriate rehabilitation services, is a large part of the counselor's day-to-day job responsibilities.

Decision making is a learned skill. Usually, trial-and-error experiences are used to generalize decision-making skills to various situations that require a choice from multiple alternatives. It is this process that often becomes "habit" in approaching decision situations. Lack of awareness of or concern for a systematic approach to alternative selection usually results in undesirable outcomes. When such outcomes occur frequently, there is the danger of developing concurrent undesirable attitudinal outcomes that influence how a counselor-

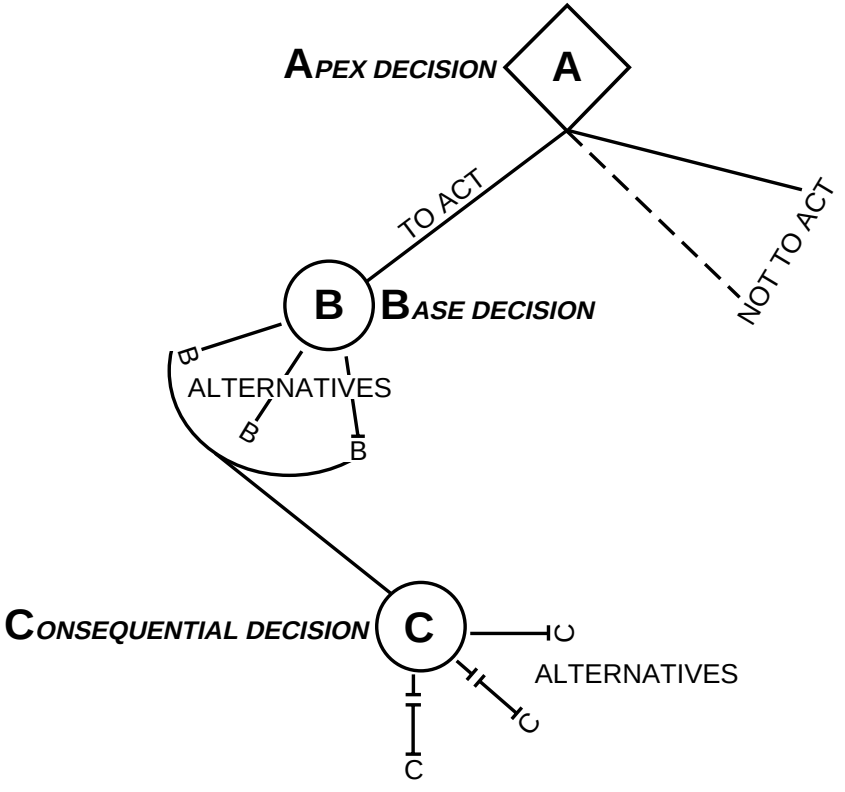


FIGURE 4.1 The ABC Decision Patterns

manager approaches future decision-making situations. The desire to avoid another bad decision might lead to a hesitancy of commitment that could be viewed as procrastination. Thus, the first decision situation encountered by the counselor-manager is to act or not to act: this is the Apex Decision.

Apex Decision

Decision-making situations initially confront decision makers with a choice between two alternative courses of action, that is, the first decision to perform the action or not to perform the action. This initial choice may be labeled the *Apex Decision,* which is the choice from which all other decisions emanate. It is unique because there will always be *only* two alternatives of concern (action or inaction) with the possibility of a decision conveyed through inaction or without noticeable expenditure of effort. Often, Apex Decisions are easily made (e.g., "I've been meaning to do that, but . . . "). However, in some

situations the Apex Decision is more troublesome (e.g., "I'm really not sure what to do, but let us start with . . .").

Figure 4.1 illustrates the inaction decision extended over a period of months. As the number of months (represented by the broken line) increases the likelihood of an action decision proportionately decreases. In other words, the longer an action is postponed, the harder it may become to implement any change at all (Arnold, 1976; Cassell & Mulkey, 1985). Situations change with the passage of time. For example, a person may seek public rehabilitation services stating a pressing need for employment. However, six months later (counselor's inaction decision) as the counselor-manager is ready to begin working toward rehabilitation goals (counselor's action decision), it is discovered that the potential client has been working for two months and is employed satisfactorily. Among other variables that changed within this time period, the person is no longer in need of employment.

Procrastination impedes an action decision. However, rehabilitation counselors may experience difficulty more often with the factor of uncertainty. Caseloads are composed of symbolic and factual information about people. As these symbols and facts merge, decision-making situations are created. For example, a person completes the application process (symbolic) for declaring an interest in rehabilitation services to assist employment efforts. However, the merging of facts (e.g., female, fifty-three years of age, no work history, completed ninth grade, diabetic) leads to decisions that can reach beyond the limits of rational certainty. Inherent in managing is the necessity to confront uncertainty by making judgments that go beyond facts and logic. Clearly, the human factors of intelligence and courage influence the action decision-making process. At times, either internal pressure (e.g., guilt, "I *have really* got to do something about . . . ") or external direction (e.g., supervisor saying, "You have far too many cases as applicants. Move them on out . . . ") is necessary to access the action alternative of the Apex Decision. Thus, some counselors will feel comfortable making a timely Apex Decision that leads to the Base Decision. In contrast, other counselors will be influenced by internal or external forces that will lead to inappropriate decision making.

Base Decision

Once the Apex alternative of action is chosen, the caseload manager is then faced with the selection of techniques and strategies that will likely *transport* clients from where they are (present circumstances) to where they want to be (rehabilitation goal). Regardless of whether the rehabilitation goal is viewed specifically (e.g., return to prior employment) or generally (e.g., remunera-

tive employment), a beginning situation and end result are identifiable for every applicant in the caseload.

The Base Decision, then, is the alternative selected as the best vehicle of transport for assisting the client to move from the present circumstances to the rehabilitation goal or negotiated settlement. Specific procedures for making Base Decisions will be considered later as we discuss decision models. For now, it is important to note that the caseload manager and the client should identify the course of action that will contribute most to the achievement of the rehabilitation goal. Base Decisions, then, are decisions that reflect the optimal choice leading to the negotiated settlement or optimal outcome for the individual. Of course, the assumption of a possible optimal course implies that one of the alternatives being considered is the best course of action. The Base Decision can be identified easily by the elimination of less desirable alternatives. It should be noted, however, that Base Decisions are not without risks. Caseload managers often make decisions from ambiguous or inconclusive information.

Consequential Decision

The third type of decision caseload managers must make relates to the consequences of change in the Base Decision. Sometimes a rehabilitation program fails to proceed as planned. Various elements (e.g., Worker's Compensation Board rejects proposed action plan) may divert the action of the Base Decision, or conditions may impede the attainment of rehabilitation objectives (e.g., the client moves to a new location). The caseload manager or the client then needs to make a Consequential Decision. A consequence of the Base Decision breaking down is a change of plans. When new information requires additions to the existing program (a change of the vocational goal and subsequent program initiatives, or case closure), a Consequential Decision must be made. Consequential Decisions require answers to questions of whether a program can continue with modifications (supplemental or amended intermediate objectives) to reach the original long-range goal or if the situation(s) of concern prevents continued action toward the original vocational objective.

Not all decisions of the caseload manager can be viewed as simply derived from available data. There are times when the appropriate decision is *temporarily* to *delay* making a decision that relates to programmatic initiatives. Fulcher (1965) called attention to the idea that whereas most decisions require the taking of some action, a decision *may* be very sound even though it is a decision of no action. Such a no-action decision is, of course, different from a passive approach to decision making and is *not* procrastination. To

illustrate, an action decision may be to delay the development of a rehabilitation program pending the outcome of an admission examination or a surgical procedure. The basics for making responsible decisions are the same even if one of the alternatives considered is to take no action.

DECISION-MAKING THEORY

As society moves more and more into the information age, the complexity of decision making is increased by available data and data sources. In fact, making any decision could be a waste of time unless appropriate procedures are used to assist accurate understanding of probable alternatives. Thus, caseload managers need to develop an effective methodology that considers increased information, which reduces the amount of unknown variables. However, today's reality mandates that even when the caseload manager has computer-produced data, the final decision is made only by the person having the ultimate responsibility for the decision.

Prior to consideration of the basic theory of decision making, it is useful to understand that the potential effectiveness of any decision should be appraised. Several authors (Anthony, 1988; Brill, 1995; Cassell & Mulkey, 1985; Maier, 1963) have noted that there were two dimensions relevant to appraising the potential effectiveness of a decision. The first of these was termed *quality* and the other *acceptance*. The quality of a decision relates to the objective or impersonal aspects that might be used to reach an alternative selection. Many caseload managers could probably cite difficulty with the quality dimension because trained rehabilitation counselors can be influenced by personal aspects that impede rational thinking. Information regarding client situations often is difficult or impossible to quantify, and the quality of rehabilitation decisions is germane to the judgment of the caseload manager. The other dimension has to do with the way the client or those involved in the implementation process accept a decision. How many times have clients terminated training programs they believed were forced on them by company or agency directives, counselors, parents, or other well-meaning advocates?

Research further contends that decision makers will likely focus on either quality *or* acceptance regardless of the nature of the situation (Cassell & Mulkey, 1985; Glass, 1991; Introna, 1997; Maier, 1963). Certainly, a person's normal style of decision making will influence whether quality or acceptance is the focus of concern in decision situations. However, as indicated by the selected review of decision theory, the decision style of caseload managers should be flexible and dependent on the nature of the problem. Every client situation is unique and the challenge for a caseload manager is to develop

a *systematic approach* for consideration of this uniqueness as it affects alternative decision selection. Certainly some understanding of basic decision-making theory is necessary to develop and implement a systematic approach to making decisions.

Hannagan (2002) described decision making as "a relationship over time between decisions, outcomes, payoffs and probabilities" (p. 370). It is this overall process that leads to an action program (e.g., the Individualized Plan for Employment). Certainly, the selection of a specific program from alternatives is a decision in itself, whereas implementation of the chosen program reveals observable dimensions of the final decision. Stemming from the many managerial requirements, the rehabilitation counselor encounters "a problem" several times each day, and is involved continually in the process of finding "a solution," while needing to understand the payoff and probability of successful rehabilitation outcomes. Therefore, decision making is an integral part of the counselor's daily work routine.

Several authors suggest that measurement of some kind is required for every rational decision (Anthony, 1988; Cassell, Mulkey, & Engen, 1997; Kiesler, 1999; Miller & Starr, 1967). In other words, a means of evaluating the degree of attainment of the objective(s) is a requisite part of every decision. This reality presents itself to the rehabilitation counselor in the form of production goals like successful rehabilitation closures ("26"), client satisfaction, counselor satisfaction, sponsor satisfaction, or other criteria used to measure outcomes.

Fulcher (1965) called decision making "an applied art," which includes the use of "applied logic, for testing conclusions," as well as "applied ethics, for testing judgments" (pp. 4–5). Decision making involves the application of the rehabilitation counselor's knowledge, experience, mental skills, and moral commitments to determine specific action(s) in various situations. The counselor's freedom to choose the best alternative from among all possible alternatives is an asset, but this same freedom can be a liability when the counselor makes unwise or unsound decisions (Egan, 1994).

The rehabilitation counselor's ability to select a workable alternative is often restricted by her or his information-handling capability. To illustrate this point, Hayes (1962) found that providing a decision maker with more than four facts not only reduced the speed of the decision, but also reduced its quality. Felsen (1976) further suggested that as decision variables increase, confusion occurs so rapidly that relevant information may have to be eliminated in order to obtain performance from the decision maker. Unfortunately, the efficiency of decision making by some caseload managers is connected so intimately to their own psychological barriers or behaviors (like fear,

vanity, hope, impatience, procrastination) that their decisions are derived primarily from and based on human emotions and instincts. For this reason, rehabilitation counselors must examine and evaluate their own systems of beliefs, values, and need structures at the outset, in order to recognize their personal and situational limitations, and to develop the necessary insight and structure on which to base professional judgments (decisions).

The important terms *theory* and *model* are used in a variety of ways throughout the literature on decision making. However, each term commands universal respect for its contributions toward understanding the dynamics of decision structure. An exhaustive account of meaningful and varied theories and/or models would likely have limited influence on developing or shaping an appropriate, individualized approach to decision making by rehabilitation professionals. Therefore, the next section will emphasize selected components of various theories and models to encourage the caseload manager to develop and use a preferred decision-making structure. A decision model is offered for consideration in Figure 4.2. Such a model may be helpful to the

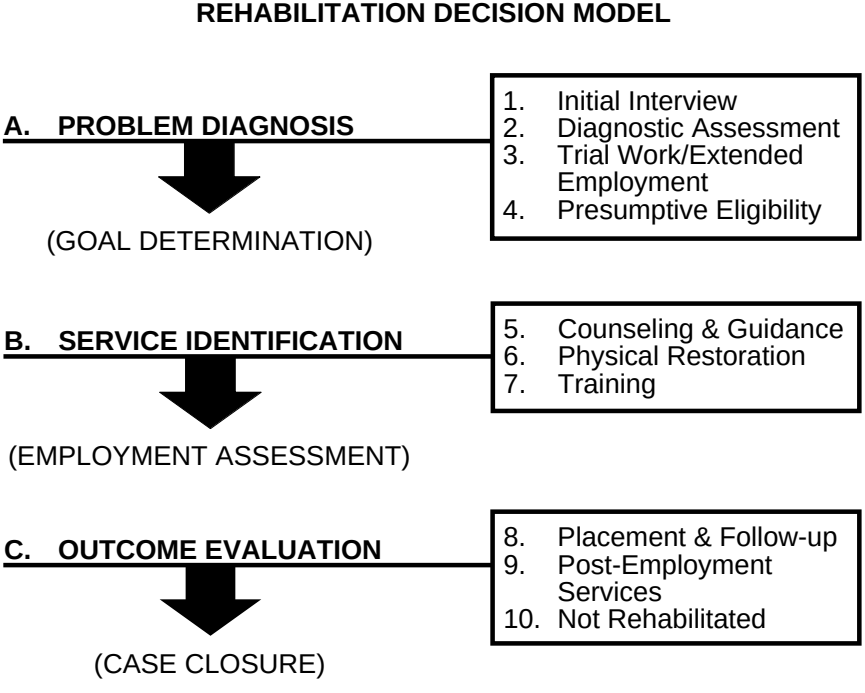


FIGURE 4.2 The Rehabilitation Decision Model

caseload manager as an organizational tool leading to effective personal and professional decision making.

THE PROCESS OF MAKING DECISIONS

Need for a Process

As a decision maker, the rehabilitation counselor must interpret, classify, describe, explain, evaluate, prescribe, and predict. Each of these activities, of course, requires a value judgment (decision) to be made and they are often interrelated within a complex problem situation. The emphasis in vocational rehabilitation is on *evaluation* and *prescription* (i.e., problem identification and solution) and both processes require intricate value judgments from the counselor regarding situations (resources, job market), institutions (agency, company, community), and people (clients, families, lawyers, vendors). The rehabilitation counselor must evaluate each client's vocational potential and prescribe a program of service(s) designed to assist the client in realizing the expected (predicted) potential.

Usually, decision making is described as (1) identifying objectives, (2) exploring alternatives and consequences, and (3) choosing the best alternative by eliminating the choices having greater consequences (Anthony, 1988; Brill, 1995; Cohen & Cohen, 1999; O'Shaughnessy, 1972). Many professionals in the field of rehabilitation apply this descriptive framework and in many situations it is an effective approach to reaching decisions. However, there are times when such a model cannot cope with existing client-situation data. Issues involving significant disability problems often mandate the need for a more complex decision model. For example, the three-step model just noted fails to consider problem identification (although it is inherent) and evaluation of its impact on identified objectives.

The unique decisions required of rehabilitation practitioners necessitate the availability of simple *and* complex decision models. Deciding which physician to use for a medical examination, or which case zone to identify, is a decision situation that can be resolved by a simple model. However, determining vocational goals and then problem evaluation or identification that leads to clarification of functional limitation(s) may well require use of a more complex decision model that includes consideration of time limits, estimation of probabilities, or even values clarification. Regardless of the complexity of decision situations, caseload managers must be able to select decision-making models germane to the problem situation. This function is activated by applying a systematic decision-making model to a specifically defined problem in distinct sequential steps (Cassell & Mulkey, 2004). In

other words, the caseload manager must maintain flexibility in decision model selection as human-service problem situations are uniquely individualized with few commonalities. The selection of the best alternative cannot precede consideration of *all* possible alternatives, nor can the identification of probable vocationally related goals. Therefore, rehabilitation counselors must recognize the function within systematic models appropriate to specific decision situations, as the mere repetition of making decisions does not necessarily improve the skill (Arnold, 1976).

Classifying Categories of Decisions

There are various ways to classify the kinds of decisions made by counselors in the management of rehabilitation caseloads. Such decisions are usually made with differing amounts of information and therefore can be categorically identified. Miller and Starr (1967) offer five classifications for problem decision-making situations. They are decision making under

1. certainty,
2. risk,
3. uncertainty,
4. partial information, and
5. conflict.

These decision conditions can be remembered by the acronym CRUPIC. Certainly, decisions made by caseload managers can be identified by their inclusion within each of these categories. Rehabilitation counselors make *routine* (familiar problem situations) and *nonroutine* (unfamiliar problem situations) decisions every day. To illustrate, the following brief discussion relates each of the above five categories to a specific caseload management situation that requires a decision from the counselor-manager.

"Decision making under certainty" can sometimes be problematic for the rehabilitation counselor. To illustrate, one of the earliest decisions the counselor must make is to schedule the client for a medical examination or additional medical evaluation. An appointment can be scheduled with any number of qualified physicians, this is certain. However, the routine decision of *which physician* can complete the examination and submit the necessary report within the shortest period of time requires judgment or prior experience relative to all elements of informed choice.

"Decision making under risk" is a familiar problem to most rehabilitation caseload managers as few (if any) caseload-related decisions are without

risk. An example familiar to counselors is the client who fails to report at the appropriate time or place after appointments have been scheduled with physicians or after evaluation or training activities have been arranged. As inherently *certain* as these situations appear to be, *risk* contamination may prevent the decision from being carried out. Another example of a rehabilitation-related situation with risk factors concerns client employment. How often have caseload managers placed a person in an employed situation with a high risk associated with continued employment? Risk factors are incorporated into every case management decision. More in-depth treatment of these factors is presented later in this chapter (see Risk-Taking Factors).

"Decision making under uncertainty" can readily be related to rehabilitation of significantly disabled individuals. Disabling conditions often impose limitations that create considerable uncertainty regarding rehabilitation or placement potential. Thus, program decisions of short duration are useful to allow assessment of new information about situations or conditions of uncertainty. Extended evaluation procedures in the public rehabilitation sector address this problem by allowing additional evaluation time to acquire information that reduces uncertainty about an individual's potential to use rehabilitation services. In the private sector, rehabilitation planning developed by practitioners is often quite uncertain until scrutinized by the compensation board or negotiated by appropriate representatives of the legal system. Because rehabilitation is concerned with productive aspects of human beings, their humanness creates uncertainty that must be considered within any rehabilitation effort.

"Decision making under partial information" is present in most (if not all) existing rehabilitation situations. The rehabilitation counselor-manager cannot, and should not, know "everything" about an individual client or prospective client. It would not be cost effective to collect "all" information about a person, and furthermore, having such information significantly increases the complexity of making appropriate decisions. Therefore, decisions are made on the *best* information available. Such information should include the *t* data that are germane to the established objectives. In other words, accurate *and* adequate information may differ for clients, but consideration is given to all possible factors that could affect outcome. To illustrate, the rehabilitation practitioner may be unaware of the influence (positive or negative) of family members or friends that could affect a person's successful rehabilitation. So, the caseload manager must be able to conceptualize an informational balance between quality and quantity as each relates to an individualized decision.

The newest decision problem situation for the rehabilitation caseload manager is "decision making under conflict." Public Law 93-112 (the Rehabilitation

Act of 1973) allowed for client advocacy from community representatives and created a situation for *possible* conflict of interest between counselor and client or the client's representative. Also, potential litigation may force private-sector counselors to make numerous decisions under conflict. However, if all are sincerely working in the best interest of the client, then flexibility should lessen the conflict. Another illustration of decision making under conflict is when a client's vocational objective is far above his or her demonstrated or evaluated performance levels. Even when appropriate negotiations reduce the conflict, the caseload manager must make decisions in the face of existing conflict.

The above examples are presented for conceptualization of the five decision problem situations and should not be construed as conclusive for all the categories of encounters rehabilitation counselors experience. Numerous other situations could be cited to illustrate the various decisions made by rehabilitation caseload managers in public, private, and facility practice.

Models for Decision Making

The rehabilitation professional needs an organizing concept in order to simplify the complexity of caseload realities. Clearly, the effective decision maker must understand that the underlying fundamental functions create the process of management. It is assumed that the caseload manager can make decisions. Some of these decisions are made in accordance with agency or company policy whereas others are more pragmatic in nature and are based on the individuality of client movement.

For example, in public rehabilitation the decision process is as simple as concluding that the applicant does not meet established eligibility criteria. However, on other occasions the decision process may be far more complicated. For instance, consider the development and provision of a service program with a person who has a specific learning disability that requires both remediation and accommodation for completion of the program (Bencomo & Schafer, 1984; Hitchings, Luzzo, Ristow, Horvath, Retish, & Tanners, 2001; Hurst, 1999; Miller, Mulkey, & Kopp, 1984; Skinner, 2003). Clearly, conceptual order demands a logical, systematic approach to these decision situations.

The following four models for decision making provide an ordered approach that has application in both public and private rehabilitation programs. However, because of theoretical differences among caseload managers, as well as situational variables, some rehabilitation counselors will choose an eclectic approach to decision making. The end result mandates that caseload managers consider the selection or development of a functional model for

structuring the decision process. One model is discussed in appropriate detail to increase understanding of those issues that caseload decision makers must consider. The other three models are presented with limited discussion as understanding of the first model is easily transferred to the others. The skeletal presentation of these selected models should provide significant elements for understanding and developing an effective and efficient decision-making process. The cited sources are recommended reading for those who want to improve their decision-making skills.

The Drucker Model

Drucker (1967) has described a comprehensive procedure for making decisions. Six sequential steps of decision making, as presented by Drucker, pp. 92–93, include

1. *Classification of the problem*: Is it generic? Is it exceptional and unique or is it the first manifestation of a new genus for which a rule has yet to be developed?
2. *Definition of the problem*: What are we dealing with?
3. *Specifications that the answer to the problem must satisfy*: What are the "boundary conditions"?
4. *Decision as to what is "right," rather than what is acceptable, in order to meet the boundary conditions*: What will fully satisfy the specifications *before* attention is given to the compromises, adaptations, and concessions needed to make the decision acceptable?
5. *Building into the decision the action to carry it out*: What does the action commitment have to be? Who has to know about it?
6. *Feedback that tests the validity and effectiveness of the decision against the actual course of events*: How is the decision being carried out? Are the assumptions on which it is based appropriate or obsolete?

Subsequent discussion will attempt to relate each of the above six steps to caseload manager functions. It should be remembered that unless a decision has been *implemented,* it is not a decision but rather a *good intention.* To illustrate: suppose a person decides to visit Rome, but never makes the trip. At best, this could only be labeled as a good intention. However, when the person steps onto the airplane *to Rome* the commitment to action clearly indicates the transfer from a good intention to *a decision.* Thus, a decision is the *result* of a systematic process that clearly defines the important aspects of a situation and considers the data in distinct sequential steps.

The decision model proposed by Drucker is considered in appropriate detail to understand a decision process as it relates to the functions of the caseload manager. Three other decision models were selected specifically for inclusion to increase options for the development of an individualized, systematic decision process. The limited discussion of these models does not reduce their importance, but rather shows the commonalities of *any* decision-making process, whatever the conceptual system. However, the decision-making technique is not nearly as important as the decision impact.

The steps described above do not, by themselves, make the decisions. Personal judgment is required to facilitate movement throughout the process. However, even if the caseload manager considered only the first two steps of the above procedure, the decision-making process would be facilitated considerably. A clear understanding of the problem is vital to the delivery of an effective decision.

Because all decisions are, in fact, risk-taking judgments, the caseload manager should do everything possible to reduce associated risks. However, unless the decision maker uses an appropriate systematic process, increased risk is almost certain. Also, the greater the amount of risk associated with a problem situation, the greater the need for a clearly defined process for making decisions.

The Drucker model identified sequential steps (discussed below) that include the use of specific rehabilitation terminology to increase understanding of this decision structure. Numerous examples from public and private rehabilitation caseload manager functions could illustrate each step of the decision process. However, the representative decision situations were selected for their value in communicating an understanding of the application of this model. The reader is encouraged to think of other caseload management situations that appropriately apply to the steps of the decision structure.

Classification (Step 1) concerns whether a problem situation is *generic* or *unique*. Although all rehabilitation cases are considered on an individual basis, rarely are the decision situations uniquely different. However, on occasion, unique problem situations do occur and each must be treated individually; counselors cannot develop a rule, policy, or principle for exceptional situations. Agencies or companies concerned with human problems function within the parameters of procedures that allow for referral of situations that are beyond policy accommodation. Referral, then, is a generic solution to a perceived exceptional problem. To illustrate a unique caseload management situation, let us focus on referral sources. Suppose that *all* referrals to a specific caseload suddenly stopped and that after several months of trying various casefinding techniques, referrals remained at zero. Clearly, the problem

does not appear to be of a generic nature as the established rules for gaining referrals failed. Thus, this situation would be classified as unique, and possible solutions could only result from examination of all the component parts of the problem.

Regardless of professional setting, most decision situations caseload managers encounter are generic and must always be resolved through a rule or principle. A good example of this in public rehabilitation is the eligibility decision. Eligibility rules are applied to evaluation data to determine if a person with a disability has functional capacities relative to an occupational objective, and whether vocational rehabilitation services will positively affect employment activities.

A common error of decision makers is the treatment of generic situations as if they were unique problems. Rehabilitation philosophy calls for treating every case situation on its own merits. However, case managers must guard against interpreting this to mean that each decision situation should have its own resolution structure. In fact, such a pragmatic approach would treat all decision situations as if they were unique, and caseload managers would not have rules or principles to guide data considerations. It is easy to imagine the confusion, conflict, and discrimination that would occur if all eligibility decisions were made on the "merits" of the case. This argument does not challenge the individuality of each case situation, but rather, advocates for the necessity of a decision structure in which individualized data can be processed. Another example would be the counselor who has extensive problems with the placement of clients in competitive employment with a number of employers. An ineffective decision maker would conclude that each problem situation (employer) is different and would demand a unique design or approach for resolving each one. The effective decision maker might conclude that the generic problem is the counselor's inability to establish a systematic approach for contacting and "selling" employers on rehabilitation and clients who have disabilities. Thus, time is spent ineffectively in developing numerous strategies for each situation when one set of *marketing* rules or principles for analyzing jobs and working with employers would be much more effective.

The first step, then, is to determine whether the problem is generic (a common situation with established procedures for seeking resolution), unique (an exceptional situation having no recognized formal procedures for finding solutions), or the first manifestation of a new genus for which rules are yet undeveloped (e.g., federal policy stating eligibility for a new disability category when state or local procedures have not been established). Just as the athlete knows whether to run or dribble by identification of the held

object as a football or basketball, the caseload manager knows what action to take by correct classification of the decision problem situation.

Defining the problem (Step 2) is often an easy task once it has been classified. Familiar questions that require answers include, "What are the functional limitations?", "Is there a treatment regime recommended for this disability?", and "What is the key to the situation solution?" Clearly, this is the beginning of the *rehabilitation diagnosis* activity.

Effective decision makers will recognize quickly that the most prominent danger at this stage of the decision is not the wrong definition, but rather the incomplete one. No one believes that half a dollar is as valuable as a whole dollar, or that an unfinished novel is likely to become a best seller. Likewise, an incomplete rehabilitation diagnosis (definition) is likely to limit vocational gains a client may reach or even cause incorrect identification of the problem. Caseload managers must guard against a plausible but incomplete definition of the problem. For example, suppose an academic training program was developed for a client with a diagnosed learning disability, but there is no information on the client's learning style. Soon after initiation of the training program it is discovered that the client is performing below average and is thus subject to termination from training. The client is thoroughly frustrated and the counselor is confused about why the client is having problems with the training activities. After all, it had seemed so plausible. Such incidents can be avoided if caseload managers observe *all* events associated with defining the problem.

The only protection against being caught with an incomplete definition is to check and recheck all information for support of the defined problem. If the facts fail to support a derived definition, then reconsideration should begin immediately. The overall cost of time, money, and frustration is considerably less at this juncture than if the incomplete definition is adjusted at some later time.

The prior examples primarily communicate aspects of problem identification as they relate to the rehabilitation diagnosis. However, these illustrations were used specifically to demonstrate this step of the decision process. It must be remembered that definition of the problem is germane to *any* decision situation.

Specifications (Step 3) should be viewed as both short- and long-term rehabilitation goals. This part of the decision process mandates a clear identification of what the decision in question must accomplish. In other words, what are the objectives (e.g., gainful employment or return to prior level of employment) the decision must reach and what are the conditions (e.g., vocational training or job modification) that must be satisfied?

The rehabilitation process itself is a supra-decision-making structure (see section on the Rehabilitation Decision Model). The system forces decisions simply by movement of cases through the basic classification system. As such, the rehabilitation process is composed of numerous building-block decisions. For example, diagnostic decisions must precede service decisions. The reverse would be a futile attempt to make the problem fit the solution. In other words, the Individualized Plan for Employment cannot be written without a thorough understanding of a client's specific functional limitations (Cox, McNair, DeFoor, Stephens, & Ladson, 1981; Downes & Thomas, 1994; Hergenrather, Rhodes, McDaniel, & Brown, 2003; Mulkey, Kopp, & Miller, 1984). Thus, specifications are an integral part of the supra-decision-making structure (like the Individualized Plan for Employment) as well as the everyday building-block decisions (e.g., obtaining medical information). In both situations, the specifications clearly identify what the decision must accomplish.

The *decision* (Step 4) should focus on the best alternative rather than the one that would be most acceptable to those concerned. There is nothing to be gained by consideration of what will be most acceptable. There will be plenty of room for compromise in the end. It is this principle that activates the discrimination among original, supplemental, and amended service programs in public rehabilitation.

Action (Step 5) is converting the decision into measurable activity. It is time consuming and responsive to the components necessary to its execution. In fact, the action *commitments* must be incorporated at the beginning if decisions are expected to be effective.

Once assignment of responsibility rests with the client, the caseload manager, a vendor, or other person concerned with the specific steps necessary for activation, the good intention advances toward a decision. Timetables for completion of specific tasks must be identified. Thus, service decisions specified on the Individualized Plan for Employment must reflect the expected time required for completion. Also, all those involved with the decision action must understand their responsibility and have the necessary information (resources) to carry it out. To illustrate, imagine that during the initial interview, a client accepted the responsibility of getting to a specific location for a medical examination. The counselor-manager was to schedule the appointment and notify the client. The appointment was made for 10:30 A.M. on November 7. However, about noon on the specified date, the counselor's office was notified that the client had not kept the appointment. An investigation revealed that the counselor had failed to tell the client of the scheduled examination. As the client had already agreed to go for the examination, the

only missing part was the information (i.e., date and time of examination) necessary to carry out the decision. Obviously, it is critical that those needing information about a decision have that information.

Finally, if the action commitment involves the changing of attitudes, habits, or behavior of participants with an interest in the decision outcome, it is critical that the planned action be one that *can* be carried out by those with major responsibility for the accomplishment. Simply stated, those involved must not only be aware of their responsibility, but must be capable of meeting established standards. One example might be a situation in which overprotective parents do not believe that their daughter who has a disability can work in the competitive labor market. A better example might be the doubting employer who has reluctantly agreed to hire a worker with a disability. In both situations, understanding the responsibility for the action precedes having the capability to carry it out. Stated differently, *failure* is an exorbitant cost that can be prevented if the decision maker has a complete understanding of the standards that must be met. Such understanding tends to ensure the matching of capabilities with demands. However, this concern should not be viewed as an attempt to protect clients from failure, but rather as a proactive approach to making effective decisions.

Feedback (Step 6) is the process of information monitoring and reporting that must be built into any decision. Feedback is necessary to determine whether the expectations of a decision become reality. In part, this is a documentation activity. The rehabilitation caseload manager must obtain periodic indications as to the progress of prior decisions. Such notations may be reflective of a single case activity (e.g., client progress in a specific training program) or of a total caseload action (e.g., a 50% reduction in total cases reported).

However, and more important, feedback provides information about how specific caseload manager decisions are being carried out and whether adjustments will be necessary to ensure their achievement. Reality is an ever-changing phenomenon. Thus, adequate and accurate feedback on prior decisions is a management tool of effective decision makers. In rehabilitation, such feedback is necessary for developing maximal gains from service-provision strategies. Of course, the best way to obtain valid feedback is an on-site inspection that incorporates appropriate interview and discussion techniques. Failure to "inspect" decision outcomes is an open invitation to extract communications (e.g., progress-report forms) that may be ineffective in noting whether progress has occurred. The rehabilitation caseload manager needs *both* progress reports and on-site inspection to provide the necessary organized information for feedback evaluation. Strategy may then be altered to meet the current reality.

In summary, it is important to note that Drucker (1967) advocates a systematic approach to decision making with the important elements clearly defined and considered in a distinct sequential order. Indeed, pervasive decision making is mandated by virtue of the caseload manager position. However, it is a knowledgeable and alert manager who can make significant and positive impact on caseload movement and client performance.

Felsen's Process

A second model of decision-making identifies factors that can be arranged according to function. Felsen (1976) views problem solving and decision making within the following four phases:

1. identification activity,
2. design,
3. choice and implementation, and
4. performance evaluation and learning.

Considering these four phases of decision making in relation to the work of the caseload manager, it is easy to recognize that they bridge a greater distance than the more detailed structure provided by Drucker (1967). Specifically, there are fewer steps to remember as one approaches a decision situation, but the personal energy and collective involvement of the decision maker may or may not be decreased. Even though the time required to reach a decision is important, it is the outcome that is eventually effective or ineffective. Ineffective decision makers are a dime a dozen, whereas effective decision makers can name their price.

A careful review of each phase indicates its utility with a single case or a total caseload. First, let's look at an individual client. The *identification activity* attempts to establish parameters around the problem situation. Suppose the client has a paraplegic condition and is seeking training to gain employment. As this client's functional limitations are understood, purposeful planning (design) can lead to the *choice* alternative and program *implementation* (Individualized Plan for Employment). Of course, *performance evaluation* is necessary to determine whether goals are attained. Finally, an important component of this model is the *learning* activity. It is this type of cognitive reflection that enhances the caseload manager's knowledge base and impacts overall performance.

Now let us consider a total caseload decision situation. Imagine that the *identification activity* established information of an excessive number of cases

lodged in Zone II (see chapter 6). The *design* mandated a reduction of stagnant cases declared eligible. The *choice* alternative was to contact each person and appropriately plan *implementation* of required rehabilitation services or close the case. *Performance evaluation* would then characterize the results and the caseload manager's *learning* would focus on prevention of the problem recurring.

Confirmation Theory

A third model is found in the Confirmation Theory of decision making with three components identifying the process: (1) problem definition and planning, (2) decision design, search, and evaluation, and (3) choice confirmation and commitment (Soelberg , 1967).

One can readily see that this decision structure parallels the work of the rehabilitation caseload manager. Whether the decision situation is simply recognizing and planning for a client to obtain psychological evaluation, planning for work-adjustment training, or placing a client in employment, aspects of this decision structure are germane. Rehabilitation counselor functions demand skills in problem identification, search for problem solutions through evaluation, selection of the best alternative, and commitment to a successful outcome. Once again, attention should be called to the importance of a decision structure for processing data to reach decisions.

Cost–Benefit Analysis

The fourth model considered was initially developed for use in making decisions in the public sector. However, this model is currently utilized in both public and private sectors. Model components of "Benefit–Cost Analysis" (Hamburg, 1967) or "Cost–Benefit Analysis" (Gross, 1988; Kierulff, 1976; Mullahy, 1998, 2004; Shrey, 1995; Shrey, 1995b) vary according to decision-making purposes. Thus, because caseload manager decisions are often complex and unstructured, the following decision-making approach will assist counselors in making *individualized* case decisions that achieve rehabilitation objectives at minimum cost. The Rehabilitation Case Cost–Benefit Analysis (RCC-BA) components are

1. The *decision situation* exists when the opportunity to assist a person's rehabilitation efforts demands a choice from possible alternatives.
2. *Rehabilitation objectives* are the vocational goals or other objectives to be achieved by the decision.
3. *Functional limitations* are those cognitive, emotional, or physical conditions (variables) that impede preparation for obtaining or retaining employment.

4. *Employability* is the qualitative assessment of achieving the vocational goal(s).
5. *Rehabilitation resources* are the positive means (tangible or intangible) of support that accrue to an individual service-delivery strategy.
6. *Budget* is the assessed monetary sacrifice necessary to attain or maximize the rehabilitation objective(s).
7. *Cost* is the sacrifice imposed on agency or counselor budget by an alternative.
8. *Benefits* are the positive gains to be accrued by the client and the budgetary savings offered by an alternative.
9. *Individualized Plan for Employment* is the design or method of achieving the rehabilitation objective(s).
10. *Placement evaluation* is the assessment of the degree of achievement of the rehabilitation objective(s).

As financial resources become more and more scarce to the rehabilitation professional, *decision accountability* comes more into focus. Sooner or later, the caseload manager will be required to justify more directly and account for caseload management decisions. To illustrate, it might be appropriate for agency supervisors to find out why a counselor's annual production is considered deficient while caseload expenditures are judged to be excessive. It would seem that a cost–benefit approach to decision situations would assist the case manager in such justifications, or even better, prevent an imbalance between production and expenditures.

To summarize, Goshen (1975) stated that "the process of reaching a decision entails the listing and ordering of some lists of alternatives, each having its own set of advantages and disadvantages as possible solutions to the problem" (p. 90). Again, the indication is that the decision-making process consists of a series of sequential steps. Goshen concluded, "the actual process of making the final choice requires the use of judgment which is a complex human phenomenon with multiple determinants and variations" (p. 90).

Decision making is a major task of rehabilitation caseload managers. The decision process requires an orderly approach to data consideration, and decision makers need appropriate structures to assist them in reaching effective decisions. Using a decision model ensures systematic and sequential treatment of the important issues related to the decision situation. The decision models presented above are useful to rehabilitation caseload managers because they enhance consistency in treating decision input data. The results of systematic decision making reflect positively on the effective decision

maker, but more important, they reflect efficient service-delivery strategies to persons with disabilities.

RISK-TAKING FACTORS

The rehabilitation counselor should not view decision making as a quest for the right (or wrong) answer to a problem, but rather as an orderly process for separating the most effective course of action from the less effective alternatives. If there is a right or wrong answer, decision making is not involved. For example, concluding that the sum of 3 + 4 = 7 requires no decision-making skills but rather access to, and retrieval of, factual knowledge. However, selection of specific client training or counseling and guidance demands a decision. Of course, caseload managers do not always make rational decisions. Values or hunches often influence the final decision even when there is a lack of data to support the chosen course of action. Personal values often increase the risk associated with successful probability of specific decisions. However, caseload managers who use decision-making systems realize at the time of decisive action that the available information on a given situation either *offers* or *denies* support for derived alternatives. As no decision is without risk, effective decision makers use structured systems to calculate risk factors and to understand the effect of personal values on the process of alternative selection and implementation.

Decisions require compromise. In fact, compromise is essential to any decision-making process. Decision theory literature usually identifies the role of compromise as relating to trade-offs or "side effects" (Anthony, 1988; Bolman & Deal, 1991; Marvin, 1971; Oshry, 1996). Risk is associated with every decision, and rehabilitation caseload managers who are unwilling or unable to assume responsibility for risk taking will likely feel dissatisfied with their job situation, unhappy with their achievements, and frustrated with every work-related effort. The *worst* management approach is to be always concerned with the prevention of poor outcomes, thinking that one cannot make errors, and striving for perfection in decision making. A better approach is to accept the inevitability of risk in decision making and the inevitability of error. Calculate the risks instead and aim for producing fewer errors in decision making rather than eliminating risks and errors. Caseload managers need to accept the responsibility for making decisions.

The avoidance of responsibility can be interpreted as a way of avoiding making one's own decisions. Such avoidance likely reflects unresolved personal conflicts that further complicate the concept of risk. Of course, the choice to accept the frustration and anxieties involved in stagnating situations

is a form of decision making. Every irresponsible (or immature) conceptual system will eventually leave its mark upon the client or others associated with those rehabilitation caseload managers who cannot risk owning their own behavior. Fortunately, such individuals usually are internally or externally forced to seek other employment, but this is not always assured. Thus, it may be helpful to consider some behavior patterns associated with personal risk situations. Goshen (1975) identified a decision-avoidance method that suggests that individuals who use avoidance systems have a tendency to explore several decision methods but usually concentrate on a particular one. Thus, as there is no such thing as a riskless decision, caseload managers must learn to make commitments and accept risks with greater understanding and clarity so that they can increase their chances for success.

Felsen (1976) also discussed aspects of decision theory dealing with decisions where risk is involved. Classical decision theory is usually associated with decision making where risk factors contribute significantly to the selection of an alternative. The probability laws characterizing any decision are unknown at the time the decision is required. Thus, the decision maker is faced with uncertainty about possible outcomes of any action. In fact, the rehabilitation counselor is confronted with many real-life decision situations (termed states of nature *in* decision theory) with every rehabilitation *client*. Each decision situation (the client's problematic situation) is characterized by some information structure that provides impetus for caseload management decisions. Thus, rehabilitation counselors must consider both controllable and uncontrollable *variables* in identifying workable alternative solutions. It is the uncontrolled variables that contribute most to the outcome of decisions made under uncertainty.

Most ordinary life situations require some risk-taking decision activity. For example, the risk elements involved in crossing a boulevard or dealing with *economic* situations may not come to awareness in daily routine. However, rehabilitation counselors routinely make decisions that affect the total lives of individuals in the present as well as the future (Cassell, Mulkey, & Engen, 1997; Spangle & Isenhart, 2003; Wehman, 2001). Rehabilitation caseload managers must be willing and able to accept the responsibility for effective decision making. As noted by Drucker (1967), "every decision is a risk-taking judgment" (p. 92).

APPLICATION OF A DECISION-MAKING FRAMEWORK

Decision models are developed in many different ways in accordance with individual need and purpose. Therefore, f decision models differ in structure, and occasionally a specific model must be modified for use with a

given organization or agency. Although decision-making models are usually presented in symbolic terms or structured frames, their purpose is to assist decision makers in conceptualizing systematic procedures that yield effective judgments. It is, therefore, the purpose of this section to develop a decision-making framework that will be useful to rehabilitation caseload managers or others who work with persons with disabilities.

There are many variables that affect decision making. Three significant ones are (1) the *situation,* (2) the *decision maker,* and (3) the *process* of making decisions. The situation (problem or state of nature) is the reason a decision is required. Personality, *attitude,* aptitude, and related factors of the decision maker are factors that either impair or facilitate the making of effective decisions. The process concept signifies that there is a mostly organized, sequential consideration of weighted characteristics in making decisions. Therefore, the process, or lack thereof, used by caseload managers to derive effective judgments has considerable impact on the decisions rendered. Our concern is with this latter variable, the process of making decisions.

Decision Variable Schema

A conceptualization of decision variables is presented in Figure 4.3, illustrating the global considerations that impact a specific decision. This design incorporates *all* aspects that have any influence on the resulting decision. These variables may be either positive or negative and have both strong and weak influence on the identified alternatives. However, only a few specific variables *should* be considered in the process of reaching decision alternatives, and the remaining variables should be discounted and relegated to a distant status or even outside the parameters as constructed in Figure 4.3.

Decision makers must recognize that there are decisions *within* decisions. Deciding which variables are important and which are not is a process that helps shape the final decision. These early decisions focus on which variables will have the greatest effect on desired outcome. Just as the poker player knows which cards to keep and which cards to throw away, the caseload manager must learn which variables to discount and which to attend to in making the decision. Such variables as disability, education, motivational direction, and degree of familial encouragement toward rehabilitation efforts are usually important to rehabilitation decisions. However, their importance must be determined on an individual basis. For example, a person's educational level may be well above that required for a specific job situation. In that case, the educational variable might be relegated to a distant parameter (III) as the specific effect is reduced. But let us suppose a person's motivation is

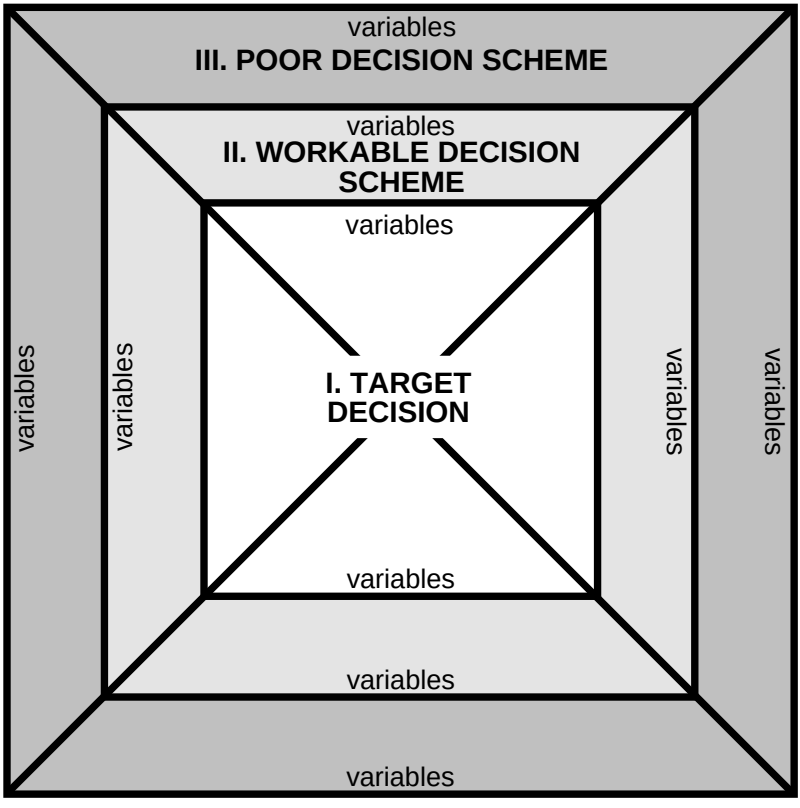


FIGURE 4.3 The Decision-Variable Schema

questionable or family support seems negligible. Then these variables might require considerable attention because they appear to have an influence on outcome. In a situation such as this, the motivation and family-support variables would likely be considered within the target parameter (I). Stated differently, because of the perceived importance of these two variables, they must remain in the scope of the Target Decision scheme as they will likely influence outcome.

It is useful to remember that decisions should be made on a minimum of variables. Because we are all restricted by our capability to process information, alternative selection is greatly impaired as decision variables increase. Hayes (1962) discovered a reduction in speed and quality of decisions when more than four variables were considered. This contention found support from Felsen (1976), who predicted a rapid increase in confusion for decision makers as the decision variables increased. Thus, important variables must

be determined in order to reach an effective decision. However, more critical to effective decision making is that those few variables that are determined important, *be* important, rather than just assigned such a value. Failure to heed this principle will result in numerous poor decisions because of error in ascribing value to those variables on which specific decisions were made. Also, because no decision-making model is capable of considering all variables that would affect a given decision situation, systematic analysis of the decision variables helps caseload managers focus on those that *are* important and critical to decision outcomes.

Further analysis of Figure 4.3 shows that the Target Decision Scheme (I) considers those variables that are strongest in affecting desired outcome. These variables will exercise some degree of control on rehabilitation outcome (successful or not). Such variables as disability, functional limitations, psychological makeup, education, motivation, training, and family encouragement *may* be given high consideration in any decision and would therefore be Target Decision variables. To err in determining Target Decision variables will surely create additional risk factors that lead to a breakdown in the resulting decision. How many times have client programs failed because a critical decision variable was ignored or overlooked?

The Workable Decision Scheme (II) conceptualizes those decisions made on variables that clearly are within "workable" parameters. Sometimes they work, sometimes they do not. The variables bounded in this area have less control over eventual outcome than those assigned to the target area. Resulting decisions made from workable variables often stay within acceptable boundaries, but probably more often require additional decisions to reach success. Thus, Consequential Decisions (see Figure 4.1) become necessary to salvage the goal or the rehabilitation direction. Consequential Decisions are costly to all parties involved in rehabilitation. Unplanned amendments to a client's program of services could simply reflect poor planning, but it may also indicate that a resulting decision was made using, workable (or poor) decision variables. Caseload managers should expend appropriate effort in considering the impact of decision variables in order to understand how each is to be used in making decisions.

Brief mention is made of the Poor Decision Scheme (III) variables. Decisions made from these variables are based on nothing more than shots in the dark. Variables placed within this parameter would be those having limited impact on successful outcome and would likely yield nothing more than chance or trial-and-error approaches to situation resolution. Decision makers who want to remain decision makers should avoid basing decisions on

variables relegated to level III status. The probability of successful decisions resulting from Poor Decision Scheme variables is restricted. In fact, these variables (III) *rarely* shape an effective decision.

Decision makers have two important tasks. First, they must establish ground rules by determining which variables hold the greatest influence on decision outcome. These must be assigned an *accurate* importance value, which can be accomplished by using the Figure 4.3 conceptualization once the decision situation is understood thoroughly. The second task requires a decision maker to choose from among available alternatives that offer solutions to the problem situation. In rehabilitation, alternative selection is influenced by client assets and liabilities as well as available community resources.

The importance of deciding which variables to include in the ground rules can be illustrated by a reduced referral example. Suppose the counselor with few referrals believes the decision variable is lack of awareness among community referral sources of the services available through the rehabilitation agency. Therefore, our counselor-manager decides that the secretary should send a brochure describing agency services to all referral sources within the specified area. Several months later, a review of caseload statistics reveals no increase in case referrals. It would seem that the decision to promote agency services by sending out brochures failed to change the decision situation (few referrals). Maybe the Target Decision variable in this case is the counselor's performance or relationship with the referral agencies. If so, a decision made on these variables is much more likely to yield the desired results.

It is the decision maker's responsibility to recognize the value of the variables that impact a decision situation, put the Decision Variable Schema concept into effect, and contemplate the use of decision variables in specific decision situations. Accuracy in determining important decision variables is related directly to making effective decisions.

The Decision Checklist

Just as clients and community resources differ, each decision situation has its own individuality. However, identification of probable service modes will start the process of deciding preliminary rehabilitation direction. Thus, the decision maker's efforts must be directed to sorting, combining, and reducing variables until the important ones within a specific situation are found. The rehabilitation counselor's main task is to determine which available alternatives offer a solution to the decision situation.

The simplest method to begin the decision-making process is the checklist assessment. This process can begin as early as the initial interview with the client by using the Counselor's Direction-Questions Checklist (CDQ Checklist) illustrated in Table 4.1. The thirteen categorical service classifications in Table 4.1 reflect the general scope of available rehabilitation alternatives to a problem solution. The public rehabilitation counselor and potential client must mutually develop and agree upon the selected alternative and promptly initiate the required steps to begin the program. The counselor and client must also consider the financial aspects of the proposed program.

Once the alternative is selected, the counselor and client must become involved in developing plans to reach the identified primary goal. An old rehabilitation cliché advises the rehabilitation counselor to "plan your work, and work your plan." However good such advice may be, it does

TABLE 4.1
Counselor's Direction-Questions Checklist

Check (✓)	Consumer Needs
	A. General diagnostic evaluation?
	B. Trial work/extended evaluation?
	C. Presumptive eligibility?
	D. Facility/workshop assessment?
	E. Counseling and guidance service?
	F. Physical restoration service?
	G. Psychological/psychiatric services?
	H. Personal adjustment training?
	I. Vocational adjustment training?
	J. Academic training?
	K. Vocational training?
	L. On-the-job training?
	M. Immediate placement?
	N. Other:
	O. Other:

PROMPT ACTION NOTES:

not offer methodology or understanding of the process involved. Because a large portion of the rehabilitation professional's function is planning, it is useful to review the planning activity as it relates to rehabilitation decisions. Woodside and McClam (2003) described planning characteristics by declaring that

1. Planning is a process that includes setting goals, deciding on objectives, and determining specific interventions.
2. Planning is required when analysis must occur in order to identify desirable outcomes.
3. Planning allows information to be scrutinized carefully so as to obtain a total picture of the case.

The reader may wish to review the section on planning included in chapter 2. However, the above characteristics are direct descriptors of the activity required to develop a program of rehabilitation services. The mutual development of the Individualized Plan for Employment (IPE) clearly requires anticipatory decision-making and a system of decisions in order to produce the desired future state—the rehabilitation goal. The caseload manager and the client share responsibility for appropriate planning, development, and documentation of the process of rehabilitation, as the IPE must be completed and appropriately signed prior to initiation (taking action) of rehabilitation services.

Identification of a service program (e.g., IPE) requires that the counselor act appropriately regarding caseload management procedures. Figure 4.4 shows the procedures involved in the service-decision process. Once the service is identified, initiated, and appropriately documented, the case file must reflect these activities. The activity indicators are located in the basic classification system discussed in chapter 6. The case activity dictates the zone by which the case will be identified. To illustrate, review Figure 4.4 and assume that a client has been determined eligible for rehabilitation services. The case file must reflect that this client is eligible for services. Further analysis of the service decision diagram reveals a specified case movement from applicant to ineligibility and/or order of selection (OOS), or from eligible applicant to IPE formation and implementation of services. The service decision diagram provides a caseload management roadmap as an aid to planning component parts of the rehabilitation process. Knowledge of case service flow patterns facilitates expeditious provision of rehabilitation services to individuals with disabilities.

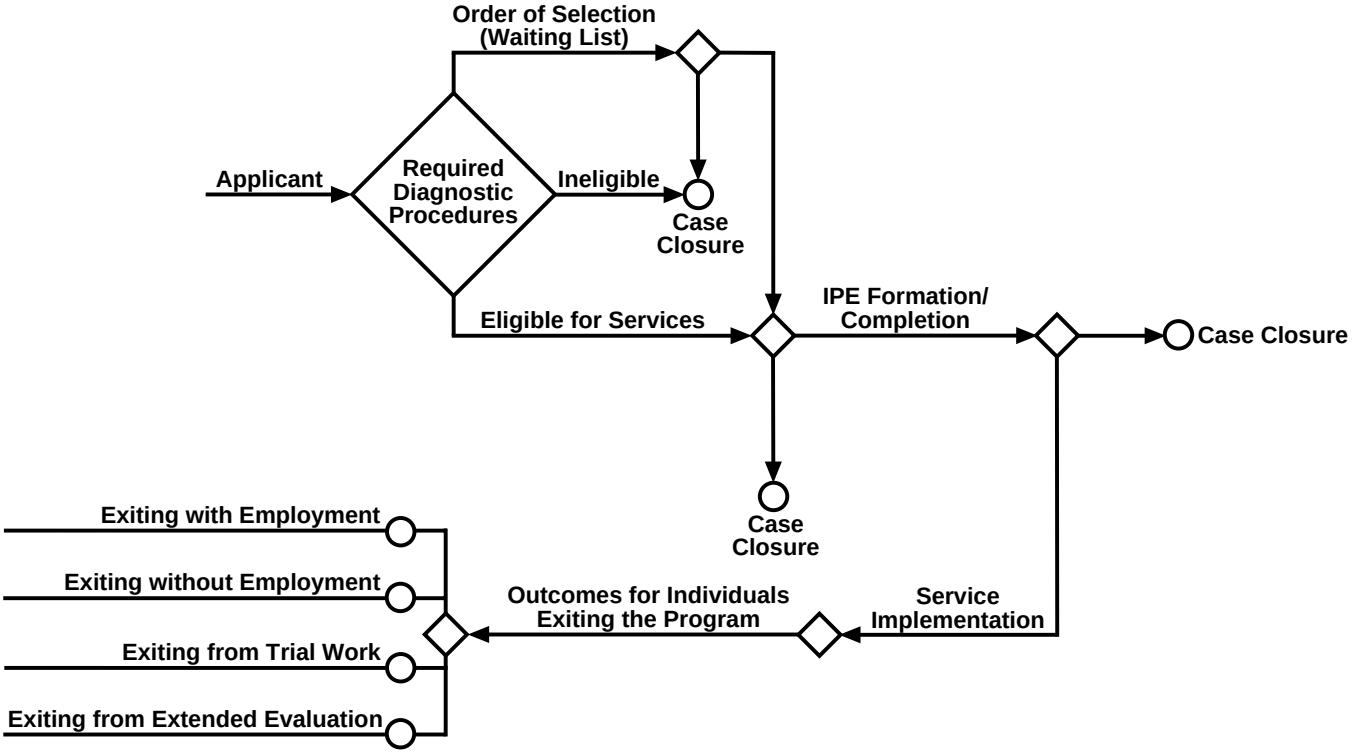


FIGURE 4.4 A Service-Decision Model

THE REHABILITATION DECISION MODEL

The rehabilitation counselor must make numerous decisions every day, and each one is made with varying amounts of information. It is likely that the decision-making process will include Apex Decisions, Base Decisions, and Consequential Decisions at different stages in the rehabilitation process. The counselor must be prepared to meet each decision as a challenge. In order to do so, a systematic evaluation of the factors involved is required. Those factors that are included within the structure of state agency rehabilitation programs and that must be incorporated in rehabilitation decision making are presented in Figure 4.2.

Inspection of Figure 4.2 reveals that three major dimensions (Problem Diagnosis, Service Identification, and Outcome Evaluation) provide a decision structure for the sequential delivery of rehabilitation services. Several functions are included within each major dimension. The relationship of these dimensions and functions to decision making is briefly discussed below.

Problem Diagnosis

The rehabilitation process requires diagnostic assessment prior to eligibility determination and service delivery. However, the diagnostic evaluation does not just happen, but rather is determined skillfully by the rehabilitation counselor in accord with agency policy and applicant needs. The *initial interview* is usually the counselor's first attempt at preliminary evaluation of the person. It is concerned with identifying an applicant's functional capacities and limitations as well as any interest in rehabilitation services and eventual employment. The general *diagnostic assessment* function consists of those medical, psychiatric, psychological, social, vocational, and other diagnostic procedures necessary to determine eligibility and to explore service alternatives. *Trial work/Extended employment* is used when the diagnostic evaluation results do not enable the counselor to determine whether the client can benefit from rehabilitation services. Finally, *presumptive eligibility* is determined when an individual is receiving SSI or SSDI on the basis of disability or blindness, provided this individual intends to become employed. The basic classification system and procedures can be found in chapter 6.

Service Identification

The services available through a rehabilitation agency can generally be referred to as solutions to problematic situations. *Counseling and guidance* are used with many clients, and quite often are the only services necessary for rehabilitation to be successful. *Physical restoration* is the solution to problems

that require medical, psychiatric, and psychological treatment. *Training,* of course, is required when the client needs to develop vocational skills to compete in the labor market. There is considerable discussion in chapter 6 of the four case zone classifications germane to rehabilitation service identification.

Outcome Evaluation

Every decision-making model must contain an evaluation dimension in order to determine whether the decision was an effective judgment. *Placement* and *follow-up* are certainly valuable indicators of whether the counselor has used good judgment. *Postemployment services* can keep the counselor and client in contact with each other and provide an opportunity for additional evaluation of the placement situation. When the client is *not rehabilitated,* the counselor should assess the situation to determine why the program failed. The basic classification system used for evaluative purposes is discussed in detail in chapter 6.

Further consideration of the model presented in Figure 4.2 shows dimensions A (Problem Diagnosis) and B (Service Identification) bridged by *Goal(s) Determination,* and dimensions B (Service Identification) and C (Outcome Evaluation) bridged by *Employment Assessment.* These two bridges are necessary to facilitate the flow of this *supra-decision-making* structure—The Rehabilitation Decision Model. This Decision Model becomes a process of clarifying the current situation of a client and placing such evaluation in relation to determined goals. The disparity between the client's current situation and determined goals is then considered in relation to an adequate functional assessment of the individual.

Any rehabilitation goal(s) should be determined as early as possible in order to expedite service delivery and to consider the identified functional limitations appropriately. Decision making is much easier once the vocational direction is established. The planning activity is also facilitated as a result of these early decisions. Thus, completion of the diagnostic study and goal determination provide a natural lead into a service program (Berven, 2004; Cassell & Mulkey, 1984; Cox et al., 1981; Mulkey et al., 1984; Power, 1991; Rubin & Roessler, 2001; Thomas, 1990).

Once a program of services has been completed the model provides an opportunity for assessment of how the client has changed. The decision maker must evaluate any new skills or functioning that increases the probability of employment. Of course, this assessment is a clinical judgment; outcome evaluation will be measured later in realistic consideration of specific competitive work skills.

Thus, we see that the rehabilitation process is in fact, a *supra-decision-making* model that provides the framework on which to base the judgments of the caseload manager. Such professional judgments are the necessary building blocks to construct an environment for probable rehabilitation of individuals with disabilities. Success correlates with the skill of the decision maker.

SUMMARY

This chapter explored decision making in the rehabilitation process. The concepts of Apex, Base, and Consequential Decisions were introduced and related to the functional role of the rehabilitation counselor. Appropriate decision theory was explored and briefly presented to provide a theoretical basis for the development of a personalized decision model for caseload managers. The process of making decisions was considered and four models were identified that have a relationship to the development of individual counselor models. The relationship between risk factors and decision making was reviewed to reflect some of the problems associated with professional judgments. Finally, a *Rehabilitation Decision Model* was presented for conceptualizing the decision-making process in rehabilitation agencies.

These concepts and tools are presented to assist caseload managers in visualizing and building a decision-making style consistent with personal and situational characteristics. However, if one is looking for a particular model or "cookbook" approach that is consistent with personality, the search will be arduous and frustrating. In the final analysis, decision making is an outcome, the end result of a process. Therefore, whether the caseload manager is effective as a decision maker will depend on the extent to which the decision variables and models are learned *and then applied.* Application is the test of any decision-making process.

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CHAPTER 5

The Understanding and Management of Time

COPING WITH TIME

"Time is an essential feature of social and organizational life. Time is the prime organizing tool. People use time in order to create, shape, and order their worlds" (Adam, Whipp, & Sabelis, 2002, p. 1). Time management in rehabilitation settings has its unique components, but problems related to overall time management are common to all rehabilitation settings, vocations, and practitioners. From the authors' observations, the rehabilitation counselor usually reports that time is the most formidable of all elements to be managed (Cassell & Mulkey, 1985). There are many explanations of this perception. The vast array of activities required of rehabilitation professionals and the frequency with which they interact with other professional groups, who themselves have similar problems, are typical of these explanations. For example, the necessity for interviewing clients, doing case recording and documentation, gathering medical data, counseling for personal adjustment problems, testing or interpreting tests for training or client adjustment, counseling for vocational-occupational problems, consulting with attorneys and other professionals, performing industrial surveys, conducting client placement, and other follow-up procedures are but a few of the diverse activities making demands on the counselor's time. A counselor who seeks some form of constancy at work and reliable behavior patterns for action will soon learn that, paradoxically, the only constancy one can depend on is that variables on the job are in a state of flux and/or perpetual, rapid change—there is little constancy.

The questions then become, "What is the counselor's understanding of time as a crucial management concern?" "What does a counselor conceptually understand about the entity time?" "What are the principles and theoreti-

cal bases for the use of time and how does one manage it successfully?" More specifically, counselors who cannot answer *in detail* the following four basic questions would do well to begin seriously considering what they must do to gain a knowledge base and an understanding of time:

1. What specific personal characteristics do you have that could be described as strengths or weaknesses in controlling or losing control of time?
2. How aware are you of the exact manner in which you spend your time?
3. Precisely, what methods, procedures, or consistent activities have you initiated to gain control of your time?
4. If you were required to do so, could you sit down and describe fully what your system for managing your time is? Could you elaborate on principles and concepts that you draw on for consistently guiding your activities?

The answers to all the above questions cannot always be found in a text, especially in one chapter of a text. Answers to counselors' time management problems come with actual performance on the job, gaining of experience, and dealing firsthand with problems. However, all of these stem from a base of understanding and awareness of time as an entity with a conceptual framework and definable limits. It has structure and form. This chapter will develop a base for understanding and dealing with time. It is a beginning from which an honest time management system can evolve from a counselor's personal commitment to control this aspect of caseload management.

DIMENSIONS AND PROPERTIES OF TIME

Before rehabilitation counselors can build an effective time management program, they must obtain a thorough understanding of the dimensions, elements, and properties contributing to and influencing their efforts. That is to say, counselors must be aware of the nature of this amorphous and ubiquitous oddity called time, or time use, so that constructive efforts will be ordered, organized, and developed from a rational basis. *Awareness and understanding are the first steps for acquiring control in any endeavor the counselor initiates* (Cassell & Mulkey, 1985).

Listed below are the basic properties that give time the conceptual reality that one experiences in daily living whether on the job dealing with clients, supervisors, and paperwork, or at home dealing with thee variables that

make up post-work living. These dimensions must be described as separate entities, but, in the final analysis, it is their coalescing properties that provide the theoretical basis for understanding time or what constitutes time use.

1. *Time has structure*. Time is not amorphous. It has definite boundaries, limits, order. It has a reality that can be objectified. It has been segmented, quantified, and formalized into a system for orientation and sequenced activities. Time has elements that can be conceptualized, and is both elastic and rigid. "The clock ticks relentlessly, and at the same speed, for everyone" (Wellner, 2004, p. 42). Thus, it is important for rehabilitation professionals to become aware of what their time limits and boundaries are by acquiring adequate assessment and monitoring techniques and relevant coping tools.
2. *Time has incessant continuum properties*. It is ordered sequentially and incessantly moves forward at a constant rate, contrary to popular expressions concerning "time flying" or "time dragging." Time waits for no one; it is a perpetual stream that moves forward at a predicted pace. A counselor can neither save time nor store it away for future use. A counselor cannot make time. Michon (1990) added that the understanding and use of time involves conscious mental processing. Therefore, one can only use wisely and effectively that period of time one has, and one can plan for wise and effective use of future time periods.
3. *Time movement inherently is goal directed*. As time is a conceptual entity and a human construct, movement within a time period is goal directed, that is, movement is almost always toward some expected end. This movement may be the negative experience of avoiding an unpleasant end result or the positive experience of anticipating a pleasant outcome. Regardless, one's present behaviors, activities, output, and the like are related to some expected end somewhere in the future (Brill, 1995). Occasionally, a counselor will experience surprising or unexpected outcomes. However, by their very nature these unexpected outcomes cannot direct or guide future behaviors. Thus, if counselors consistently experience negative outcomes over periods of time, the only logical conclusion to be reached is that they have contributed greatly to *those outcomes and in a real sense are directing themselves toward those ends*. Movement or lines of behavior toward these negative outcomes could have been anticipated earlier with adequate foresight and self-analysis. This dimension of time provides a fundamental basis for self-guiding techniques such as prioritization of activities and objective-setting practices.

4. *Time-use activities evolve from reinforcement principles*. Although movement in a time frame is goal directed, this tells us nothing about the progress that gets one into the goal region. That is to say, we must understand how the counselor builds on experiences to reach goals in order to duplicate this process for effective management purposes. The guiding principle we need to understand is that we tend to continue to rely on those behavior patterns that are most immediately gratifying. Thus rehabilitation professionals may waste time in much the same way every day and not correct poor time-use management practices because of the possible choices facing them. That is, the choices selected are the most reinforcing, and the remaining alternatives usually are not valued highly for their usefulness in reaching complex objectives that may be more encompassing. For this reason counselors will often engage in activities that can be accomplished in a relatively short amount of time.Thus the activities provide reinforcement for a completed task while the counselor avoids activities that contribute toward a longer-range goal. These latter activities provide minimal reinforcement, and gratification is delayed until the end goals are reached. Counselors unable to get control of their reinforcers usually exhibit a great deal of efficiency in their work but the extent to which they are effective is minimized.
5. *Time use involves personal properties*. Time has rigid physical dimensions, and therefore effective use of time periods must involve humanistic elements, as was illustrated above. That is, the counselor's self-organization—or way of coping with frustrations, fears, anxieties, abilities, and general psychological make-up—is the basic determiner of the management of time (Cassell & Mulkey, 1985). Thus, time-use management must begin with a personal management program to get control of one's emotional state and deal with those need states likely to thwart a constructed time-use program. A truism appropriate for a counselor's desk plaque is *Manage yourself, then learn to manage your time*.
6. *Time use involves situational properties*. This dimension states the interactive nature of any time-use program a counselor attempts to construct. The above five dimensions address structural properties and personal characteristics, but here we come to realize that our individual time-use programs interact with many other time systems outside of ourselves. These situational factors can be demanding and threatening. If these outside or situational areas have inadequate or poor management practices, the inefficiencies will affect the counselor's own time-use management efforts.

Thus, we see that time evolves as a more solid entity, stripped somewhat of its ambiguity and fleeting character. Time has quantifiable boundaries; it has movement, always forward at a constant rate; movement is toward a goal, a definable end. Sequential time use builds by way of a reinforcement process. Effective time use is a function of several interacting variables in specific situational contexts. A personal time management program can be started using these basic ideas as a foundation to build upon, taking into full consideration the impact of the six areas mentioned. However, in and of themselves, these areas do not form a base on which to initiate immediate action. Counselors must take them into account and elaborate upon them as much as their developing maturity will allow.

Finally, the conceptualization of time use and the formalization of an approach for managing it more effectively will depend upon the extent to which the rehabilitation professional acquires an understanding of the two primary schemes of thought on managing time. These two essentially opposed schools of thought can be called the Quantitative-Analytical Approach and the Intuitive Approach. Both of these schools purport to have the principles and concepts for guiding one's practice in managing personal time use. The discussion below will examine these areas for their contributions to a personal time management program and then put them into proper perspective with a summary statement.

THE QUANTITATIVE-ANALYTICAL APPROACH

In its most rigid form the Quantitative-Analytical Approach involves partitioning off one's activities into units of time and examining what is happening within each time period. Then one projects what must be done to get the best performance or outcome from that sequence of activities in the period under consideration. This area has also been called a time and motion approach. Time and motion studies are primarily concerned with *efficient* time use. Focus is on the task and the specifics of the task, which tells us little about impact on a more encompassing scale. With a good time and motion program we can become aware of specific routines to do a job faster or more efficiently. However, we must look elsewhere for ideas on how to manage ourselves in order to put together the outcomes from these time and motion management efforts effectively. The discussion below will introduce the counselor to the basic concepts and procedures for acquiring proficiency in quantitative time management, a necessary segment of a complete personal time management system.

Principles of a Quantitative Analytical Time Management Approach

When counselors begin to consider revamping their present methods of managing time, a frantic search often ensues for quickie techniques, cookbook formulas, and magical steps for bringing a rapid solution to bear on frustrated performances. The search often terminates in dead-ending behaviors, added frustrations, general defeatist attitudes, a lapse back into the old "system" that seemed to get them by in the past, and so on ad infinitum (Cassell & Mulkey, 1985). The realization that there are no major tricks or effective stopgap solutions is the first step toward seeking and accepting principles and concepts for forming sound practices as part of a functional system. There are six principles which, if internalized and used consistently, will become a sound basis for establishing a systematic approach to managing one's time effectively. Remember, however, principles are just fundamental guideposts that must be accompanied by personal commitment to or owning of the principles and the follow-up actions on which they are based. The six basic principles for the Quantitative-Analytical Approach are discussed in the following narrative.

Principle of Self-Motivation

Time management programs are no different than any structured behavior change program one attempts; at the outset one must have a real need or desire to make changes. There must be a willingness to initiate actions and accept consequences, to make sacrifices and be willing to tolerate concomitant anxieties. Without this strong desire to make some change, counselors merely accept their present level of performance. Without this desire, they can choose to accept themselves as ineffective time managers or time wasters, and stop perseverating emotionally over poor performance, that is, if they are willing to accept the costly consequences. With continual feelings of distress will come anxieties and further deterioration in performance. Thus, one's high level of motivation to make constructive changes is a prerequisite that cannot be waived or compromised if one's goal is an adequate time management program (Cassell & Mulkey, 1985).

Principle of Effectiveness

Though the quantitative approach we are discussing falls primarily in an efficiency dimension, we cannot ignore the fact that time management practices must be directed toward a more encompassing effectiveness dimension. Efficiency concepts help counselors organize themselves to do specific tasks but tell them little about the value of those tasks for accomplishing objectives and arriving at goals. Examples of efficiency operations are meeting the demands

of caseflow requirements adequately, doing timely case recording, returning telephone calls and paying bills owed to vendors promptly.

Effectiveness concepts help counselors understand what progress is being made toward particular goals. This area is broader in scope and more encompassing than the efficiency area described above. As counselors more fully meet client needs and fulfill agency and personal goals; as they become more fully aware of the functioning of the entire agency and what their part in it is; and as they develop a truly organized system of operations and exert control over this system, effectiveness becomes a reality. All too often, counselors are so busy engaging in low-value tasks that are quick and easy to do that little time remains to think, plan, and evaluate within a broader scope. The common fallacy under these conditions is the belief that efficiency will automatically produce effectiveness; it does not. Efficiency can be achieved on a particular task for short periods of time, but if the counselor has responsibility for producing an end result, for example, taking a case from an initial stage to a final stage, then just being efficient will not yield a high percentage of positive outcomes (Cassell & Mulkey, 1985; Kelly, 2002; Smith, 1994). Thus, one can be efficient without being effective, but one cannot be effective without being efficient.

Principle of Quantitative Analysis

We come now to a crucial principle in this quantitative approach to time management that involves the gathering and analyzing of data that reveal what is actually occurring in daily efforts to manage oneself. This means that one must establish concretely where one consistently expends those 480 minutes available in a work day. Thus, a *record* of one's time is essential. A time log kept for a set period will assist in overcoming barriers set up by our perceptual processes, which tend to err in favor of how we would like things to be rather than how they exist in reality.

The time log can take almost any form but there are a few rules that govern a time manager's construction and use of such a record:

1. The log should be organized to record approximately every 15 minutes of behavior throughout a work day. A broader time span will not catch the nuances the time manager needs to be aware of, and narrower time sections are cumbersome and will not yield results proportionate to the effort expended in the collecting of the data.
2. One should record with whom interactions occurred and a brief statement of the essence of what happened in the time period under consideration.

3. The log should be kept for about two weeks, depending on the variety of activities in which a counselor engages. For example, some counselors stay in the office three days a week and are out the other two days; they would need to know what is happening to their time in these two different settings.
4. The log need not be kept more than once every six months. It may be necessary to do a log sooner if the counselor's usual work pattern undergoes major revisions.
5. In the analysis phase, conceptual categories must be constructed that communicate to counselors the potential areas they can affect or over which they can exert a measure of control. For example, counselors might respond to the following four conceptual categories by supplying definite quantitative results from a time log:
   a. Who dominates or is in command of the counselor's workday? Is it the supervisor, system imposed requirements, client demands, self-imposed activities, or outside influences?
   b. What portion of the day actually evolves from a plan of activities, or what seemingly spontaneous happenings could have been planned?
   c. What percentage of the time is the counselor performing tasks the secretary or the client could do?
   d. How often is the counselor interrupted? Are the interruptions telephone calls, drop-in visitors, or other kinds?

Riley, McKinney, and Mantel (1976) describe a useful format for quantifying one's time use. Their format indicates ways a time record may be analyzed by suggesting three summarizing categories. Effective caseload managers can draw upon these categories and suggest their own as they utilize this principle of quantitative analysis to guide their time management program.

The time log described and the analysis of the log were included in training programs on caseload management conducted by one of the authors (i.e. Dr. Jack Casell). Data from these sessions were collected and computed in order to establish a base for comparisons or a quasi-standard for counselors to compare against their individual performance. The data collected represent the results from actual time logs brought to the sessions by over 400 vocational rehabilitation counselors from eight different states. The computations in Table 5.1 represent the actual averages of the counselors in training sessions conducted by the author. When the averages of one state are compared with another, striking consistencies emerge. The data indicate that clients are the major controller of a counselor's time. Approximately 36% of a counselor's

TABLE 5.1
Time Record Data for Rehabilitation Personnel

A. Control of Time	Percentage of Day
Supervisors	6
Clients	36
Systems (policies, procedures)	30
Correlative Areas Combined	16
Self-imposed	12
B. Extent of Planning	
Planned	67
Unplanned	33
C. Work Base	
Operating	26
Managing	74

week is spent attending to client-imposed activities whereas he or she engages in self-initiated activities such as structured planning time with no interruptions allowed only 12% of the time.

In vocational rehabilitation settings there appears to be a law of spontaneity working in that the groups consistently report that 33% of their activities cannot be planned in advance. These groups were composed of highly or moderately experienced counselors, so this 33% spontaneity zone appears not to be a function of ability versus inability to manage. Instead, owing to the nature of a vocational rehabilitation setting, counselors must be content with or learn to adapt to an approximately 30% ambiguity level. Also, the philosophy of the rehabilitation agency comes into play when we realize that state agencies are established to meet the needs of individuals with disabilities, and that such needs do not arise on a predictable, regular schedule. Furthermore, the rigidity of a planned structure could quite possibly negate individual differences. The question for future research then becomes, "Can the approximately 70% planned activities level be improved upon with little or no sacrifices in meeting client needs?"

Finally, we can also see from the data that 26%, or slightly more than one day per week, is spent in performing operations someone else could be doing if such a person were available to do it. Although the 74% managing level is an admirable accomplishment, the data do not tell us the extent to which all of these managed activities contribute to achieving organized, planned goals. The ability of counselors to realize an approximately 70% production

of planned activities from only the 12% of self-imposed time discovered in the data analysis is also admirable. Remember, self-imposed time is that opportunity taken by counselors for planning or self-organizing.

The above discussion demonstrates that, with just minimal data and through the establishment of conceptual categories for analysis, a great deal can be accomplished with this method of time management. In private rehabilitation settings, this principle of quantitative analysis is paramount. Indeed, in this setting "time is money." Owing to the generally independent, mostly unsupervised functioning of counselors in these settings, extensive travel, and the necessity to work closely with other time-pressured professionals like attorneys and medical personnel, subtle ineffective time management practices can mount quickly and often imperceptibly. Effective counselors will want to construct their own target categories for investigation, for example, interruptions, travel time, and meetings, but one cannot manage without some objective data. Offhand estimates and attempts at reconstructing events after a period of time seldom gives one a sound basis for managing activities within specific time periods.

Principle of Managing Interfaced Systems

Table 5.1 demonstrates the consistency with which counselors give up control of portions of their day-to-day activities initiated by others (88% for all categories combined except the self-imposed category), and thus we come to the realization that we are not alone. Others' time systems interface or are linked with our own, as Figure 5.1 depicts. Therefore, the logical conclusion is that if inefficiencies exist in others' efforts to manage their time effectively, then by virtue of the counselor's interaction with them, inefficiencies will exist for the counselor as well. Some efforts then must be directed toward managing these interfaced systems.

The highly popularized "team approach" is a workable alternative to managing time more effectively. Counselors must mutually initiate a program of time management with those persons who make the greatest demands on their time. This means the counselor must (1) first identify with whom the greatest problem exists, (2) discover in what specific areas there are problems (i.e., establish conceptual categories again), and (3) determine to what degree these problems exist or in what order of priority they must be addressed (Cassell & Mulkey, 1985).

Clues to a method for attacking these issues and directions for their management can be generalized from the techniques used in decision making. For the time-use area, one significant tool that can give structure to

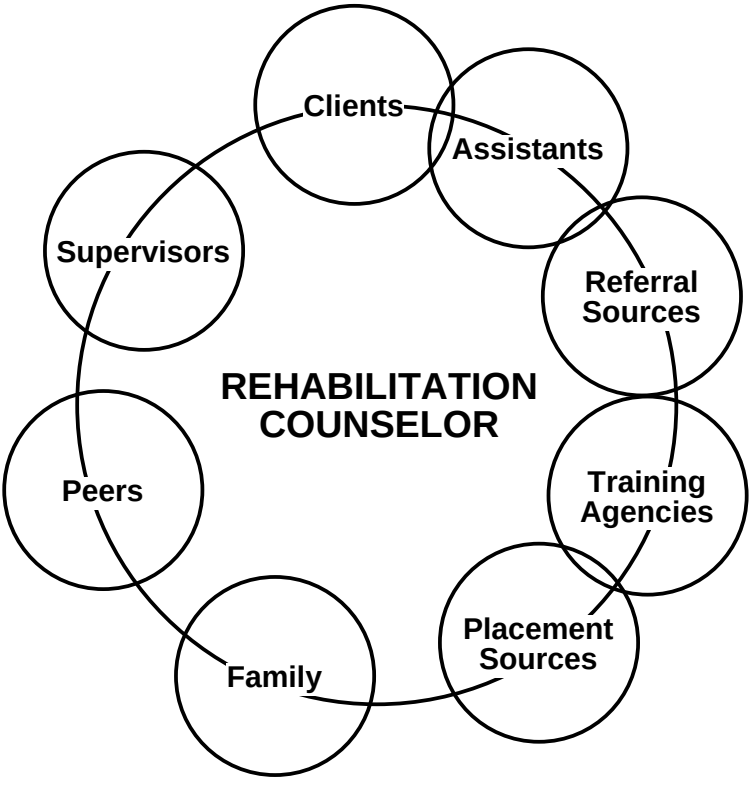

FIGURE 5.1 The Influence of Interfaced Time Systems

our decision making is the practice of assigning exact numerical values to our subjective states, which essentially are nonmathematical as they occur naturally or in a natural sequence of events. Thus, counselors have only a subjective appraisal of what is happening around them in their time management area and therefore must assign realistic numerical values to these and compute the resulting effect.

As an example, when we observe the data in Table 5.2, we see that the primary problem with Sam appears to be a communication problem. Discussion with Sam could lead to great improvements in managing this counselor's time.

Note that the final outcome for each person rated in Table 5.2 is arrived at through a multiplication process: a variable is multiplied by the next adjacent variable and that product is used with the next adjacent variable and so on. This is done first to reflect the multiplicative relationship these variables

TABLE 5.2
Example of the Method for Comparing Time Team Members

Name	I	II	III	IV	Total Gives Emphasis to the Action Step
Maggie	1	1	3	2	6
Sam	2	2	2	2	16
Waldo	3	3	2	3	54

have with one another. Rarely, in reality, do variables combine in a simple additive way. Each variable can influence the next in such a way as to make their combined impact more intense than if they affected a person one at a time. Second, the multiplication gives the counselor a means for highlighting significant deviations of a magnitude to call to action his or her coping processes. Usually, we allow a single event to impact us psychologically only if there is a wide disparity between that event and others occurring at approximately the same time.

When the counselor has combined all available resources, techniques, and tools, it is possible to direct them toward overcoming the barriers that are likely to exist when varying professional systems link up. It is at this point that a giant step is taken toward more effective time management. The interaction with significant others in a counselor's time management world is that beginning step. Through discussions of common time management problems and by teasing out the specific areas of conflict, a supportive or facilitative framework will evolve. It is then that the managing of interfaced time systems begins to come under the counselor's control.

If the above principles have given the counselor appropriate guidance, then the next stage follows logically. The counselor is now ready to begin selecting those areas on which action will be taken. The prior principles all assisted in gathering data, assessing situations, and readying the counselor for action. Now a priority system must be established to thwart procrastination and foot-dragging behaviors. No mathematical computations are necessary here. Instead, a mental attitude or state of mind is the focal point. Self-discipline or self-motivation that we saw emerge in the first principle now becomes a crucial force.

The application of self-reinforcement for action must be monitored closely. Misapplication can set one back. Remember that action structuring itself (i.e., the purposeful, goal-directed initiation of action that is the first forward movement counselors make) should be the target for self-reinforcement. Clearly, the completion of a single task should receive personal recognition but never a

deep, gratifying reward. In our past, reinforcements almost always have been linked intricately with outcomes, productions, and *completion* of a task or a maze. However, this has sometimes been one of the most damaging systems to human motivation ever devised because a closure effect can temporarily immobilize an individual while the gratification elements are in process. As such, elaborate reward systems are inappropriate for initial action-setting maneuvers. If one can circumvent this effect and apply only the minimally satisfying positive feelings *when one makes that first movement toward structuring* a *new action step,* then common elements that thwart time management, like procrastination and nonmotivational inactivity, become less threatening and less destructive.

Finally, action structuring must be initiated naturally from a sound management base. Effective action is usually not possible without properly executed planning, organizing, directing, coordinating, and controlling phases. Remember, that in working toward end goals, if you do not have a plan for action, any road will get you there. This means inefficient routes will present themselves at least as often as efficient ones, and the costs of taking them are apparent.

Principle of Reevaluation

The principle of reevaluation is the one that links all the others together to formalize them as a system. It states that an adequate time management system is only as effective as permitted by the *current* status of the other five principles. If the status of principle four (Interfaced Time Systems), for example, is not current but instead a counselor's activities are based on old perceptions and outdated information, then effectiveness will be an elusive goal. The effective time manager must continually appraise current conditions, current forces, and current issues to sustain a proactive stance. Reevaluation activities enhance problem-prevention activities and relieve the counselor from the all-too-often encountered time-consuming crisis or "fire-fighting" orientations.

Reevaluation is a process of developing self-awareness cues and making vigilance an everyday activity. It is the act of assessing "Where have I been?", "Where am I now?", and "Where am I going?"These and other self-quizzing guideposts will appear initially to be time consuming and energy draining but will soon become time saving and energy conserving, if consistently applied behaviors follow commitment to these principles.

In summary, the Quantitative Analytical Approach is essentially a formalized means of bringing time use into manageable limits. At the outset counselors often view this approach as arduous and time and energy consuming, and thus they have reservations as to its value. However, in the final

analysis, no control over time management problems is possible without an objective (quantitative) understanding of one's use of time. This approach is not without its sacrifices at first, but the dividends of a formalized management approach far outweigh merely groping through one's day or week with only a subjective basis for evaluation and action. In the end, the skills gained for self-managing efficiently and effectively will provide even more time to perform those activities the counselor finds now can be done only at great sacrifice, and that consequently are often left undone.

THE INTUITIVE APPROACH

The management of time cannot always stem from an objective, quantifiable, completely rational process, but must at times develop from an intuitive base. This means the basis for action need not be achieved painstakingly through a process of gather data-evaluate-gather data, ad infinitum. Instead, action can be based on immediate, spontaneous insight if the counselor has a few handy tools, principles, or rules of thumb to put this insight to work. The discussions to follow offer a number of these tools that can lead to still other tools the counselor can construct. In any event, for a systematic time management program, tools complement and provide necessary embellishment to the skeletal framework given by the Quantitative Analytical Approach. However, the Intuitive Approach, as its label implies, cannot be bounded strictly by organized principles and concepts to make it into a real system, and so the following discussions consist of a compilation of some of those tools or ideas that can initiate intuition for the purpose of better time management.

List Construction

It would seem that the first tool to be described in this section is a return to the objective approach. The list-construction tool, however, requires less rigid structure and is less strict in this application. It consists of two strategies: Listing for goal planning and To-Do lists.

Listing for Goal Planning

This tool falls within the purview of the planning and organizing functions of a manager, which was described in chapter 2. As Alan Lakein (1973) has stated, a manager's first step is to ask, "Exactly what are my goals? What am I trying to achieve? What is it I am working toward?" Lakein suggests one take a blank page of paper and (1) list lifetime goals, (2) list professional or work goals, and (3) list short-term goals. These lists should be made spontaneously,

with attention given to quantity not quality. The goals should be specific and reachable. For example, a reasonable goal might be "to close X number of cases 'rehabilitated' in the next year, six months, or month," as opposed to simply stating, "I will be a better counselor."

Next, because the counselor will have listed far more things than can be accomplished in the amount of time under consideration, these goals must be given varying levels of significance. Lakein suggests that one establish a priority system using the A, B, C technique. Simply rank these goals as A (most important) to C (minimally important).

Finally, to make this approach most useful, the counselor must list activities that will lead to the achievement of desired end results. This must be done because one cannot "do" a goal. Next, the counselor applies the A, B, C technique once again to single out the high-value activities from those of less value. Always attempt to do A's first, not B's or C's, but be watchful for the B's that may be elevated to A's. As a means for finding the highest value A to work with, the counselor then must describe the A's as A_1, A_2, A_3, and so on, in order to find the A_1 activity with which to begin action. Once these lists are made and the items rated as A, B, or C, they only require updating periodically or as needed. The time one saves yields a high pay-off value for the time invested.

To-Do Lists

The daily To-Do List is a traditional hallmark of time-management practice and is probably the most used tool among successful managers (Buck, 2003; Cassell & Mulkey, 1985). It functions as a daily activity map to get counselors to where they should be at day's end. The To-Do List must be done daily to be effective. When asked if they use daily To-Do Lists, some counselors in training sessions humorously responded "sometimes." The To-Do List should be the only list you have; never scatter your To-Do's on different scraps of paper. Establish a priority system to determine which activities on your List are of higher value to you than others. The A, B, C method is one example. Some counselors use columns with asterisks (*, * *, * * *), with three asterisks indicating the activity with the highest value. To-Do Lists should be done in the evening or early morning for maximum effect. However, if the counselor keeps a running list of To-Do's and stars them for value, then the level assigned might dictate the order of priority for items on the list rather than setting priority in the evening or morning.

If the list is done correctly, the time manager should have a few A's, a few more B's than A's, and a large group of C's or low-priority activities. These

low-priority items are troublesome because they usually are quick and easy-to-do activities that are reinforcing when completed. Counselors often find themselves crossing a great number of these low-priority items off their lists at the cost of low attention to A_1 items. One must guard against the tendency merely to complete an activity to achieve psychological closure. Action or movement on A items should be one's primary goal, rather than merely getting things done.

To-Do Lists of counselors are also notorious for their leftovers. Lists at day's end usually contain numerous items left undone. Transfers, of course, to the next day's agenda should be permissible without penalty. However, the serious time manager should ask whether items carried over more than a day or so are authentic A items. Otherwise, procrastination might creep into the management program.

Intuitive Flags

The above list-construction method and consequent actions depend on flexibility and an intuitive process, but nowhere is the spontaneity requirement for this approach under more prominent consideration than with the use of Intuitive Flags. The tools one gains from this base are tools for immediate action.

"Intuitive Flags" is the authors' label for those personal, usually unobtrusive, neural processes that one can establish over time through practice or a completed habit formation. Once established, these neural processes or mental flags can be raised into awareness without a great deal of conscious effort and immediate coping action can result. These flags must be established firmly as cues that become automatic. Although counselors can establish their own Intuitive Flags, three examples will be provided as a base to give impetus to the counselor's own creative ideas. The Intuitive Flags section consists of three strategies: (1) instant evaluation, (2) instant action, and (3) paper control.

Instant Evaluation

Lakein (1973), in his work on time management, notes that a pertinent question one should ask spontaneously and frequently is, "What is the best use of my time right now?" This becomes our first Intuitive Flag. At the outset, conscious effort will be required numerous times throughout the day. At some point in the maturity of the counselor, the neural pattern laid down will begin to operate at a level that moves the counselor smoothly toward high-value tasks without the mental flag being shoved into consciousness.

Counselors who find themselves involved in wasting time in non–goal-directed activities, or doing low production or low priority tasks should find this tool extremely valuable. It will release ties to those activities and initiate action in a productive direction.

Instant Action

Another personal neural process that can act as an Intuitive Flag is what the authors call "Instant Action." Procrastination has so many roots embedded in a counselor's time management program that it is impossible to cut off all the causes. However, some control is possible if a means for overcoming inertia is found. This tool consists of forming a mental image of the command to oneself to take action now—do the task now! If used often and spontaneously, this tool will become as useful as the reverberating question the counselor practiced above. This command for instant action can eventually be a stimulus to jar one from excessive daydreaming or inaction.

Paper Control

A final Intuitive Flag a counselor must be ready to raise is the cardinal rule stated by Lakein (1973), "Handle each piece of paper only once" (p. 79). Counselors in vocational rehabilitation agencies might find this rule difficult to follow. However, it is a functional tool if the counselor remembers that just moving the paper ahead in some small way toward its final destination is indeed handling the paper only once, even if the paper remains on the counselor's desk. That is, the counselor has done something with the paper, made a phone call, made a note to take action on a particular day, or made brief summary notes on what is needed to move the client or paper ahead. Thus, the counselor has "handled" the paper only once, if handling is considered to be the same as establishing control.

Slow Down in Order to Speed Up

No one would deny that speeding up will produce greater outcomes. However, managed poorly, this belief thwarts effective practices. Stupak and Greisler's (2005) idea is that one must slow down in order to speed up. These authors from the management field have an observant eye focused on rehabilitation when they note that the problem with managing time comes from an oversupply of tasks coupled with the assumption that all those tasks have to be done as quickly as possible. The authors of the present text might add another false assumption, one that is prominent in the rehabilitation field,

and that is the belief that the counselor must be the one to do all the tasks *for* a client. After all, the client's involvement in the rehabilitation process is at the core of the present-day empowerment philosophy/edict.

Stupak and Greisler list the "sacred seven" techniques for slowing down in order to speed up. For our purposes, four of these are given below:

1. Change yourself on the inside. To be an effective rehabilitation counselor, knowing yourself is better than *knowing*. Knowledge can make one an expert in the field but it is secondary to knowing one's value foundations, ethical standards, and personal priorities. Input that could make one a more effective manager of time might be rejected if the *inside* foundations, priorities, and personal standards do not match best practices for the field.
2. Make quality trade-offs between tasks and obligations. Make a conscious distinction between what is critical and what is marginal. Don't be busy and hyperactive; be focused. Tasks only require expending energy. Obligations require commitment and goal directed actions. Don't commit yourself to just doing tasks. Obligate yourself to priority-selected goals.
3. Eliminate trivia—don't fall into the Trivia Trap and be seduced by unimportant items. (See more on this in Categorized Time Use in this chapter.)
4. Develop active listening. This, of course, is a basic counseling skill. Stupak and Greisler (2005) note, "By listening for the intrinsic value of what others say, you develop relationships that lead to dialogue, collaboration, and trust" (p. 5). Getting a client's commitment and cooperation in the rehabilitation process certainly takes off the seeming obligation of doing for a client.

The "sacred seven" was drawn from a larger list compiled by Stupak and Greisler. At least two of those that dropped out of their list have guidance for rehabilitation personnel: (1) what gets measured gets done, and (2) trust is not a feeling; trust is a behavior.

Categorized Time Use

In order for intuition about time control to develop, counselors must be aware of the time motivation patterns that influence their actions. That is, they must categorize time according to the motivational elements present in order to organize any kind of intuitive orientation to the problems experienced.

Bliss (1976) has conceptualized five basic categories, four of which require the time manager's attention in order to respond appropriately to the elements imposed by a particular category.

I. *Important and urgent*: This category of time use is readily recognized and blatantly demands attention. These time problems should be recognized immediately as true crisis situations. Caseload managers have few problems with initiating action on the time problems that fall within this category. These situations demand and receive immediate attention.
II. *Important but low in urgency*: This category of time can present problems to the counselor. The large majority of activities or demands on counselors' time, although they are high in importance, are not urgent. Therefore, the tendency is to postpone action. But, usually, what one postpones, one abandons. If the problem is not abandoned, counselors will usually tend to draw upon a "crisis style" to energize themselves for action. They then become "adrenalin addicts," seeking that chemical jolt to carry them to task completion at the appropriate time. This approach is not effective management. We must develop our own sense of urgency. Bliss notes, "If your activities are keyed to other people's priorities, or to system-imposed deadlines that make things 'urgent,' you will never get around to your own priorities" (p. 20).
III. *High urgency-low importance*: These are activities the counselor initially perceives as urgent when, in fact, further investigation or clarification of the need reveals that they are much lower in priority than first thought. As Mackenzie (1972) has stated, there is a certain tyranny imposed by urgency. The urgent-but-not-important situation can often look like a major project requiring immediate attention. The counselor will usually find that a great number of these demands are someone else's A's, or they come from authority figures or someone to whom the counselor feels responsible.
IV. *Diversionary work*: These are activities of a busywork nature. Time use here is devoted to those many C's that dominate daily To-Do Lists. Bliss (1976) notes that work in this area gives one the excuse to delay tackling Category II tasks, that is, those tasks that have a far greater benefit for the counselor.
V. *Wasted time*: This category presents less of a problem because in contrast to the often disguised Categories III and IV of time use, wasted time usually is blatantly obvious to most individuals. We are

almost instantly aware of wasted time when, after we complete an activity, that certain negative feeling appears that tells us we could have used that time for something far more productive.

Time-Use Laws

A caseload manager's Intuitive Approach to time use can be aided or hindered, depending on the recognition and wise use of at least two laws or principles operating daily that affect those efforts. Two examples of Time-Use Laws that are discussed include Parkinson's Law and Pareto's law.

Parkinson's Law

Parkinson's Law states that tasks will expand or lengthen to fill the time made available for their completion (Cassell & Mulkey, 1985). The problem in setting aside excess time for a task is that the counselor will usually find a few more finishing touches that can be added or can always polish up the task under the guise of "doing it right" or "getting it perfect." In effect, these guises can be uncloaked as wheel-spinning activities, although the counselor usually can put up a fairly convincing argument that efficiency, quality, and similar "straw issues" are being served for the good of the client and the agency. The repeal of Parkinson's Law begins with the act of making less time available for particular tasks, setting deadlines, and forming a daily plan without those mental margins of error that almost unconsciously are added into a counselor's well-meaning efforts to control time limitations. Once the deadlines are established from this new awareness base, the next act is to hold firmly to the limits set and complete the tasks. A cardinal rule to support attitude change in these efforts is: *Strive for excellence, never perfection*. Stupak and Greisler (2005) posit: "Never let perfection become the enemy of accuracy."

Pareto's Law

Vilfredo Pareto, a nineteenth-century Italian sociologist, established a significant principle that is sometimes elevated to the status of a law. Pareto's principle states that the really significant and high-value items in any given group will usually make up only a small portion of all the items included in that group (Cassell & Mulkey, 1985). This principle has also been discussed in terms of the "Trivial Many" versus the "Vital Few" (Mackenzie, 1970) and the 80/20 Rule (Lakein, 1973). It offers an understanding of a great many of our everyday and our professional activities, for example:

1. 80% of counselors' phone calls come from 20% of their callers.
2. 80% of a counselor's time is spent working on 20% of the cases in a caseload.
3. 80% of grocery dollars are spent on 20% of the meat and grocery items purchased.
4. 80% of eating out is done at 20% of the favorite restaurants available.
5. 80% of one's time spent reading a newspaper is spent on 20% of the pages.
6. 80% of the absenteeism of a unit will come from 20% of the employees.
7. 80% of the discussion in a training session will come from 20% of the participants.

This rule applies to managing time when we realize that the many trivial problems or situations with which a counselor is involved will usually take up 80% of the counselor's time, and yet only 20% of the results achieved are arrived at through this extensive outlay of energy, effort, and time. However, the few vital situations with which a counselor is involved will usually take up only 20% of her or his time, *yet 80% of the total results achieved are gained in this 20% of time spent*! Likewise, in a counselor's list of, for example, twenty items to be accomplished, by working on four of these the counselor will achieve the most value (80% of the time), that is, if the counselor's priorities are valid.

Thus, attempts to deal with Pareto's principle should consist of, first, constructing the boundaries within which one will work (e.g., make a list); second, set an order of priority (e.g., by the A, B, C method); and finally, select the two or three (vital few) items that will yield the most results, set aside a chunk of time, and stay with the task to completion.If counselors can make even small gains in this 20% of highly concentrated time and effort (e.g., say to 23% or 25%), then total output is going to be increased tremendously in the long run. If counselors are struggling with frustrations and anxieties over whether they will achieve the new and increased production goals set at the beginning of a particular year, then the answer to their dilemma is making the Pareto principle work positively for them.

Time Traps

The final area in the Intuitive Approach to be described in this text is understanding and coping with time traps. Regardless of counselors' efforts to measure time, analyze activities, and establish action programs, other processes and situations exist that can trap them and rob them of their efficiency. [These constitute a group whose members are linked only by the common

characteristic of excessive time loss to the counselor.] These time traps can be controlled through an intuitive or personalized approach.

In working closely with counselors in training sessions for a number of years, the authors have compiled a list of the most consistently voiced time traps. Ten of these traps are listed below:

1. interruptions,
2. procrastination,
3. drop-ins,
4. no shows and latecomers,
5. reverse delegation or doing the A's of others
6. incomplete information,
7. overcommitment,
8. poor communication,
9. meetings, and
10. personal disorganization.

Notes on each of these ten traps are discussed subsequently so that the caseload manager can begin to understand and deal with these time robbers. The beginning, of course, is a base and will require a seriously planned and executed time management program.

Interruptions

The two basic types of interruptions are those initiated by self and those initiated by others. To get this time trap into proper perspective in terms of the

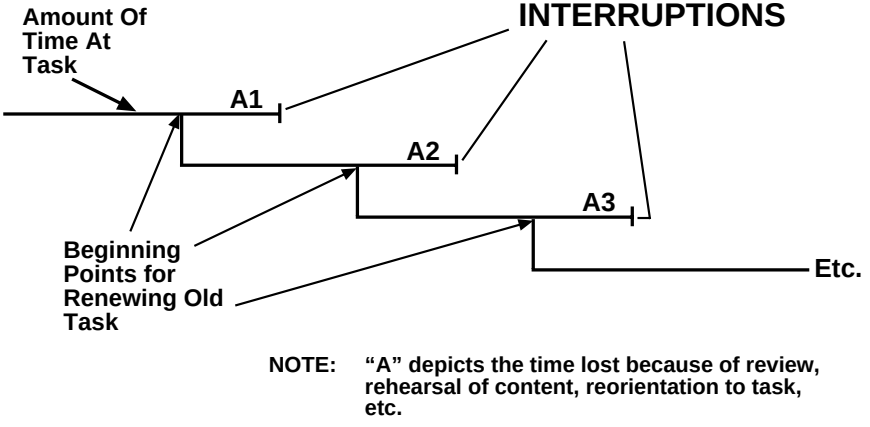

FIGURE 5.2 Hypothetical Example of the Costs in Lost Time Caused by Interruptions

extensive damage it can do to a time management program, the rehabilitation caseload manager should expect to be interrupted several times daily (Cassell & Mulkey, 1985; Riley et al., 1976; Smith, 1994; Woodside & McClam, 2003). The return to a task is never at the point at which one stopped just as the interruption occurred; rather backtracking and redundancy are the result (see Figure 5.2).

Another reason interruptions are so time costly is the nature of most interruptions. Figure 5.3 depicts the anatomy of an interruption. Here, one can see

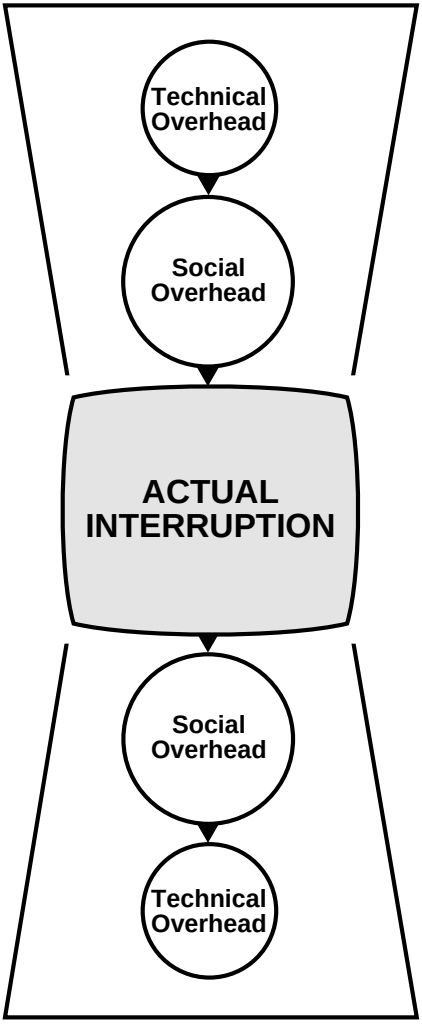

FIGURE 5.3 The Component Parts of an Interruption

that the *overhead* portions of an interruption (Technical and Social Overhead) use a far greater proportion of time than does the Body or actual purpose or content for which the interruption was initiated (Riley et al., 1976). Usually, the caseload manager will find Technical Overhead (e.g., getting papers ready and assembling notes for the interruption) and Social Overhead (e.g., excessive greetings and warm-up conversations) exist in 2:1, 3:1, and sometimes 10:1 ratios in relation to the real body of the interruption.

Interruptions also stem from the communication process. If clients, parents, vendors, employers, and other professionals do not understand what to do after communicating with the counselor, little wonder interruptions become excessive. These individuals will be forced to make frequent renewed contacts with the counselor, some of which will occur in the form of interruptions.

Interruptions can be controlled by (1) wise self-disciplining, (2) blocking time (partition a period of time for certain activities and allow only *real* crises to filter in—remember, one uninterrupted hour can be worth 2 to 3 uncontrolled hours), (3) interrupting or allowing interruptions only when "hot and heavy" issues are at stake, (4) positioning desks and office furniture so as to discourage interruptions, (5) employing body language and attitudes that signal a polite busy posture, and (6) giving the communication process its due respect and attention.

Procrastination

"Whereas interruptions are the most common form of 'other-inflicted' time robber, procrastination is the most common (and readily admitted) self-inflicted time robber" (Smith, 1994, p. 33). Procrastination has many roots: (1) lack of confidence, (2) desire for perfection, (3) resentment of the requirement for performing a task, (4) fear of failure, or (5) a general low-key or passive approach (an attribute of the true procrastinator). Except possibly for category five, fear is usually at the base of most procrastination problems. Fear tends to greatly exaggerate a counselor's problems and barriers. "Putting it off" has probably caused more failure than all other management problems combined (Smith, 1994). Therefore, *the result of procrastination is then guilt from inaction*. If a counselor would ask others the simple question, "Do you see me as a procrastinator?" the answer should confirm to the counselor that guilt, not procrastination, is the greatest adversity experienced. To confront procrastination: (1) Never be fearful of errors; they are learning experiences. (2) Establish a prioritizing system and believe in it. (3) Always start the day by doing the most unpleasant (not necessarily the most important) task first. (4) Never end the day feeling you did not accomplish

enough—avoid the guilt syndrome. Remember, if your management system is working for you, then you have filled the day with all the high-priority activities the day could tolerate and other high-priority activities will have to wait until another day.

Drop-ins

The two broad classes of drop-ins are clients (new, current, or former) and others (e.g., other counselors). In a state agency serving individuals with disabilities, some drop-ins of new clients must be tolerated. Sometimes former or current clients also must be tolerated, but only occasionally. This latter group can be trained to assist the counselor and themselves in managing time and respecting priorities. The others mentioned above may be trained tactfully to respect a counselor's attempts to establish a functional time management program. There are many ways to deal effectively with drop-ins: (1) Be tactful but honest with drop-ins; their respect of your honesty should guide their own time management program. (2) Suggest meeting them later in their offices. (3) Close your door at times to communicate your attitude. (4) If possible, stand and remain standing until the drop-in leaves. (5) Train support staff to give assistance to drop-ins by setting up appointments and/or giving them information sought. (6) Have intake counselors in a rehabilitation unit who can be designated to handle new client drop-ins on a rotating basis.

No Shows and Latecomers

There should always be alternatives for time gaps. Never allow yourself to be kept waiting. This gap in time is a gift of time. Always have an alternative set of high-priority tasks to accomplish. Latecomers sometimes cannot be avoided; however, their time management practices may need revamping. If clients are involved, their successful placement may depend on this type of assistance.

Reverse Delegation

This time trap occurs when a good caseload manager's directing function has been thwarted and the proverbial monkey (Oncken & Wass, 1974) is on the counselor's back. Here the responsibility for a task and often the actual work are *delegated from the client, peer, or others upward to the counselor*. That is, the counselor has become the "managee" in the rehabilitation process rather than the manager. The counselor must learn to accept reverse delegation, but only when appropriate. This acceptance short-circuits the negative emotional reac-

tions that are likely to come from feeling put upon by others. Asignificant strategy is to develop appropriate initiative levels in clients, peers, and others.

Oncken and Wass (1974) instruct managers on the effective guidance of initiative of the part of individuals on a caseload. The rehabilitation caseload manager must learn how to transfer initiative to clients. There are five levels noted regarding client initiative (Cassell & Mulkey, 1985, 2004; Oncken & Wass, 1974; Parker, 2002):

1. waiting to be told what to do,
2. asking, "What is the next thing to be done?",
3. recommending a course of action, then taking some of that action,
4. actually taking action on one's own but reporting immediately to the caseload manager the initiatives taken, and
5. acting on one's own and only reporting on a routine basis.

The focus of this change in initiative on the part of the caseload manager is to assist the client to achieve a Level 5 response. Caseload managers with 20% to 40% of individuals in levels 1 and 2 are involved in excessive doing for the client instead of doing with the client, in a counselor-manager-client interaction cycle. Once Level 5 is achieved, the client is very close to the closure stage in the rehabilitation process. It is at this time that a paradigm shift has occurred allowing the client to channel constructive actions. This permits clients "to experience the rewarding opportunity of establishing internal control over their own processes, thereby enhancing stable, lasting rehabilitation results" (Cassell & Mulkey, 2004, p. 263).

Incomplete Information

This time trap can have the counselor chasing around expending time at an enormous rate. However, as was learned earlier, one characteristic of internally controlled counselors is the drive to attain more information in order to be in greater command of their situation. This gathering of complete information will improve the decision-making process, ensure more valid planning, and lower risk taking and inference-based action. The time used for seeking out more complete information is a trade-off for a larger portion of time saved later on.

Overcommitment

This is probably the most detrimental time trap a vocational rehabilitation counselor can experience. Rehabilitation counselors are administrators of

caseloads that bring them into interaction with a myriad array of systems, each with its own requirements and demands on their time. Counselors must not only deal with clients' personal systems of values, attitudes, and psychological conditions, but also must interact in some manner with state and federal systems that demand accountability and record keeping. Examples of these systems include (1) social service, (2) parent-familial, (3) community and organization, (4) medical/psychological examination and treatment, (5) industry and placement, (6) vocational evaluation training, (7) tracking, follow-up and/or follow-along, and (8) attorney and judicial demand for clients. All these systems require a knowledge base and the establishment of a continuing relationship with them. Little wonder then that over-commitment might be a problem.

Dealing with overcommitment requires the ultimate in establishing viable, complete management skills to stand complementary to the counselor skills. The only other approach is dealing superficially with some of these systems while focusing greater attention on others. This latter approach, of course, is only a stopgap measure and eventually becomes costly in terms of quality and quantity of outcomes.

Poor Communication

The effects of this time trap include a steady pattern of interruptions by clients, redundancy of effort by counselors (if the faulty communication is downward in the organization), and redundancy of effort by clients (the taking of other individuals' proverbial monkeys onto the counselor's back). The alert caseload manager by now should be able to diagnose these and similar patterns as stemming from a faulty communication process.

Poor communication networks are the result of problem areas that are reaching critical limits. Among these problem areas are (1) conflicting values systems, which force one to hear only what one wants to hear, (2) overcommitment, which creates weakened ties with the target of communicative attempts, (3) inattention to detail (which is often the result of basing action on inferences rather than observations), and (4) anxieties stemming from the frustrated juggling of priorities.

Treon (1979) illustrates the fact that poor communication is costly to caseload managers. Addressing himself to private rehabilitation of injured persons, Treon states that

> rehabilitation professionals (rehabilitation psychologists, vocational evaluators, rehabilitation counselors, job development and placement specialists, and case management specialists) and injured persons' lawyers really

> do not speak the same language or communicate with a basic understanding of the other's point of view. . . . The problem is, as I see it, we do not understand each other; we do not communicate well; we do not serve our clients as well as we could and should if we did understand each other's point of view. [Treon, 1979, p. 34]

The rectifying of poor communication problems begins with the introduction of positive redundancy into the communication process, striving for clarity with the communicator while interactions are in progress, and ending with mental or verbal quizzing of one's understanding of the transactions.

Meetings

Meetings are usually approached with disdain by almost everyone. However, concerned managers will do their part to be prepared for specific meetings and assist in keeping those meetings on target and moving at a reasonable pace. They will offer summaries of progress made when the meeting seems to be wheel spinning and have standing rather than sitting meetings. When possible, the effective caseload manager will set and stick to objectives for meetings and gain a knowledge base of the psychology of group processes. Sometimes it may be more productive to get minutes of a meeting later rather than attend. The counselor with a sufficient maturity level will ask, "What is the best use of my time right now?" and respond appropriately.

Personal Disorganization

Personal disorganization incorporates many of the above traps and focuses on the need to initiate coping processes to deal with time problems. Frequently time problems come into the counselor's world from outside sources, but one must look first to those areas that can be affected more easily and where immediate results can be realized from personal, internal dynamics. Only through a strong personal commitment to the consistent application of a system of management can the counselor hope to become a time manager rather than a time subordinate. The cumulative cost of time lost to the time traps just described is so high that it is amazing any sizable portion of the job gets accomplished. However, by initiating minimal management efforts counselors can realize gratifying payoffs in production and personal adjustment to the job immediately.

SUMMARY

In summary, the caseload manager must develop techniques and practices for dealing with time-related problems if effectiveness is the goal. These tech-

niques and practices are formalized from a thorough, functional time management system. This chapter offered most of the necessary elements for a systematic approach. The internalization and use of these components is a beginning. The counselor must build a personalized system from this skeletal framework.

The chapter discussed the six theoretical dimensions of time that give it a reality base for study and for initiating counselor action. Time has structure, time has incessant continuum properties, time movement is inherently goal directed, time-use activities evolve from reinforcement principles, time use involves personal properties, and time use involves situational properties.

Approaches to time management emanate from two different basic areas: a Quantitative-Analytical Approach and an Intuitive Approach. A quantitative approach is grounded in the realization that an objective, analytical base is an essential component of a management system. This approach can validate experiences by thwarting perceptual and subliminal inferential processes that are ever present. Six principles of a Quantitative Analytical Approach were discussed. They are (1) the Principle of Self-Motivation, (2) the Principle of Effectiveness, (3) the Principle of Quantitative Analysis, (4) the Principle of Managing Interfaced Systems, (5) the Principle of Action Structuring, and (6) the Principle of Reevaluation.

The Intuitive Approach is offered as a means of conceptualizing a balanced management system to bring under control those situations that the more strict, often rigid Quantitative-Analytical Approach cannot address. The Intuitive Approach relies on the counselor's insight, creativity, and spontaneity upon which to base action for managing time problems. This Intuitive Approach is of course a personally derived program from techniques and tools that do not fall within the purview of a formal system with prescribed boundaries. Therefore, several conceptual areas were described to act as catalysts for generating a truly intuitive approach: (1) List Construction, (2) Intuitive Flags, (3) Categorized Time Use, (4) Time-Use Logs, and (5) Time Traps.

In the final analysis, effective self-management in relation to time frames is related to the extent to which the counselor is able to draw from the Quantitative-Analytical Approach and make use of her or his own intuitive skills for control. Which approach to rely on most heavily at the proper time is something that will come with experience. The telltale clue that one approach is relied upon more exclusively than the other will come when the counselor feels anxiety and frustrations about time-related problems over an extended period. Although there are time-related problems over which counselors feel they have absolutely no control, it is at this time that they must

realize that one measure of control is always possible. That measure is control over the emotional or attitudinal component that can affect consequent action. If one cannot control the situation as such, one can control such possibly negative internal dynamics as guilt, anxiety, anger, and frustration, which can be barriers to effective management.

PART II

Practical Aspects of Caseload Management

The second part of this text provides insights into the practical dimensions of caseload manager functions, especially as these operations relate to rehabilitation counselor practices. Specific aspects of a counselor's ongoing activities are explored and clarified to assist understanding and performance. The foundation presented in Part I provides support for the developing skill patterns to be gained from understanding and integrating material in the subsequent chapters, with the expected result being a more effective caseload manager.

Although these discussions are directed toward the practices of rehabilitation counselors, and in some instances public sector counselors, the practicality of the information for professionals working in other rehabilitation caseload management situations is obvious. Whether referring clients for possible rehabilitation services or maintaining caseloads that contain rehabilitation clients, an understanding of these systematic procedures should facilitate expertise in developing service-delivery strategies. This journey is one of growth and learning, with an implied challenge to the counselors' ability to generalize the data to their unique situations.

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CHAPTER 6

Case Classifications in the Vocational Rehabilitation Process

NEED FOR A CODING STRUCTURE

The Smith-Fess Act of 1920 (Public Law 66-236) initiated public vocational rehabilitation (VR) services in America.These funds could be used to provide vocational training and placement services (Rubin & Roessler, 1995, 2001). This same legislation created a need for a service-delivery system that would be responsive to client needs and accountable to the funding source. Therefore, a service tracking system emerged that allowed monitoring activities to reflect the essence of rehabilitation service delivery.

During the late 1930s and the early 1940s, vocational rehabilitation implemented several important initiatives to improve program administration: (1) status system development, (2) a case control device, and (3) a uniform service record system describing services. These efforts shaped how VR programs were and are still administered through a federal-state partnership. The initiatives focused on gathering of information on the services provided by agencies, types of outcomes achieved by the individuals being served within the agencies, and demographic information about those individuals (Thomas, 1970). This crucial information demonstrated the numerous achievements of the VR program, and assisted efforts to improve its overall effectiveness.

Out of these initiatives emerged the development of a rehabilitation process that provided structure and identified the skills and techniques necessary for good case management. Two Federal staff members, Terry Foster, a former state director of the Alabama vocational rehabilitation program, and Donald Dabelstein, former state director of the Minnesota program, were the creative team behind the development of a systematic and linear process that was used to ensure the adequacy of services provided to individuals in rehabilitation programs. According to Thomas (1970), these two individuals

developed the original rehabilitation process paradigm that was composed of three major components:

1. a status system,
2. a case control device for measuring an individual's progress through the successive steps of the process, and
3. a uniform system of service record recording.

Initial Public Coding System

The first product of this team's work was a status system that represented each step or stage in the rehabilitation process, beginning at referral and ending with case closure or outcome. Nine statuses were constructed, numbered consecutively "0" to "8." Specific definitions accompanied each of these statuses and states were required to submit reports detailing the number of individuals within each status. This original status system, formed by Foster and Dabelstein and described by Thomas (1970) is shown in Table 6.1. This system and basic design has served as a model for present and future iterations of the status system used in the VR program.

A second product was the development of a case control device called the "Flow Sheet." At the beginning of each fiscal year, states were required to show on this form the number of individuals within each status. This information was to be updated quarterly to reflect the movement of individuals through the rehabilitation process. These reports were then submitted to Vocational Rehabilitation Services for monitoring (Thomas, 1970).

TABLE 6.1
Foster and Dabelstein's Status System

Status Number	Classification
Status 0	Application to vocational rehabilitation for services
Status 1	Case being studied after determination of eligibility
Status 2	In process of planning a program of services
Status 3	Plan completed
Status 4	In a training program
Status 5	Physical restoration services being provided
Status 6	Awaiting employment
Status 7	In employment while being followed up
Status 8	Service interrupted

A final product that developed was a uniform service record system to describe service provision, demographics, and outcomes achieved by individual clients. A form was adopted for each step in this process. These forms were numbered consecutively starting with R-1 and were used by all states.

This linear framework for statistical reporting developed by Foster and Dabelstein created a structured process to track individuals as they moved within the VR system. The influence of their contributions was so pervasive that it introduced into the program a rigid mentality among practitioners as to what could and could not be done within the various steps of the rehabilitation process (Thomas, 1970).

According to Abbott (personal correspondence, September 28, 2004), with 15–20 years of operating the program based on the 1920 legislation and its heavy emphasis on disability, and also the work of Foster and Dabelstein, the rehabilitation program took on a medical model as its primary means of program administration. As rehabilitation agencies increased in numbers, personnel, program initiatives, clients served, and dollars expended, change became almost immeasurable (Matkin, 1981). However, in the late 1960s, total service-system accountability in public rehabilitation became tracked largely by a system of case status classifications. These classifications followed the rehabilitation process and provided easy tracking of service delivery strategies among public agency programs.

Revised Public Coding System

During the 1960s and 1970s, state rehabilitation agencies focused on using sixteen case status classifications, which consisted of the previous federal coding structure beginning with 00 and continuing with even numbers ending with 34 (see Table 6.2). These status classifications were used by the rehabilitation counselor as tools for the management of cases and by the agency as a reporting system of rehabilitation activities within a given state or region.

Private Sector Coding System

Continuing to be refined, private rehabilitation tracking systems follow the rehabilitation process by the use of various stage (or step) identifiers. The process of case management in private rehabilitation can be broken down into distinctive categories: (1) case finding and targeting, (2) gathering and assessing of information, (3) planning, (4) reporting, (5) obtaining approval, (6) coordinating or putting the plan into action, (7) follow-up, and (8) evaluation (Mullahy, 2004). Such categories denote the stages of service delivery. However, the specificity of service tracking systems used in private rehabili-

TABLE 6.2
Statistical Reporting System

Status Number	Classification
Status 00	Referral
Status 02	Applicant
Status 06	Extended evaluation
Status 08	Closed from referral, applicant, or extended evaluation, statuses
Status 10	Individualized Plan for Employment development
Status 12	Individualized Plan for Employment completed
Status 14	Counseling and guidance only
Status 16	Physical and mental restoration
Status 18	Training
Status 20	Ready for employment
Status 22	In employment
Status 24	Service interrupted
Status 26	Closed rehabilitated
Status 28	Closed other reasons for Individualized Plan for Employment initiated
Status 30	Closed other reasons before Individualized Plan for Employment initiated
Status 32	Postemployment services
Subsequently	
Status 34	Closed from postemployment services

tation is not discussed in this chapter (see chapter 9). The focus is specific to public rehabilitation and current case classification systems.

The rehabilitation case classifications are neither simple nor exceedingly complex in design. However, many rehabilitation counselors fail to understand the dynamics of this systematic component of *process* management and its relationship to effective and accountable service delivery.

The need to understand and use a coding structure in the management of a rehabilitation caseload is usually scoffed at as something extra to be done, as superfluous to counseling, and viewed as nonrewarding to the counselor. The genesis of these problems is a lack of understanding or a lack of commitment to the role of a vocational rehabilitation counselor in a state agency. First of all, no organization that must produce a quality product can function without an adequate tracking system. An organization charged with such an immense responsibility as "processing" people is thus in critical need of a self-

administering, self-adjusting system for ensuring that quality, timely services are afforded to clientele. The case classification system allows counselors to build a methodology for self-supervision of their own minisystems, lifting the counselor from mere technician status. The use of a coding system is part of the prescribed job duties of counselors, and is as much a responsibility as establishing therapeutic counseling relationships with clients. The fact that working with a case reporting system is nonrewarding also relates to the role misperception problem. If counselors accept the coding-reporting system as an integral part of their position and they identify with the system emotionally as part of their responsibilities, only then will they begin to manage this aspect of the vocational rehabilitation process adequately.

Specifically, it is the rehabilitation counselor who must assume the major responsibility for directing, expediting, and managing caseload development (Cassell & Mulkey, 1985; Maki & Riggar, 2004; Szufnarowski, 1972). It becomes an administrative function of the rehabilitation counselor to ensure proper service delivery within a uniform reporting system while maintaining flexibility and individualizing the program of services. Therefore, the rehabilitation counselor must maintain an accurate understanding of the case classifications used in identification of case movement in order to adequately reflect counselor activities and properly trace service delivery.

THE BASIC PUBLIC CLASSIFICATION SYSTEM

It is generally accepted that the rehabilitation process is a planned, orderly sequence of services related to the total needs of the individual with a disability (Cassell & Mulkey, 1985; McGowan & Porter, 1967; Thomas, 1970). Specifically, case development can be considered a dynamic process because it is client oriented. As this type of orientation recognizes the individuality of each client, the process will vary in duration and service delivery. For example, less than one year may be required to "rehabilitate" one individual needing fewer services to complete specific rehabilitation goals, whereas as much as five years might be required for another seeking a more extensive and long-term goal.

The case status classification system can be divided into four zones in accordance with specified movement that occurs throughout the case management schema. These categorical zones are: (I) Applications and Eligibility, (II) Signed Individualized Plan for Employment (IPE) and Awaiting Services, (III) Service Implementation, and (IV) Outcomes for Individuals Exiting the Program. A zone flow chart and specific status identifications are shown in Figure 6.1. Each categorical grouping and the particular status classifications

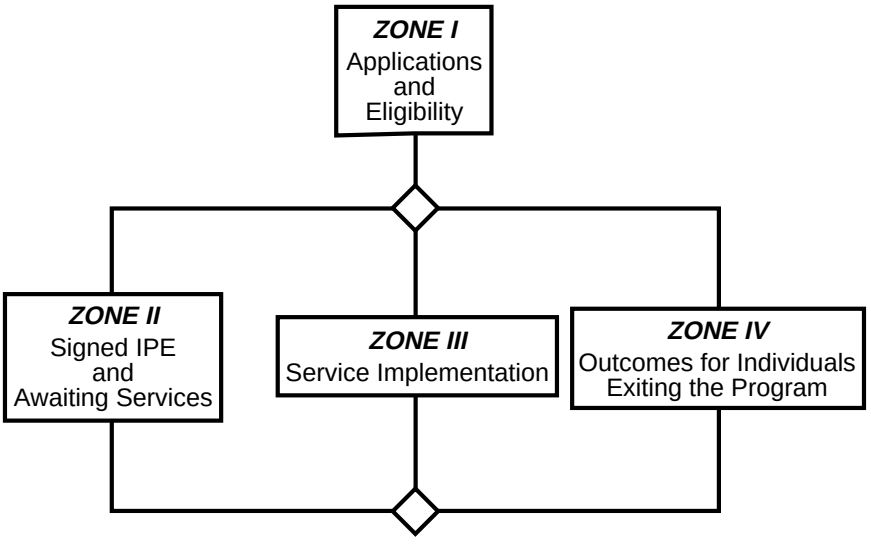

FIGURE 6.1 Status-Function Zone Chart

are discussed in the following sections. The definitions for each caseload item listed in Table 6.1 are found in Policy Directive RSA-PD-03–03 (U.S. Department of Education/Office of Special Education and Rehabilitation Services, 2003).

Careful review of Figure 6.1 reveals required reporting zones identified by the Rehabilitation Services Administration (RSA). The Rehabilitation Decision Model is illustrated in Figure 4.2 (chapter 4) and service applications are specified in Figure 4.4. The interaction of concepts and practice reflected through these three figures will be applied to federal structure and reporting paradigms used by state rehabilitation agencies. Knowledge and understanding will be enhanced by the dissection of Figure 4.4 and incorporating the dissected components into the discussion of Figure 6.1 and the status-function zone chart. Further, caseload items relating to each zone will be illustrated in tables and defined.

Zone I: A. Applications and Eligibility

The first zone (Zone I) to be considered is Applications and Eligibility (see Figure 6.2). These classifications are used as the client enters the vocational rehabilitation process. It is here that the diagnostic evaluation begins to determine whether the individual is eligible for rehabilitation services available through the agency.

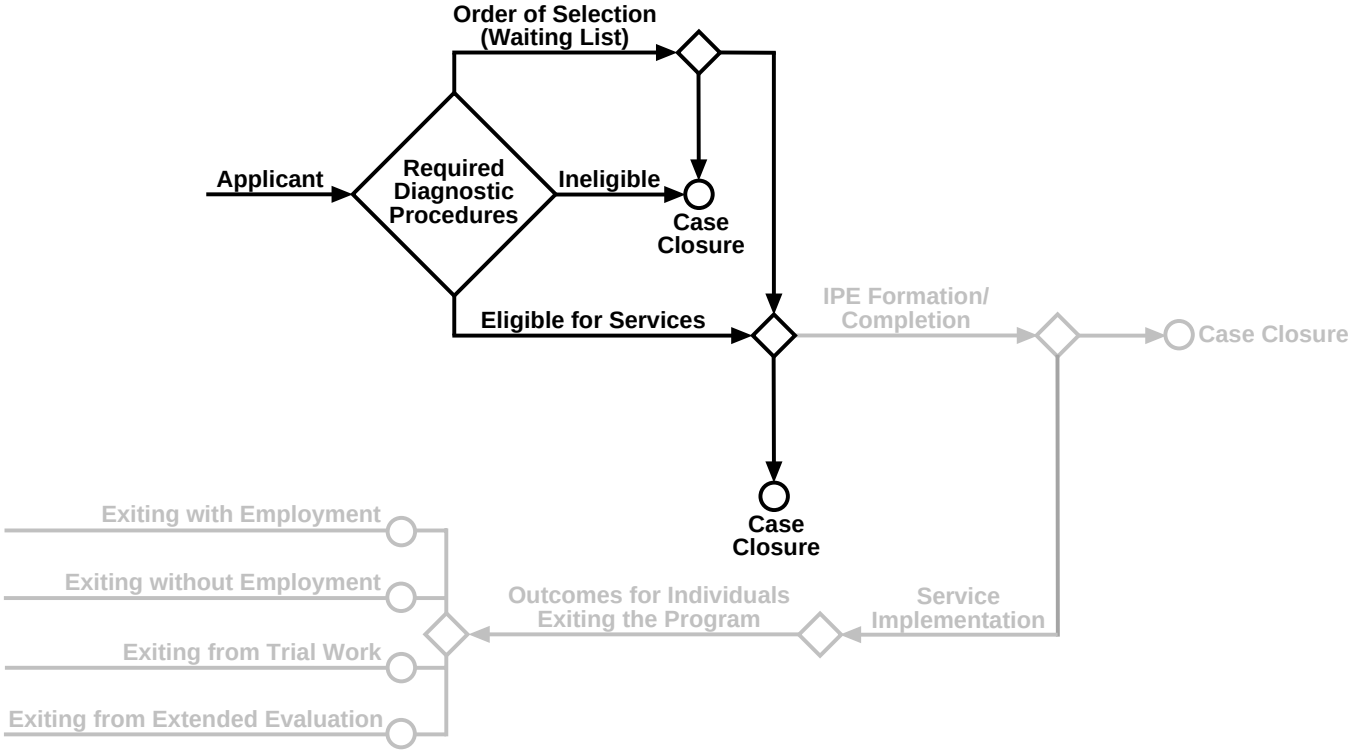

FIGURE 6.2 Components of the Service-Decision Model: Applied to Zone I

Applicants

This classification system represents entrance into the vocational rehabilitation process. Entry into this process is traditionally handled through a referral to an agency. A referral is defined as any individual who has applied to or been referred to the vocational rehabilitation agency by letter, telephone, direct contact, or any other means, and for whom the following minimum information has been furnished (1) name and address, (2) disability, (3) age and sex, (4) date of referral, and (5) source of referral (Cassell & Mulkey, 1985).

It is important to note that the referral definition does not include those persons who are screened out through established criteria in cooperative agreements between other agencies and the vocational rehabilitation agency. However, all individuals not screened out through such means should be recorded and reported as referrals to vocational rehabilitation. It will be determined whether these referrals have vocational rehabilitation potential following appropriate diagnostic evaluation and counselor investigation.

The counselor must record and report all cases as soon as the minimum basic information is available. It is essential that this principle be recognized as standard operating procedure even though the referral may be closed almost immediately as being ineligible for services of the agency (see Table 6.3).

A1. *Applicant on Hand, October 1*: This caseload item represents those persons who applied for VR services in the last fiscal year, and for whom no determination of eligibility was made as of the end of that fiscal year. This figure stays constant throughout the current fiscal year.

A2. *Applicants New This FY*: This caseload item represents the cumulative number of persons who have applied for vocational rehabilitation services since the beginning of the fiscal year.

TABLE 6.3
Caseload Items: Applicants

A. Applications and Eligibility
Applicants
1. Applicants on Hand October 1
2. Applicants, New This FY
3. Applicants at End of Period (A1+A2-A5-A8-A12-D7)
4. Applicants in Trial Work/EE on Hand, October 1
5. Applicants in Trial Work/EE Referred This FY
6. Applicants in Trial Work/EE at End of Period (A4+A5-A9-A13-D6)

Source: Form RSA-113

A3. *Applicants at End of Period*: This caseload item indicates the number of applicants for whom a determination of eligibility has not yet been made at the end of the period. This is a data verification item and may be represented by the computation (A1+A2-A5-A8-A12-D7).

A4. *Applicants in Trial Work/EE on Hand, October 1*: This caseload item represents those individuals currently in Trial Work Experiences and/or Extended Evaluation since the beginning of this fiscal year. This number will also reflect those in this category whose disabilities are significant.

A5. *Applicants in Trial Work/EE Referred This FY*: This caseload item indicates the number of applicants who were referred and placed into Trial Work Experiences and/or Extended Evaluation since the beginning of this fiscal year. This number will also reflect those in this category whose disabilities are significant.

A6. *Applicants in Trial Work/EE at End of Period*: This caseload item indicates the number of individuals who remain in Trial Work Experiences and/or Extended Evaluation at the end of the period, prior to a determination of eligibility.

Eligible Individuals on Order of Selection (OOS) Waiting List

The items in this section apply only to those State Vocational Rehabilitation agencies that are operating under an order of selection at some time during the reporting period. The major purpose for the order of selection is to provide an organized, equitable method of serving individuals with disabilities if all eligible persons who apply cannot be served. The first priority is given to individuals with the most significant disabilities.

The order of selection will ensure that services are continued for cases already receiving services under an Individualized Plan for Employment (IPE), as well as provide services to new clients in an open priority category. It will also ensure that adequate funds are conserved to provide diagnostic services for all new applicants to determine their eligibility.

Each case determined eligible must be classified into a priority category before development of an IPE. A client must be assigned the highest priority category that is justifiable. A client should be reclassified into a higher priority category any time circumstances justify the reclassification. However, a client may not be reclassified into a lower priority category once the IPE has been developed and signed (see Table 6.4). The definitions used for the order of selection process are found in Section 2001.00 of the *Rehabilitation Services Manual* (Federal Register 40, 2001a).

TABLE 6.4
Caseload Items: Eligible Individuals on Order of Selection (OOS) Waiting List

A. Applicants and Eligibility
Eligible Individuals on Order of Selection (OOS) Waiting List
7. Individuals on OOS Waiting List on Hand October 1
8. Individuals on OOS Waiting List, New This FY from Application
9. Individuals on OOS Waiting List, New This FY from Trial Work/EE
10. Individuals on OOS Waiting List at End of Period (A7+A8+A9-A14-D5)

Source: Form RSA-113

A7. *Individuals on OOS Waiting List on Hand, October 1*: This caseload item represents the number of persons who previously were determined eligible for VR services and who continue to wait on an order of selection waiting list from the last fiscal year because the severity of their disabilities does not correspond with the State VR agency's order of selection categories that are currently being served. This number will also reflect those in this category whose disabilities are significant.

A8. *Individuals on OSS Waiting List, New This FY from Application*: This caseload item indicates the cumulative number of persons who were determined eligible for VR services this fiscal year for whom VR services will be delayed because the severity of their disabilities does not correspond with the State VR agency's order of selection categories that are currently being utilized. This number will also reflect those in this category whose disabilities are significant.

A9. *Individuals on OSS Waiting List, New This FY from Trial Work/EE*: This caseload item represents those individuals who were determined eligible after trial work experiences or an extended evaluation, but were placed on a waiting list in accordance with the State VR agency's order of selection criteria. This number will also reflect those in this category whose disabilities are significant.

A10. *Individuals on OSS Waiting List at End of Period*: This caseload item indicates the number of eligible individuals remaining on a waiting list at the end of the reporting period. This number will also reflect those in this category whose disabilities are significant. This is a data verification item and may be represented by the computation (A7+A8+A9-A14-D5).

Individuals Determined Eligible, Before Signed IPE

This section sets forth the requirements for determining eligibility before signing of the Individualized Plan for Employment (IPE). It includes requirements for eligibility certification and for recording the basis for the provision of trial work experiences to determine whether an individual can benefit from services in terms of an employment outcome.

Basic eligibility requires that three criteria be met for each individual who is eligible for Vocational Rehabilitation Services. These criteria are as follows: (1) the individual has a physical or mental impairment that constitutes or results in a substantial impediment to employment, (2) the individual can benefit in terms of an employment outcome from Vocational Rehabilitation services, and (3) the individual requires Vocational Rehabilitation services to prepare for, secure, retain, or regain employment. However, an individual receiving SSI or SSDI on the basis of disability or blindness is *presumed* eligible, provided that he or she intends to achieve an employment outcome, unless the agency demonstrates by clear and convincing evidence that the disability is too severe for the individual to benefit in terms of an employment outcome (see Table 6.5). The definitions used for the determination of eligibility process are found in Section 2001.00 of the *Rehabilitation Services Manual* (Federal Register 40, 2001a).

A11. *Eligible Individuals Before Signed IPE, on Hand October 1*: This caseload item indicates the number of persons who are determined eligible during the last fiscal year, but had not yet developed and signed an IPE at the end of the year (individuals on an order of selection waiting list are not included in this number). This number will also reflect those in this category whose disabilities are significant.

TABLE 6.5

Caseload Items: Individuals Determined Eligible, Before Signed IPE

A. Applications and Eligibility
Individuals Determined Eligible, Before Signed IPE
11. Eligible Individuals Before Signed IPE on Hand, October 1
12. Eligible Individuals Before Signed IPE, New This FY from Application
13. Eligible Individuals Before Signed IPE, New This FY from Trial Work/EE
14. Eligible Individuals Before Signed IPE, New This FY from OOS Waiting List
15. Eligible Individuals Before Signed IPE at End of Period (A11+A12+A13+A14-B2-D3)

Source: Form RSA-113

A12. *Eligible Individuals Before Signed IPE, New This FY from Application*: This caseload item represents the cumulative number of persons who were determined eligible this fiscal year and began employment planning after application. This number does not include those individuals who were determined eligible after trial work experiences and/or an extended evaluation, or individuals who were determined eligible but are on a waiting list because the severity of their disabilities does not correspond with the State VR agency's order of selection categories that are currently being served.

A13. *Eligible Individuals Before Signed IPE, New This FY from Trial Work/EE*: This caseload item represents the cumulative number of individuals determined eligible who began employment planning this year after trial work experiences and/or an extended evaluation. This number will also reflect those in this category whose disabilities are significant.

A14. *Eligible Individuals Before Signed IPE, New This FY from OOS Waiting List*: This caseload item indicates the cumulative number of individuals who began developing an IPE, after waiting on an order of selection list, since the beginning of this fiscal year. This number will also reflect those in this category whose disabilities are significant.

A15. *Eligible Individuals Before Signed IPE at End of Period*: This caseload item represents the total number of persons remaining at the end of the period who are eligible, but have not completed developing an IPE. This number will also reflect those in this category whose disabilities are significant. This is a data verification item and may be represented by the computation (A11+A12+A13+A14-B2-D3).

Zone II B. Signed Individualized Plan for Employment (IPE) and Awaiting Services

The next zone (Zone II) is the Signed Individualized Plan for Employment (IPE) and Awaiting Services (see Figure 6.3). The term *awaiting services* is used often and indicates that an individual has met the eligibility criteria and can now be referred to as a **client** of the agency. Within a liberal structure, the individualized services are related, although the function of each is to identify the diverse activities in the total managerial aspect of caseload accountability. The signed Individualized Plan for Employment (IPE) identifies

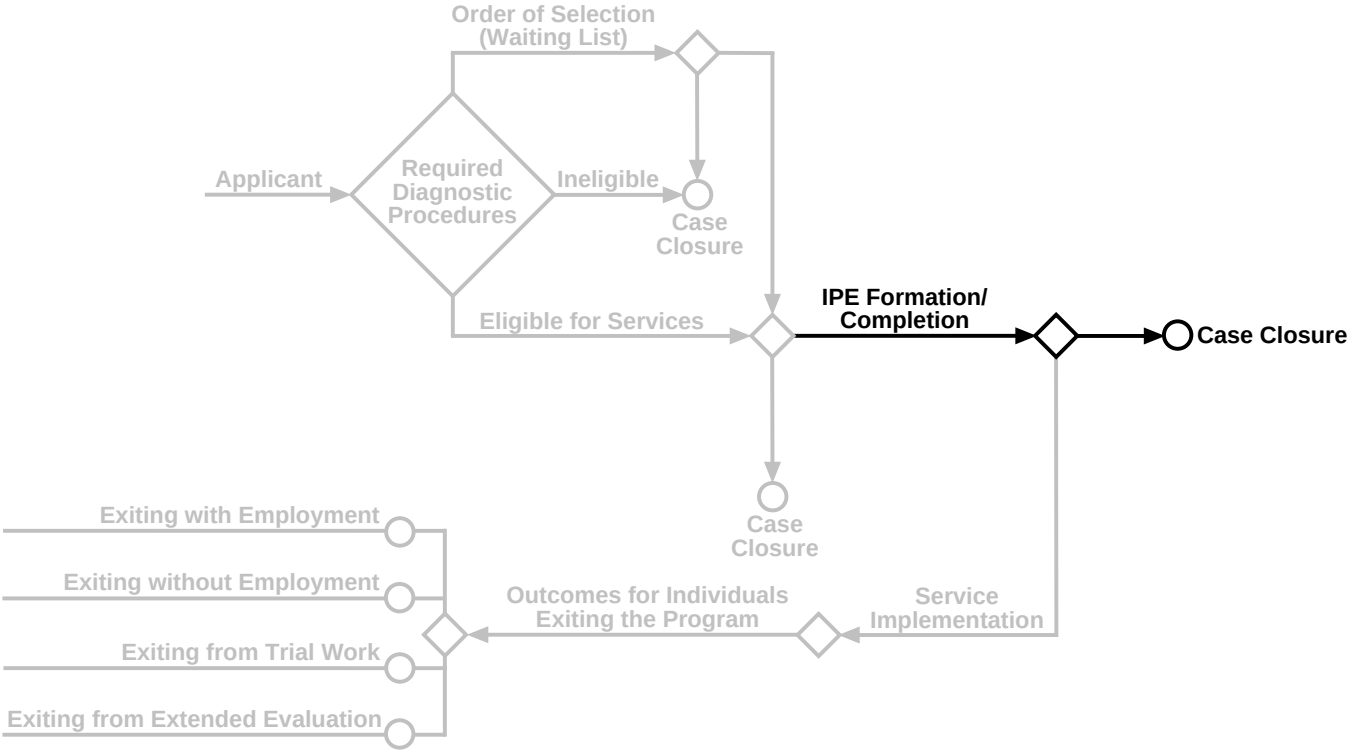

FIGURE 6.3 Components of the Service-Decision Model: Applied to Zone II

the *development* and *completion* of the vocational rehabilitation plan, and outlines the procurement and provision of service delivery toward achievement of a vocational goal. The definitions used in the development of the IPE are found in Section 1507.00 of the *Rehabilitation Services Manual* (Federal Register 40, 2001b).

While a client's file is in this part of the rehabilitation process, the case study and diagnosis are completed in order to provide a basis for the formulation of the Individualized Plan for Employment. A comprehensive case study is basic to determining the nature and scope of services to be provided in order to accomplish the individual's vocational rehabilitation objective. The counselor and client formulate and plan the rehabilitation services necessary to the solution of the client's problems, and those services are clearly outlined to the individual.

The second area of classification in Zone II provides identification for those case folders holding a written and approved IPE. The vocational rehabilitation services planned have not been initiated and may even lack specific arrangements for their provision. However, the counselor's signature on the IPE document is usually indicative of case movement (see Table 6.6).

B1. *Individuals with Signed IPE, Before Receiving Services, on Hand October 1*: This caseload item represents the cumulative number of eligible persons who developed and signed an IPE but for whom services under the plan were not yet implemented as of the end of the last fiscal year. This number will also reflect those in this category whose disabilities are significant.

B2. *Individuals with Signed IPE, Before Receiving Services, This FY*: This caseload item represents the cumulative number of eligible persons who have developed and signed an IPE since the beginning of this fiscal year. This number does not include those individuals who developed plans for Trial Work Experiences and/or Extended Evaluation. This

TABLE 6.6

Caseload Items: Signed Individualized Plan for Employment (IPE) and Awaiting Services

B. Signed Individualized Plan For Employment (IPE) and Awaiting Services
1. Individuals with Signed IPE, Before Receiving Services, on Hand October 1
2. Individuals with Signed IPE, Before Receeiving Services, This FY
3. Individuals with Signed IPE, Before Receiving Services, at End of Period (B1+B2-C2-D4)

Source: Form RSA-113

number will also reflect those in this category whose disabilities are significant.

B3. *Individuals with Signed IPE, Before Receiving Services, at End of Period*: This caseload item represents the total number of persons remaining at the end of the period who have developed and signed an IPE, but for whom services on the IPE have not yet been implemented. This number will also reflect those in this category whose disabilities are significant. This is a data verification item and may be represented by the computation (B1+B2-C2-D4).

Zone III C. Service Implementation

The third zone (Zone III) is the Service Implementation (see Figure 6.4). This zone includes finalization and implementation of the Individualized Plan for Employment (IPE). The IPE formalizes the case planning, including the development of employment goals, means and time frames for achievement of the employment outcome, criteria for evaluation of progress, terms and conditions, and protection of rights. This plan should be understood as a starting point after eligibility for services or for trial work experiences. It is subject to additions, deletions, and amendments. In addition to being a plan of action, it is a statement of understanding regarding rights, responsibilities, and steps toward achievement of the employment outcome. The definitions used for the implementation of services are found in Section 1507.00 of the *Rehabilitation Services Manual* (Federal Register 40, 2001b).

The IPE is to be developed and implemented in a manner that affords eligible individuals the opportunity to exercise informed choice in selecting the employment outcome, the specific vocational rehabilitation services to be provided, the entity that will provide the services, and the methods used to procure the services. It is to be agreed to and signed by the eligible individual or, as appropriate, the individual's representative. It is to be approved and signed by the qualified vocational rehabilitation counselor, and a copy of the plan is to be provided to the client.

The plan will be initiated concurrently with, or reasonably soon after, the completion of the certification of eligibility for VR services or for trial work experiences. The plan is subject to change by nature of the VR process, and may be amended only when there is substantial change in the plan or when a change has the potential for contention or misunderstanding. Any revisions or amendments to the plan will not take effect until agreed to and signed by the client or the client's representative and approved by the counselor. If the

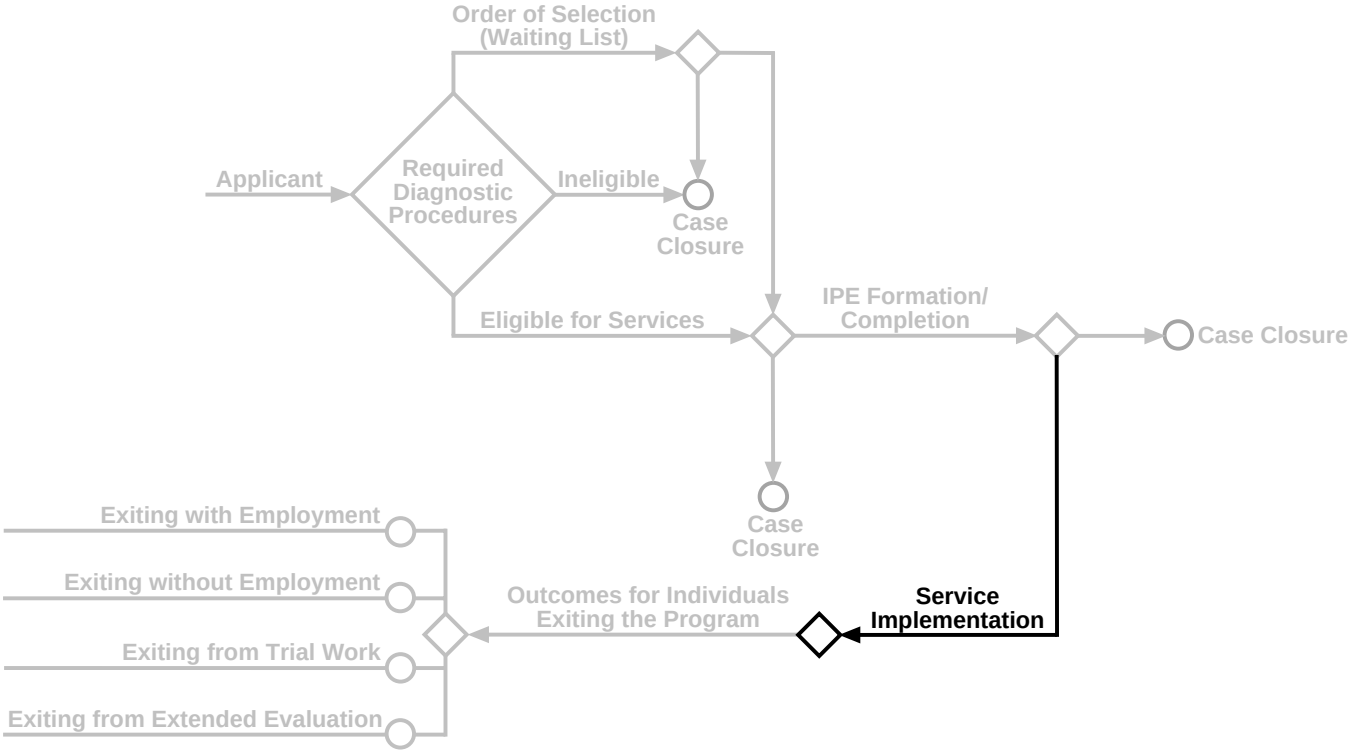

FIGURE 6.4 Components of the Service-Decision Model: Applied to Zone III

TABLE 6.7
Caseload Items: Service Implementation

C. Service Implementation
1. Individuals Receiving Services, on Hand October 1
2. Individuals Receiving Services, Beginning This FY
3. Individuals Receiving Services, at End of Period (C1+C2-D1-D2)

Source: Form RSA-113

state is under Order of Selection provisions, the IPE is developed only for individuals in an open priority category (see Table 6.7).

C1. *Individuals Receiving Services, on Hand October 1*: This caseload item represents the number of persons who were receiving VR services in accordance with their IPE at the end of the last fiscal year. This number will also reflect those in this category whose disabilities are significant.

C2. *Individuals Receiving Services, Beginning This FY*: This caseload item represents the number of persons who started receiving services in accordance with their IPE since the beginning of the fiscal year. This number will also reflect those in this category whose disabilities are significant.

C3. *Individuals Receiving Services at End of Period*: This caseload item represents the total number of individuals remaining at the end of the period who are receiving VR services according to their IPE. This number will also reflect those in this category whose disabilities are significant. This is a data verification item and may be represented by the computation (C1+C2-D1-D2).

Zone IV D. Outcomes for Individuals Exiting the Program

The final zone (Zone IV) places emphasis on the Outcomes for Individuals Exiting the Program (see Figure 6.5). This zone serves the system as outlets from the rehabilitation process identifying the termination activity within the statistical system. Once a case has been declared eligible it must leave the system, depending on the status classification at the determination of the necessity for closure. Clients must be observed in employment for a minimum of 60 days prior to closing the case rehabilitated ("26") to ensure adequacy of employment in accordance with the needs and limitations of the individual. The initiating action is any information, verbal or written, declaring that the client has actually begun employment.

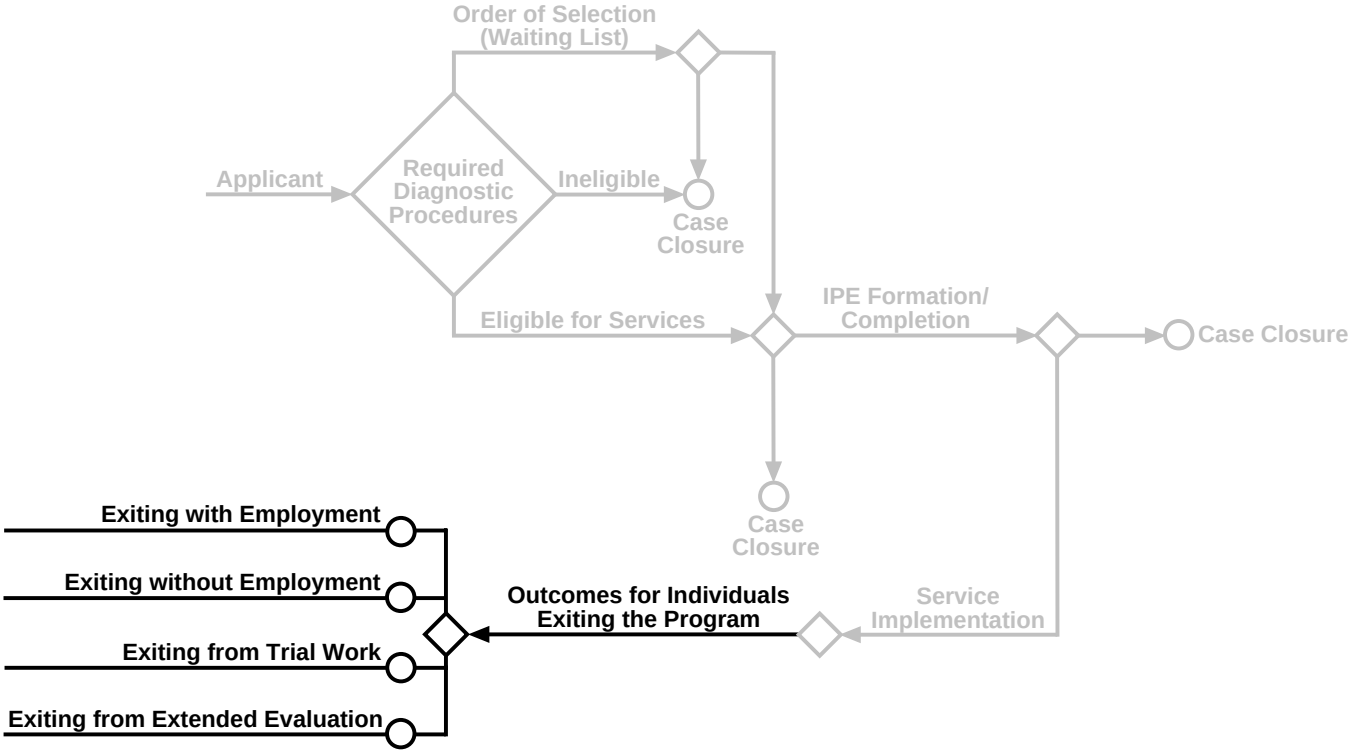

FIGURE 6.5 Components of the Service-Decision Model: Applied to Zone IV

Outcomes for Individuals Exiting the Program have been provided to furnish a means for identifying all persons considered (1) rehabilitated with employment outcomes, (2) all persons processed through referral, applicant, or extended evaluation and not accepted into the active caseload for vocational rehabilitation services, (3) individuals in this category who have been declared eligible, received appropriate diagnostic and related services, and had a program for vocational rehabilitation services formulated, but have not completed the program or have not been provided counseling, or have not been determined to be suitably employed for a minimum of 60 days, (4) persons for whom a program of vocational rehabilitation services was initiated but for some reason(s) lacked completion, and (5) although accepted for rehabilitation services, these individuals did not progress to the point that services were actually initiated under a rehabilitation plan. If the state is under Order of Selection provisions, the counselor is to refer those clients placed in a closed priority category to other federal and state programs for assistance in preparing or entering employment; these cases may not be closed without this referral (see Table 6.8). The definitions used to describe rehabilitation outcomes are found in Section 1549.00 of the *Rehabilitation Services Manual* (Federal Register 40, 2001c).

D1. *Individuals Exiting with Employment Outcomes*: This caseload item represents the number of persons who achieved employment outcomes since the beginning of the fiscal year. This number will also reflect those in this category whose disabilities are significant.

D2. *Individuals Exiting without Employment, after Receiving Services*: This caseload item represents the number of persons whose service records were closed this fiscal year after an IPE was developed and

TABLE 6.8
Caseload Items: Outcomes for Individuals Exiting the Program

D. Outcomes For Individuals Exiting The Program
1. Individuals Exiting with Employment Outcomes
2. Individuals Exiting without Employment, After Receiving Services
3. Individuals Exiting without Employment, After Eligibility, Before Signed IPE
4. Individuals Exiting without Employment, After Signed IPE, Before Receiving Services
5. Individuals Exiting from OOS Waiting List
6. Individuals Exiting from Trial Work/EE
7. Individual Exiting as Applicants
8. Total Number of Individuals Exiting the Program (D1+D2+D3+D4+D5+D6+D7)

Source: Form RSA-113

VR services were initiated, but before achieving an employment outcome. This number will also reflect those in this category whose disabilities are significant.

D3. *Individuals Exiting without Employment, after Eligibility, before Signed IPE*: This caseload item describes the number of eligible individuals, not an order of selection waiting list, who did not complete developing and signing an IPE, and whose service records were closed before VR services were initiated. This number will also reflect those in this category whose disabilities are significant.

D4. *Individuals Exiting without Employment, after IPE, before Receiving Services*: This caseload item represents the number of individuals whose records were closed after they developed and signed an IPE, but before services were initiated. This number will also reflect those in this category whose disabilities are significant.

D5. *Individuals Exiting from OOS Waiting List*: This caseload item represents the number of eligible persons whose service records were closed without services, from the order of selection waiting list, since the beginning of the fiscal year. This number will also reflect those in this category whose disabilities are significant.

D6. *Individuals Exiting from Trial Work/EE*: This caseload item represents the number of persons in Trial Work Experiences and/or Extended Evaluation whose service records were closed without a determination of eligibility for any reason since the beginning of this fiscal year. This number will also reflect those in this category whose disabilities are significant.

D7. *Individuals Exiting as Applicants*: This caseload item represents the number of applicants whose service records were closed before a determination of eligibility was made since the beginning of the fiscal year. This number will also reflect those in this category whose disabilities are significant.

D8. *Total Number of Individuals Exiting the Program*: This caseload item represents the total number of individuals exiting the VR program during this fiscal year, and whose service records were closed. This is a data verification item and may be represented by the computation (D1+D2+D3+D4+D5+D6+D7).

CONCLUSIONS

It should be remembered that the case classification system is used primarily for reporting statistical information to the appropriate state and federal

offices involved in monitoring and auditing functions. However, it is also a process management system to be used by the counselor.

Effective rehabilitation caseload management is dependent upon the counselor's dynamic understanding of the rehabilitation case classification system. The counselor must understand clearly when to use a particular status in order to reflect an accurate and meaningful statistical picture of the caseload. Therefore, when the counselor is in command of the mechanics of the rehabilitation case management process, proficiency is demonstrated and the delay in service delivery is reduced.

Probably the best criterion by which a counselor's effectiveness is measured is casework continuity. Computer printouts can reflect where cases are identified in the process and how long each has been in a particular classification, but only the counselor can decide when a case is to be changed or moved within the system. Thus, case management is the counselor's job, and the counselor can be effective only if she or he fully understands and practices the tools of management.

SUMMARY

This chapter has presented the mechanical dimensions, or tools, of a basic framework necessary for effective caseload management in the vocational rehabilitation agency. It is important for the counselor to understand the function of each tool necessary to perform the job. Suppose, for example, that a carpenter tried to saw a board with a hammer. Then, suppose a counselor manager tried to serve a rehabilitation caseload without a systematic approach or structure. Now, would you want such a carpenter to build your house, or such a rehabilitation counselor to help you structure your life?

The case classification system used in vocational rehabilitation programs was presented in this chapter. The system was divided into four categorical zones for explanatory purposes. These identifications are (I) Applications and Eligibility, (II) Signed Individualized Plan for Employment (IPE) and Awaiting Services, (III) Service Implementation, and (IV) Outcomes for Individuals Exiting the Program. Counselor actions and considerations were presented for each specified zone. These considerations offered a means for giving boundaries to these areas. As boundary elements, they are not the totality of considerations causing the counselor managerial concerns. The counselor can establish other germane elements through knowledge and understanding of the variables that must be controlled and managed.

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CHAPTER 7

Case Recording and Documentation in Rehabilitation

CASE RECORDS: A PERSPECTIVE

Although the terms *case recording* and *case documentation* are frequently used interchangeably by personnel in the field of rehabilitation, they are distinctively different functions with different meanings, even when they merge at the counselor's operative level in the process of case folder development (Cassell & Mulkey, 1985). Case recording is best described as individual counselor contributions to case folder development. Such contributions may reflect factual information (like the client's work history) or subjective information (like the client's reaction to working) regarding the client–counselor interaction. Case documentation, on the other hand, is best understood as case folder contributions from the totality of resources that affect the client's rehabilitation efforts (Austin & McClelland, 1996; Woodside & McClam, 2003). Records from the Workers' Compensation Board, medical reports, academic records, and other pertinent information acquired by the counselor represent *documentation* efforts. Completed case recording by the counselor becomes documentation material once it is admitted to the case folder and made a part of the official record of the client.

The professional rehabilitation practitioner is encumbered with enormous responsibilities. Therefore, it becomes vitally important that counselors be able not only to facilitate the rehabilitation process, but to document it as well. Unless the counselor has these skills, much of the high-quality work that goes on remains hidden from the profession and the legislative community that assesses the accountability factor inherent in the field of vocational rehabilitation. All too often counselors, supervisors, and agencies are criticized for the seeming lack of rehabilitation involvement (particularly counseling involvement) between clients and counselors. Such criticism is

not usually a reaction to apparent poor counseling techniques, but rather to poorly developed case records or lack of documentation provided by the caseload manager.

An excellent and basic way for supervisory personnel to determine the quality of a counselor's work is to read the case folder. Such a review generally provides the most accurate record of a counselor's level of service delivery to clients. Because much of the counselor's work is done behind closed doors in a one-to-one relationship with the client, case-record development is the only way to show the rehabilitation process and to tell the "rehabilitation story" of individual clients. Satisfactory case folder development, then, requires the counselor to function with skill in both case recording and case documentation.

This chapter considers methods and procedures designed to develop or enhance skills in case recording and documentation that can mean the difference between mediocrity and excellence as a caseload manager. There is no attempt to standardize case recording practices, but, rather, to present a structural framework by which the caseload manager can objectify the practice of effective case development. Individual practices among the various state agencies or companies in case folder requirements precludes standardization.

RATIONALE FOR CASE RECORDING

Adequate and accurate case recording is one of the most significant aspects of the role and function of a rehabilitation practitioner (Cassell & Mulkey, 1985). Case recording is a dynamic aid to effective service delivery by its provision of a visible description of case progression and direction. Specifically, in private-sector rehabilitation, documented case folders are scrutinized by many parties with varied interests in the rehabilitation outcome or negotiated settlement. For example, typical parties participating in medical or postmedical rehabilitation include the injured claimant, an insurance carrier representative, the rehabilitation company representative, attorney(s) representing the client, attorney(s) representing the insurance carrier, an individual from a state or federal agency, and the rehabilitation specialist (Conte & Parker, 1983; Matkin, 1983b; Mullahy, 2004; Shrey & Lacerte, 1995). Rehabilitation perspectives may differ on effective rehabilitation and planning within a given client situation. Both case recording *and* documentation assist with communication among the involved participants in regard to case movement.

The primary purpose of case recording and documentation is to bring together *all* pertinent data that facilitate the relationship of *all* persons associated with the efforts toward rehabilitation (Young, 2001). Adequate and

accurate information is essential to the provision of quality rehabilitation services. Thus, case recording aids all parties directly involved in the rehabilitation process: the client, the counselor, and the agency or company.

The Client

A prime rationale for case recording is to facilitate the client–counselor relationship by converging pertinent data about the client at strategic points so as to effect the rehabilitation process. There is general agreement (Cassell & Mulkey, 1985; Cassell, Mulkey, & Engen, 1997; McGowan & Porter, 1967; Thomason & Barrett, 1959) that the most important objective of case recording in public rehabilitation is to aid in providing better services to the client. In 1992, Public Law 102–56, commonly referred to as the Rehabilitation Act of 1973 as Amended, continued to place legal emphasis upon greater client involvement in the rehabilitation process, especially in the development of the IPE, and underscored the centrality of informed choice within rehabilitation outcomes. It is during this participative case recording process that clients' interests, attitudes, and aptitudes become evident, and serve as formal documentation on which decisions can be made regarding rehabilitation direction. In other words, case recording provides the information necessary for establishing a professional relationship with the client. Services should be noted and justified in accordance with the client's progress toward the rehabilitation goal.

The Counselor

The continuity provided by appropriate case recording enables the counselor to better understand the client and contributes to sound reasoning practices in the management of a rehabilitation case. The case record, particularly the last counselor contact entry, provides a reference point for making decisions about initial programs or additional services necessary to predict rehabilitation direction and/or outcomes. As the counselor reviews recorded information about past interactions with the client, it frequently becomes easier to anticipate future problems and begin to focus on solutions. Noted in case recording will be information on the client's participation in rehabilitation efforts, as well as interests and motivations toward the ultimate rehabilitation goal.

Adequate case recording should reflect the counselor's success as a problem solver by detailing counseling activities related to the proposed solution (Frankel & Gelman, 1998). All written material should be relevant to the counselor's complete understanding of the case situation. Certainly important to this effort is the counselor's consideration of the meanings drawn from the

experiences of the client and their relationship as they relate to a program of rehabilitation services. Then, as other diagnostic data are deemed appropriate to the specific needs of the client, the counselor is provided with validation for planned service programs. Thus, documentation of the logical sequence of decisions pertinent to the informed choice of the individual client is preserved. Also, because counselors are not immune to legal action pursuant to case decisions, the documentation of concrete evidence that contributed to counselor decisions and activities affords a record in the event the actions of the counselor are challenged.

Appropriate case recording and periodic case review provide the counselor a means of evaluating personal effectiveness and enhancing professionalism. The record is indispensable as a tool for evaluating the quality of individual skills associated with rehabilitation services. The progress made toward the cultivation of counselor skills certainly would seem contingent upon the study and review of past performance through quality assurance, case records, and documents.

The Agency or Company

Case recording and folder documentation are essential to effective supervision and administration. They provide a means for the agency or company to improve and maintain the quality of operations while testing the effectiveness of its services. Case records contain an enormous amount of information that can be used in an individual supervisory context or expanded to the development of group training programs. Considerable teaching material and/or research data can be derived from review of the case folders. Administratively, case recording and documentation establish whether services are being provided in accordance with legislation, regulations, or policies specific to the program, thus forming the basis of a monitoring tool. In other words, the expenditure of public or private funds must be justified through case documentation that establishes the basis for the provision of further client services, identifies the cost and kinds of services provided, and reflects a measurement of the outcome related to client benefits. Adequate and accurate case records are essential to effective agency administration.

STYLES OF CASE RECORDING

Every state rehabilitation agency has the primary responsibility for developing basic standards for case recording within the program. These basic standards become policy and will dictate the style of case recording used by individual

rehabilitation counselors. To ensure conformity in case development, the agency's standards are usually contained in a casework manual issued to each caseload manager or are maintained at an office location. Generally, agencies attempt to facilitate case recording by use of basic case-study forms or outlines that can be tailored individually for each client. Sometimes these forms are related to a general need to assist counselors in the identification of significant and insignificant information within a specific case study. More likely, the forms contribute to principles of good management.

The agency's standards for case recording should be under constant review and subject to revision to preclude continued use of antiquated forms or outlines that no longer facilitate service delivery. Any duplication should be eliminated from the current standards. The process used for case development should be functional and never allowed to become an encumbrance to the service delivery system.

Appropriate case recording reflects accomplishments of the individual client at each step of the rehabilitation process. The counselor needs to be able to elaborate with precise detail some components of the process (i.e., diagnostic interpretations or service program justification) whereas other components may require nothing more than simple demographic entries (i.e., gender or age) for identification. However, this range of flexibility requires constant effort by counselors to improve their skills in case recording. Five common styles of recording were reported by the First Institute on Rehabilitation Services Committee on Case Recording (Macdonald, 1963) as appropriate for use in rehabilitation programs. These styles are (1) Recording on Established Forms, (2) Summary Recording, (3) Process or Verbatim Recording, (4) Research Recording, and (5) Narrative Recording. These styles will be addressed briefly.

Recording on Established Forms

Obviously, included in this category is the face sheet, including a social history and work history. Forms are useful when minimal amounts and types of information must be gathered uniformly in all cases. For uniform reporting and data processing, established or prescribed forms are essential.

Summary Recording

Summary recording is a condensed account of transactions between client, rehabilitation practitioner, agency, or company. This may be a summary of what occurred in a given interview or over several interviews, with particular nota-

tions as to the important characteristics of the client or of the events that transpired during the interview(s). This form of recording may also be a periodic review of progress toward an objective agreed upon by the client, rehabilitation professional, and agency or company. Summary accounts, then, describe any movement or retrogression regarding the vocational or rehabilitation objective during the time period the summary covers. Summary recording works best when a clear-cut objective is spelled out early in the case record.

Process or Verbatim Recording

Process recording refers to a highly detailed record that covers the actions, emotions, and events that transpire in the interview situation. Verbatim recording is the complete record or word-by-word transcription of the interview. These types of records are primarily useful for psychological evaluation, content analysis or thematic analysis, and training purposes to demonstrate methods and techniques in interviewing and counseling. For example, legal transcripts become part of case development activities for specialists in the private sector.

The process record is familiar to any practitioner who has ever attempted to describe and analyze the feeling tones, attitudes, and behavior of the counselor and the client in an interview. Obviously, such recording is helpful when the focus is on the counseling process. Whenever the counselor has some question as to what is occurring in the process, or consultation is desired regarding the counselor's interviewing methods and techniques, process recording can be a useful device.

Recording for Research Purposes

The use of research schedules is analogous to the use of forms. When the data to be gathered are known and the format for gathering is decided in advance, either a structured or semistructured recording format is appropriate. Parenthetically, it should be noted that the study committee from the Third Institute on Rehabilitation Services (Muthard, 1965) did not consider the case record as it is ordinarily recorded for the purposes of research. Almost all studies on closed case records or studies using information recorded for counseling, rather than for research purposes, indicate that the records are inadequate for the purpose of research. The committee restated its position that the case record cannot satisfy all purposes for all people. It may be a useful device for evaluating the effectiveness of services but only if it is decided beforehand what the format of the record should be and if the case record is then uniformly recorded using such a format.

Narrative Recording

The narrative form of recording is considered the standard form. Usually, the narrative *tells a story* about the client, the counselor, and the agency. Therefore, it should include factual data about the background of the client's problem, what the client has done about the problem, and what has motivated the client to seek additional help at this time. The narrative should also describe the client's total situation, giving a clear picture of the effect of relationships with significant people, such as family, community or work associates, friends, and authority figures, as well as the relationship with the counselor and agency. The narrative form may lend itself to brief shorthand descriptions or to a more lengthy diary-like recording or even to a style approaching the novel. Recording may be either descriptive or analytic, or both. It may be either static or dynamic or contain aspects of both. What is needed is a dynamic picture of what has happened, and what is happening, to the client in important relationships as the client strives to attain new objectives in cooperation with the counselor and the agency. Therefore, the record must be considered an account of the process.

Clearly, the style of case recording used is determined primarily by the purpose for which records are maintained. The counselor may combine aspects of different styles of case recording as necessary to enhance case file development.

BASIC ELEMENTS OF CASE RECORDING

The recorded information about an applicant or client should be accurate and reliable. It should be concise and consistent with the counselor's professional understanding of the client's behavior and any conditions or circumstances associated with the client's current situation. Any significant information about previous experience or behavior of the client should be considered by the caseload manager for admission into the case record (Holt, 2000). Observations or generalizations about a client should be explained adequately and labeled as such when included in case recording. Likewise, conflicting or contradictory reports should be reconciled or explained to remove any confusion about the information or its accuracy. Thus, one can assume that counselors are successful at case recording because of hard work, a professional attitude, and decision-making ability. Case recording is not an easy process; it demands that the counselor be personally and professionally secure, and willing to risk documentation of judgments.

However difficult case recording may be for practitioners, it is crucial to the rehabilitation process. The objectives of the client, counselor, and agency must be appropriately defined, pursued, and evaluated for inclusion as entries to the client file. This process is logical and dynamic in presentation of the basis for service eligibility and program development. When the counselor has integrated a style or technique for case recording that includes a logical organization of germane data, what formerly seemed difficult becomes much easier. Beyond expected improvement in the quality of recorded information, less time will be spent as the counselor will not linger over insignificant aspects of the client situation.

A Systematic Approach

The counselor should adopt a systematic approach to case recording tasks. He or she must be aware of certain basic case recording rules or techniques in order to document the individualized needs of clients. Otherwise, the recording process becomes a mere mechanical activity rather than the selection of meaningful data. Some clients present relatively minor problems that require only routine services whereas others have significant disabilities that require extensive evaluation, and treatment may be necessary to specify rehabilitation direction. Thus, there can be no specific rules regarding the amount of information that should be included in the case record. The information recorded by the counselor in each case file should, at minimum, be adequate to support a clear understanding of the client's total situation.

Figure 7.1. illustrates a conception of quality case recording in a rehabilitation program. For clarity, each step is discussed below.

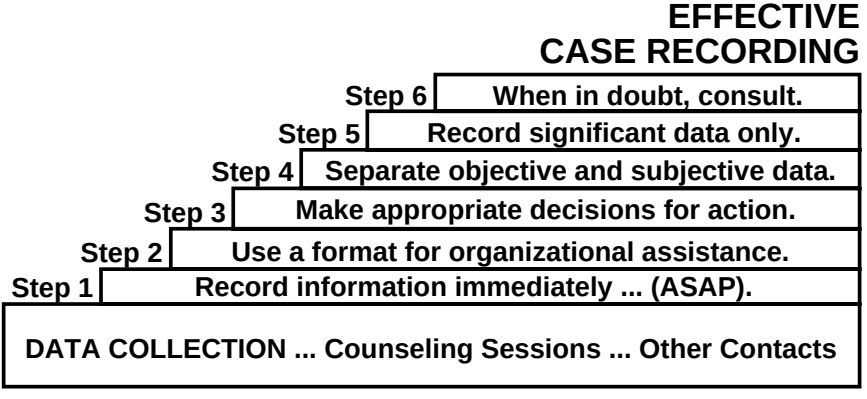

FIGURE 7.1 Schematic for Effective Case Recording

Step 1. Record Information Immediately . . . (ASAP)

One of the simplest yet often most difficult to initiate actions toward improving case recording is to record case data as soon as possible following a client interview or the acquisition of information regarding a client. The best method is to record immediately, while the information and experience are fresh in the mind of the counselor. The counselor may even gain insight into the client situation from clues that become evident during the recording process. Delay increases the tendency for further delay as the paperwork demands begin to pile up. Even worse, the tendency to defer may become the road to flagrant procrastination. Thus, Step 1 is guided by a concept of controlled immediacy.

Step 2. Use a Format for Organizational Assistance

The use of a recording format or guide will assist in organizing data and the counselor's thinking. Once proficiency is gained, the caseload manager will require considerably less time for recording. Step 2 is guided by an objectivity to make immediately visible the intangibles that transpired during the interview or counseling session with the client. The next section of this chapter will present formats designed to facilitate case recording at various points throughout the rehabilitation process.

Step 3. Make Appropriate Decisions for Action

The counselor frequently defers action when faced with a difficult decision. Often the reason for the delay is never documented in spite of the counselor's best intentions to do so at a later date. Not only does this contribute to a breakdown in the flow of case documentation, it also breaches the rehabilitation process and service delivery. The counselor must accept responsibility for making decisions that eventually facilitate case closure. The decisions of the caseload manager must be *accurately recorded* and *adequately documented.* Every entry or lack of an entry represents a decision. This step needs to be motivated by a commitment to action. The tendency to put off case recording, or to say, "I'll do it later," must be replaced by "Do it now."

Step 4. Separate Objective and Subjective Data

The counselor must learn to distinguish between objective and subjective data. As was illustrated in chapter 3, much of the information counselors deal with arises from inferences. Thus, decisions have various levels of risk built into them, depending on their position on a subjective-objective continuum.

Whenever objective facts, client perceptions, and counselor impressions are thrown together without proper labeling, a distorted view of the situation results. Later actions based on this distorted mixture are likewise distorted, indecisive, and characterized by excessive trial-and-error cycles rather than by accurate goal setting and decision making. Any use of highly subjective data should be appropriately identified according to source and the particular meaning of the information to the client or the counselor.

Step 5. Record Significant Data Only

The most important yet most difficult-to-accomplish measure of effective case recording is to record significant data only. Some counselors record too little data, whereas others record too much. Quality and quantity are not equal when it comes to case recording. Unless agencies have adequate guidelines to assist counselors with this dilemma, the decision remains with the individual caseload manager. However, even guidelines may lack the specificity necessary for appropriate case recording. The counselor's professional judgment, then, is necessary for selection of pertinent data to be recorded. If certain information is unimportant to the development of the case, it should *not* be recorded. However, the case file *must* provide a complete understanding of the client and the situations relevant to rehabilitation efforts. The prerequisite ability for taking this step is crucial because it is nothing less than the ability to conceptualize. Counselors must be able to visualize and understand the major variables involved in the system they manage. They must be able to categorize, summarize, and condense groups of action patterns and group thoughts into succinct labels or words that can give future guidance or clarify past activities.

Step 6. When in Doubt, Consult

This last step is a means for the counselor to overcome procrastination habits and begin to grow in maturity in the case recording process. Consultations with other counselors or supervisors who have superior case recording skills and case review personnel who judge the adequacy of case recording are a means of establishing one's own professional practices. Counselors often need good models from whom to learn; peers or supervisors may offer such models. Among other responsibilities, the rehabilitation supervisor is a consultant to the counselor. The supervisor's experience and expertise can provide guidance on decisions and techniques to facilitate case development. The counselor should not hesitate to consult on any aspect of case recording with the unit supervisor or a competent counselor and use this consultation as a growth experience.

USE OF FORMATS

A format provides a general design for organizing case recording activities along definite dimensions. It offers a framework to *guide* the counselor's case recording and provides continuity to the recorded entries that contribute to the flow of case development. A format is somewhat related to established forms except that the format allows a greater latitude for counselor freedom and creativity. It must be understood, however, that a format, as the term is used here, is a conceptualization process. That is, the idea that a format is basic to case recording is the conceptual base, and the specific concrete formats developed become the techniques or methods stemming from that base (Cassell & Mulkey, 1985; Frankel & Gelman, 1998; Moxley, 1997). A format assists the counselor at various stages of the rehabilitation process. Then it is the counselor's responsibility to select the appropriate style of case recording that will depict the client's movement from one stage of the rehabilitation process to another.

The formats presented here relate to the content areas of case development; they in no way attempt to standardize case recording nor are they forms to be filled out mechanically. It is important to remember that the format is only a *guide* to help the counselor select the kinds of data that are pertinent to a particular case.

Therefore, it is essential to consider six critical components of the rehabilitation process that are frequently susceptible to inadequate case recording (see Figure 7.2): (1) Initial Interview, (2) Routine Contacts, (3) Diagnostic Study, (4) Eligibility, (5) Service(s), and (6) Case Closure. Each component is clarified

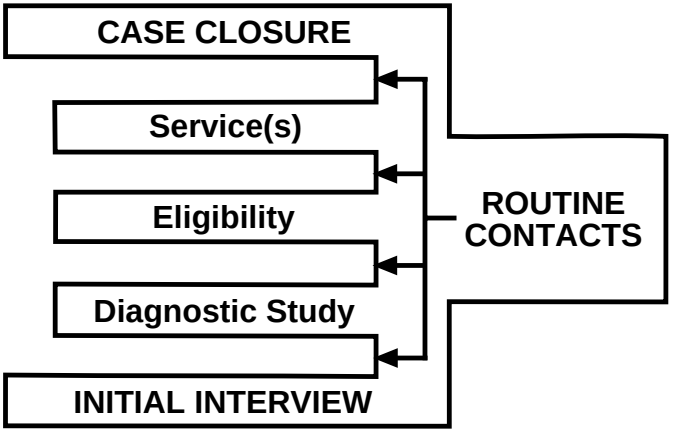

FIGURE 7.2 Critical Areas of Case Recording

in a brief discussion prior to introduction of a specific format. The formats themselves are designed to call attention to the significant elements that lead to a concise understanding of a rehabilitation case. Although the authors reviewed numerous case recording guides, the subsequent formats are adaptations of standards prepared by the Oklahoma Division of Vocational Rehabilitation and its counterpart in Tennessee (Cassell & Mulkey, 1985).

Initial Interview

The initial interview between the counselor and the referral has immense importance because it is the information acquired at this stage that provides the point of departure on the road toward successful rehabilitation. In addition to the information likely obtained from standardized or established agency forms, the interview will offer other data that should be made objective in the recording process. The complexity of the information flowing in this initial interview and lack of any prior knowledge base on the referral make this situation extremely rich in data. However, without adequate recording much of the data critical to case direction can be lost. This information forms the base, and the caseload manager must continually be aware of emerging content that supports or refutes a preliminary understanding of the referral's condition and situation.

Format A

To record appropriate information here the counselor should

1. Give identification of referral, counselor, and date.
2. Tell why referral came to the agency.
3. Describe counselor's preliminary perception of referral.
4. Discuss referral's capacities, functional limitations, and problems.
5. Identify referral's verbalized vocational interest.
6. Explore referral's work experience.
7. Clarify referral's understanding of the rehabilitation program.
8. Discuss referral's current circumstances, including family situation.
9. Consider referral's personality characteristics.
10. Discuss educational level or vocational training of referral.
11. Discuss significance of referral's social or leisure activities.
12. Justify opening a case (if appropriate).
13. Identify source and amount of any financial assistance.
14. List type(s) of evaluations necessary to determine individual's functional capacities and limitations.
15. State next step(s) of action.

There may be other information with particular significance to the referral. If so, it should be appropriately recorded, identifying the proper meaning to the counselor or the referral. This format, however, attempts to focus on significant information elements that emerge in the initial interview.

Routine Contacts

It is appropriate to discuss routine case recording at this time because the counselor periodically records data relative to the referral-applicant-client. Numerous progress reports may be generated during the life of a case file to document movement toward the rehabilitation goal. As Figure 7.2 depicts, routine case recording contacts permeates documentation from the time a case file is opened until it is closed. Generally, the purpose of routine contact reports is to facilitate the counseling relationship through concentration on germane data about the individual. Certainly, routine recordings assist the counselor to systematically monitor service provision.

Format B

The routine contact is basically a counselor tool and here the counselor should

1. identify referral-applicant-client, counselor, and date,
2. identify person(s), agency, company, or institution contacted,
3. explain reason(s) for the contact,
4. discuss what was accomplished,
5. state or explore the next action step(s).

As with all recorded entries, the counselor should avoid procrastination or undue delay in recording the acquired information. Otherwise, the full impact and meaning of the data will likely escape documentation.

Diagnostic Study

The diagnostic study is basically concerned with the initial steps in determining eligibility for public rehabilitation services. It is imperative that the caseload manager act as expeditiously as possible to secure medical, psychological, and other necessary evaluative data pertinent to a complete understanding of the applicant. Economic considerations may compel the rehabilitation professional to develop skills in making decisions relating to the type and amount of diagnostic data required. Thus, the competent professional will secure an

adequate amount of data relative to the various areas of investigation, *but* only when it is valuable.

It is important to remember that the accumulated data are eventually used by the public caseload manager to determine eligibility or ineligibility. Specifically, these data are used to determine whether the applicant meets the established criteria for services or whether further evaluation will be needed. Obviously, when the applicant is not eligible, the case is closed.

Format C

The counselor must secure specific diagnostic information relative to each applicant. However, case recording should reflect information relative to

1. applicant, counselor, and date identification,
2. medical examination(s) scheduled,
3. psychological evaluation(s) arranged.
4. any facility or workshop evaluations required.

Once the necessary data are acquired, the counselor must carefully consider the information to gain a total understanding of the applicant's disability, impediments to employment, and any problems preventing satisfactory work adjustment. The results of such an analysis must be recorded appropriately in the case file, showing the counselor's reasoning for his or her decisions.

Eligibility

At this juncture, the public caseload manager is concerned primarily with the eligibility decision. If the diagnostic study data clearly identify the existence of disability and impediment to employment then the counselor must decide whether additional evaluative services are necessary to ascertain that the person *can* benefit from services.

Because the goals of extended evaluation/trial work and vocational rehabilitation services differ, the recorded information will also diff. The following formats are suggestive of eligibility determination information that the counselor should explore.

Format D

When the counselor decides on a program for extended evaluation, the case recording should relate to a certification process identifying

1. applicant, counselor, and date,
2. diagnosis of the applicant's condition(s),
3. reason(s) for further evaluation of the applicant,
4. reason(s) applicant may benefit from services,
5. mandatory termination date of extended evaluation.
6. whether applicant has significant disability or does not have significant disability,
7. way(s) the proposed evaluation will assist the counselor.

The primary purpose of providing extended evaluation/trial work services is to assess the effect of specific services on the applicant to determine whether the individual can and/or will benefit from rehabilitation services in terms of employability.

Format E

Most often the diagnostic study data provide the counselor with sufficient information to determine that the applicant is eligible for some agency services. Also, at the conclusion of extended evaluation/trial work programs, the applicant *may* be determined eligible for rehabilitation services. For this eligibility narrative the counselor should

1. identify the client, counselor, and date,
2. identify the client's primary, and any secondary, disability,
3. explain the functional limitation(s) imposed by each disability,
4. describe the client's impediments to employment,
5. explore the client's motivation toward employment.
6. tell how the client can benefit from agency services,
7. state whether the client has a significant disability,
8. discuss tentative problem solution strategies,
9. indicate the next appropriate step toward rehabilitation.

The counselor must document the complete exploration of the client's disability, impediment to employment, and prognosis for a successful rehabilitation outcome. Case recording should begin to focus on the client's progress toward a suitable work adjustment.

Services

Once the client is declared eligible for services, the counselor should proceed expeditiously to put the existing tentative program of action into final

form. It is important that services be initiated as soon as possible after certification of eligibility in order to maximize the client's potential for successful rehabilitation. The counselor has a dual role of assisting the client to select appropriate services through informed choice and documenting the collaborative efforts of everyone associated with the client's rehabilitation program.

Three primary dimensions of the service component require counselor attention for effective case recording. These relate to *planning, provision,* and *completion* of the required rehabilitation services. Specific information is admitted to the case file showing any exploration or analysis relevant to the dimension being considered. In some agencies, the specified data are recorded in conjunction with a particular classification change, whereas in other agencies, it may simply be allowed to merge into routine case recording. Whichever way it is done, certain information must be systematically stored in the case file. The following three formats provide assistance in selection of data associated with each dimension that merits recording consideration.

Format F

The counselor and client must share responsibility (informed choice) for the planning and development of the program of rehabilitation services. However, it is the counselor who is responsible for accurate *documentation* of the *planning* process. For recording purposes, here the counselor should

1. identify client, counselor, and date,
2. review the client's vocational interests,
3. discuss available employment in the area of stated interests,
4. describe client's abilities or potential abilities in interest areas,
5. explain why the vocational objective was selected,
6. show the client's participation in the planning process,
7. identify necessary services,
8. identify and justify selection of vendor(s) of service(s),
9. justify expenditures to be authorized,
10. make a statement relative to program prognosis.

Through case recording, the caseload manager shows the development of decisions that culminate in a specific program of rehabilitation services. This documentation becomes the support system for monitoring the provision of the defined services.

Format G

Any case recording related to the *provision* of rehabilitation services may be identified as routine recording (i.e., Format 7-B). However, Format 7-B may not provide sufficient information to the counselor on the supervision of client services. The following format offers more specificity in documentation of service delivery. Here the counselor should

1. identify client, counselor, and date,
2. verify vendor performance in provision of authorized service(s),
3. describe client progress in program of service(s),
4. indicate counselor performance in facilitating the program,
5. recommend any modification of the service program.

The periodic review of service programs provides a continuity of energy directed to the potential success of the rehabilitation program. This periodic review process keeps the counselor continuously in touch with case flow. It further provides a base of information for counselor use in resolution of any problems that may threaten successful outcome of the program.

Format H

Once the program has reached *completion,* it is necessary for the counselor to evaluate its effect on the client in order to evaluate the effectiveness of the services provided. For case recording here the counselor should

1. identify the client, counselor, and date,
2. summarize the services provided,
3. indicate how the services contributed to the client's vocational objective,
4. state specific action plans for job placement and employment,
5. describe the client's feelings about rehabilitation efforts.

The caseload manager must not allow case flow to stall at this point. The client is ready to go to work (or already employed) and appropriate efforts must be applied to the job placement/employment function of the process.

Case Closure

The basic classification system public rehabilitation agencies use will acknowledge only four types of closure action: (1) exiting with employment, (2) exiting without employment, (3) exiting from trial work, and (4) exiting from

extended evaluations. Each classification identifies cases removed from the system following the application of certain procedural components of the total process. Thus, the specificity of the information necessarily recorded is largely a function of the type of closure action to be completed. However, bcause the goal for the client is successful rehabilitation, consideration here will only be given to the "26" type of closure. This does not imply that the recorded information necessary for the other closure types is unimportant, but, rather, that it is simply not the present focus.

The counselor's case recording entry that substantiates closure of the successful rehabilitation case should focus on the contributions of the various services to the total adjustment of the rehabilitated client. Job and wage considerations are important, of course, but so is a comprehensive analysis of the way the client has changed since the problem situation was first brought to the counselor's attention. Any information gathered should be integrated accurately into the counselor's case recording process.

Format I

For most cases, the recorded closure entry is the last counselor contribution to case file documentation. The content of this recording should

1. identify the client, counselor, and date,
2. specifically describe the employment situation.
3. discuss the appropriateness of the client's job,
4. explore impressions of the client's total adjustment,
5. state why the case is being closed.

The case closure entry to the case file provides an excellent opportunity for counselor self-evaluation. The willingness to review and critique one's performance is an important step toward improvement of the skills necessary for effective rehabilitation counseling.

The counselor's case recording, then, becomes file documentation and a part of the client's permanent record. The significance of this responsibility alone should cause the counselor to seek improvement of case recording techniques.

CASE FILE DOCUMENTATION

The caseload manager has a dual responsibility relative to case file documentation. First, the manager must be concerned with the previously discussed counselor entries. Second, she or he must be concerned with the totality of significant

information from community resources that provide insight into the client and the direction of rehabilitation efforts. *It is imperative that appropriate documentation precede any significant case action.* For example, prior to implementation of a training program with a client, the caseload manager must collect supportive data to document the particular client's interests and capabilities. In other words, there must be a logical expectation of successful accomplishment of goals, and the *rationale* for this expectancy must be supported fully by case file documents.

A useful definition of case development is provided by Hagner and DiLeo (1993) showing that this process allows for movement through a program continuum, or assessing employability, readiness or any other preparatory concept, assists each individual with a disability to achieve a satisfying career. Although this definition refers to a special kind of process with specified goals, the degree of variance among clients and the variability of "suitable employment" require managerial skills from the person responsible for *directing, expediting,* and *managing* the case development process. Therefore, it is the caseload manager functions of the professional counselor that come into focus as file documentation is explored and accepted.

Case development may be referred to as an individualized, client-oriented process, and so it is appropriate to envision a systematic managerial approach to acquiring necessary data while protecting the individuality of the applicant or client. Figure 7.3 provides a framework for considering the six areas that may influence individuals in their rehabilitation efforts: (1) Medical, (2) Psychological, (3) Social, (4) Vocational, (5) Educational, and (6) Situational. Usually, the caseload manager will acquire relevant data in all six areas for inclusion in the case file as documentation pertinent to rehabilitation direction. However, the amount of information available in each area will likely vary in accordance with the individuality of the applicant or client. The following discussion will explore each of the areas identified in Figure 7.3.

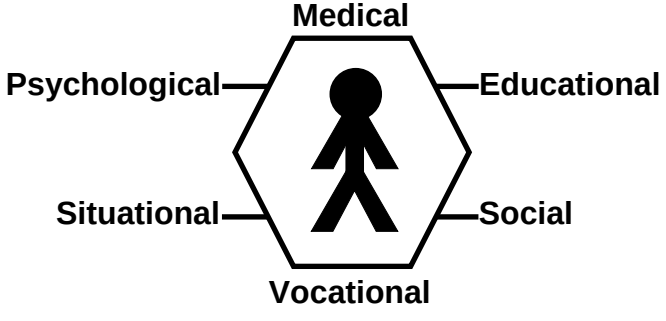

FIGURE 7.3 Rehabilitation Documentation Hexagon

Medical Data

The rehabilitation professional must coordinate the acquisition of appropriate medical data on *every* applicant prior to eligibility consideration. Whether the necessary data include a comprehensive evaluation with multiple examinations or simply a required general examination, counselors are drawing upon their coordination skills within the management process. The caseload manager must be effective and efficient in collecting adequate medical data to establish the existence and boundaries of a defined disability. Generally, medical documentation occurs only in the early segments of the process, but occasionally, as some clients' conditions change, it is necessary to update the medical data. It is also advisable to secure current medical documentation annually on those clients receiving services over extended periods of time. Usually, private practitioners receive considerable medical data at referral, but decisions are often necessary regarding additional medical *or* psychological evaluation.

The two primary areas of medical concern are the *physical* and *emotional* dimensions of the individual. General and specific data about the individual's physical condition may be necessary for comprehensive understanding of the extent of disability. Additionally, psychiatric evaluation (or psychological, where appropriate) may be required to identify emotional disorders. It is also frequently useful to procure hospital or clinic records on an individual, especially when the information is relevant to alleged or diagnosed disability.

Psychological Data

The counselor should never hesitate to secure psychological evaluation on *any* applicant or client. It can be extremely useful in understanding the individual's past and present behavior as well as providing clues to future behavior. Certainly, such evaluation provides valuable data relative to capacities and limitations in cases of mental or emotional disorders. Usually, psychological data is secured as early documentation applicable to the diagnostic study, but it can also be beneficial later in the process. For example, effective counseling is likely to be contingent upon an adequate understanding of the psychological ramifications that may accompany the physical or mental disability.

Psychological data is usually acquired directly from a psychologist following appropriate interview and evaluation of the applicant or client. However, valuable psychological data can be obtained from psychiatric hospitals and mental health clinics or centers, as well as from the counselor's own observations.

Social Data

The applicant or client is the primary source of social data. However, such data can sometimes be acquired from workers at social agencies who may be acquainted with the individual. Regardless of its source, the caseload manager should remain focused on acquiring the desired information. Forms or formats are often used to guide the counselor in acquiring the necessary social data. It is also important to remember that social data become part of the permanent record as a result of counselor entry documents.

Vocational Data

Although the prime source of vocational information is the applicant or client, there may be times when it is appropriate for the counselor to explore a situation further with an employer. As an example, job modification may render an employment situation more suitable for a particular client. It is also important to know whether the individual has work experience, and, if so, to understand why his or her employment record reflects certain job situations. If the applicant or client states a particular vocational interest, it should be explored, appropriately, in view of the totality of data forming the diagnostic study. The significance of the vocational situation is usually interpreted and recorded as counselor entry documentation to the case record. Certainly, because the goal of rehabilitation services has vocational ramifications, it is advisable for public and private practitioners to document clearly the vocational base the individual has already established.

Educational Data

Educational documentation may come from the applicant or client or any academic institution or other training site with which the individual has prior association. The caseload manager should obtain academic and performance records whenever possible because of their value in reflecting the present proficiency of the individual, as opposed to simply asking for and noting the highest grade completed or level attained. School-related psychological evaluations may also provide significant information. It is important, however, to remember that numerous factors (i.e., geographical location; mental, emotional, and physical health; and cultural influence) have contributed to an individual's education. Therefore, appropriate interpretations of the meaning of the individual's educational and training performance can only help in understanding the previous situational circumstances of the client. Such documentation can become an integral part of the data necessary for accurate understanding of the particular person.

Situational Data

Kurt Lewin (1935) has stated that the behavior of an individual is always a function of the person's characteristics and environment—B = *f*(P, E). Documentation of situational elements are generally counselor entry descriptions of factors having *positive, neutral,* or *negative* influence upon the individual, the individual's potential for rehabilitation, or the flow of the rehabilitation process. For example, deteriorating health problems may negatively affect the attitude of the client toward *any* rehabilitation efforts, as well as interrupt the flow of existing services. Situational documentation may also originate from such external sources as social or correctional agencies, family members, or simply from some person interested in the applicant or client. To illustrate: suppose a client is participating in remedial education with the goal of passing the high school equivalency examination. It would certainly be helpful to acquire information from the instructor on the client's progress if vocational outcome is contingent upon a passing score. In other words, the results may determine whether the individual is admitted to a training program or if the vocational objective will have to be changed. Usually, situational documentation relates to the core elements of the counselor–client relationship and describes the progress being made toward the rehabilitation goal. The caseload manager should consider carefully *all* situational circumstances of the applicant or client for possible documentation to the case record.

The previous discussion has provided a beginning for distinguishing the difference between case recording and case documentation, and thus a foundation has been laid for constructive on-target action. It should also be evident that the discrete role of *counselor* and the more encompassing role of *caseload manager* merge to expedite a management process related to rehabilitation case file development.

LEGAL IMPLICATIONS FOR THE COUNSELOR

The intent of this section is not to dwell on the ramifications of the legal actions possible in this area but simply to develop *awareness* of the counselor's vulnerability to legal action regarding the contents of the case record. Therefore, it offers neither discussion of precedent litigation nor strategies for the counselor concerned with possible litigation. The basic premise is that, aside from ethical responsibility, the counselor *may* also have a legal responsibility to maintain accuracy and authenticity in the contents of the case file.

Riscalla (1974) notes that the case file "contains a legal record" and that the possibility of litigation could encourage "defensive recordkeeping" by the

practitioner. However, the *possibility* of legal action should not preclude the acquisition of adequate and accurate information necessary for the provision of services to rehabilitate the individual. The entire area of record maintenance is still in a considerably ambiguous state.

The report from the Third Institute on Rehabilitation Issues (1976), "Legal Concerns of the Rehabilitation Counselor," indicates that although the counselor's responsibilities, liabilities, and protections vary from state to state, the legal liability is personal and may result in personal judgment against the counselor. However, the Prime Study Group of the Third Institute found that most state agencies have formal or informal procedures for obtaining legal counsel if necessary. The authors recommend that rehabilitation practitioners have access to, and study, the above-cited document for its application to legal concerns. Counselors' awareness of current legal issues facilitates effective and reasonable approaches to these concerns. However, counselors should not forget that *adequate* case recording can be a positive reinforcer to caseload managers who have concerns about the legal implications of their jobs.

SUMMARY

This chapter has considered case recording and case documentation, and has briefly called attention to the legal concerns of the rehabilitation counselor. As a tool for the client, the counselor, and the agency, case recording was explored and distinguished from case documentation, which is specific information acquired by the caseload manager. Five styles of common case recording procedures were presented for consideration in total case file development activities. A systematic approach to case recording was discussed in relation to the basic elements that constitute a responsive procedure for relating significant referral-applicant-client aspects to the specified rehabilitation process goals. Formats were presented with brief discussion to structure efforts in the development of effective case recording skills.

Case file documentation was viewed from six areas, with appropriate discussion to establish understanding of the value of such information. Illustrations and examples were presented to provide insight into procedures for acquisition of such data.

Finally, attention was called to the ambiguous state of the legal issues involving case record maintenance and the caseload manager's responsibility for accountability. It was further noted that the counselor has a personal, legal liability for actions or inactions pursuant to rehabilitation service delivery.

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CHAPTER 8

Correlative Dimensions in Caseload Management

THE PROMINENT DIMENSIONS

The purpose of this chapter is to focus briefly on (1) Casefinding, (2) Counseling, (3) Job Placement/Employment, and (4) Follow-up as prominent correlatives within the caseload management model developed in this text. These dimensions are considered correlative areas because each one is role specific in assisting the rehabilitation counselor in caseload manager functions. To illustrate, some counselors may fail to engage in an active or systematic approach to any of these dimensions and simply allow each to develop haphazardly, while they focus more specific managerial efforts on other components of the caseload. This, of course, is contrary to the view that these dimensions encourage effective caseload management. In other words, the effective caseload manager will incorporate these four dimensions within a systematic approach to the management of a total caseload. The reasoning is that without adequate attention to these measures, counselors cannot perform caseload management; they can only engage in some key activities included in a caseload management model. Thus, efficiency and effectiveness will be lacking in caseload management if these dimensions are not afforded proper perspective. Clearly, each one contributes specifically to an overall managerial process germane to effective delivery of rehabilitation services.

It should be noted that the treatment of these four dimensions as *correlative* to caseload management in no way depreciates their stature within the rehabilitation process. In fact, each one is prominent, especially counseling and job placement/employment. Also, with the possible exception of follow-up, each dimension is supported by a considerable volume of literature that is readily available through other publications. Therefore, the following overview simply provides insight into each dimension relative to its merits

as a correlative component of a caseload management process. Keep in mind that each dimension provides for specific activities within the rehabilitation process, and facilitates total case movement when used within a systematic approach to managing a rehabilitation caseload. Therefore, if the counselor does not have the knowledge and skills necessary for effective, constructive, and organized activity in these areas, further development is warranted.

CASEFINDING FUNCTIONS

Generally, casefinding in vocational rehabilitation refers to the identification of persons with disabilities for the purpose of considering services in accordance with their needs and interests. As indicated by Frankel and Gelman (1998), "Case management involves improving the quality of care to vulnerable populations, while controlling such care . . . thereby linking a client to needed services, and other elements involved in advocacy and social action" (p. 3). It is logical that the major responsibility for assuring this quality and opportunity for services lies with the counselor. Therefore, the focus is on the counselor's referral source development activities. It is what the counselor does, or does not do, that sets conditions at the entry process of caseload management.

No general rule can be stated for establishing a standard casefinding program because situational and personal variables contribute to the development of any adequate referral source. However, when the counselor approaches casefinding functions professionally, he or she can develop a systematic program that produces a continuous flow of possible clients for the rehabilitation system.

Figure 8.1 provides a global perspective for the development of casefinding functions within a given geographic location. Certainly, there may be other considerations in a casefinding program, but the following core elements remain universal aspects (1) client targeting, (2) agency targeting, and (3) system targeting.

Client Targeting

It is critical that the counselor begin to target specific populations, particularly those at risk for high-cost institutional care or those in need of multiple services provided by the public vocational rehabilitation system. Moxley (1997) suggests that the view of client targeting will persist as case management is directed toward the needs of the most significantly disabled populations who will be the future consumers of rehabilitation services.

FIGURE 8.1 A Basic Casefinding Model

Caseload management must begin to restructure service delivery systems for a variety of purposes, and "must include efforts to increase accountability and individualized service delivery in response to complex situations and in recognition of client difference" (Gursansky, Harvey, & Kennedy, 2003, p. 49). Therefore, it is crucial that counselors understand the function of all possible sources of referral within the given geographic region, and develop a working relationship with these sources to ensure that individuals with disabilities are serviced.

Agency Targeting

The rehabilitation caseload manager should be aggressive and comprehensive in identification of social, educational, health, vocational, or other programmatic endeavors within the geographic territory, and proceed to develop these avenues for referral. This leads to the second element, which is developing community relationships and resourcing. Professional relationships facilitate fulfillment of a counselor's responsibility for assuring that referral sources realistically understand the objectives of the agency. One of the objectives of the system is to create seamless services and maximize resources available to individuals with disabilities. This idea of seamless delivery of services has challenged the organizational ownership of certain client populations. In addition, emphasis has been placed on cooperation across agencies and sectors. Rather than providing only those services that can be offered through a single agency, rehabilitation professionals can resource and work in collaboration with a variety of service providers and agencies within the community. Thus, creating an environment conducive to stronger inter-agency ties leads to

a more cost-effective use of informal, contracted, and inter-agency resources (Gursansky et al., 2003).

System Targeting

It is of paramount importance that rehabilitation professionals develop monitoring, tracking, and long-term maintenance systems that will enhance and nurture the provision of feedback from clients (e.g., annual satisfaction surveys). Of particular importance is tracking clients once they have been placed in employment. Rehabilitation professionals also conduct assessments, collect information, and form hypotheses about how clients may remain successful in their places of employment. This is a crucial part of the system targeting process, in light of the rates of recidivism in the rehabilitation services delivery system. "Recidivism involves the general breakdown in a community support system that is unable to help clients make significant and lasting lifestyle changes" (Frankel & Gelman, 1998, p. 136). Tracking allows rehabilitation professionals to inhibit recidivism rates and solve problems that arise while the client is working.

Monitoring also assists rehabilitation professionals in tracking the delivery of the services and support that have been identified by the service plan. It determines how well the service plan is being implemented. It is during this monitoring phase that the rehabilitation professional begins to establish credibility. This is usually accomplished when the counselor can provide services that significantly benefit the referred individual, and is why the caseload manager should maintain preplanned periodic contacts with all potential sources within the system.

Aside from the above-indicated sources, referrals can be identified through efforts directed at education of the public. Speaking before community groups (i.e., civic organizations, churches, and schools) is an outreach effort that not only locates potential clients, but also helps the counselor establish public relations. Such efforts in casefinding are time consuming, but they are a critical dimension of effective caseload management. Each caseload manager should develop a systematic approach to casefinding functions in vocational rehabilitation.

THE COUNSELING DIMENSION

Counseling activity mandates involvement with a client's personal world (counselor role) as well as involvement with various systems or service

delivery components (manager role). These roles fluctuate according to client needs and counselor competence to meet those needs. The counselor's orientation (e.g., directive versus nondirective) and ability to apply theory are undoubtedly influenced by the strength of the managerial procedure developed.

However, the purpose of including the counseling component here is to focus on it as a definite correlative dimension of caseload management, and not the provision of an overview of counseling theories and application. The counseling literature is voluminous and specifics can be obtained through appropriate investigation. Perhaps the importance of this section can be understood best through the following statement by Means (1973). He states, "Counseling skills should be considered as appropriate and integral elements of the management of clients for at least five purposes: relevant information gathering, planning, modification of client program, referral, and counseling" (p. 8).

Clearly, these activities require the counselor's time and judgment, and, as such, are critical elements of the flow or case movement process. Imagine the frustration produced should the counselor completely avoid each of the five purposes identified above. The result would be absolute chaos and total inefficiency. Thus, the greater the efficiency in the counseling dimension of caseload management, the less the frustration in dealing with such aspects as case movement.

THE JOB PLACEMENT/EMPLOYMENT PROCESS

The placement process is not a single occurrence in the client–counselor relationship, but rather a series of events leading to employment (or related activity). In fact, it may be argued that the placement process begins as early as the initial meeting between counselor and prospective client. Certainly, vocational information is discussed in the first meeting of the applicant and counselor. From this basis, initial vocational planning emerges, pending certification of eligibility. Thus it is readily apparent that the placement process converges on the rehabilitation process early in the client–counselor relationship.

The public agency counselor has the legal responsibility for vocational placement of individuals with disabilities through the administration of a state and federally funded program. How this responsibility is executed determines how critical placement is to case movement toward ultimate rehabilitation. To illustrate, the caseload manager may

1. actively engage in employer contacts seeking placement opportunities,
2. simply *urge* the client to explore placement possibilities,
3. cooperatively work with the client in locating potential employment situations, or
4. involve the client in placement clinics as part of a rehabilitation workshop or facility program.

It is imperative that the counselor develop a systematic approach to the job placement/employment responsibility in order to effectuate the flow of cases through the process management scheme.

An abundance of literature exists that deals with placement philosophy, techniques, and current research. However, the purpose here is not to address the placement process except to focus on its significance as a correlative dimension of caseload management. Regardless of the style embraced by the caseload manager, the placement process is integral to any system of caseload management. Placement remains associated with the ultimate goal of rehabilitation; thus it is the initial observable procedure for resolving the successful case. Just as the caseload manager is concerned with the referral process as a means of bringing new cases into the system, the closing procedure that arises from satisfactory placement becomes the outlet for the exit of cases and anchors the flow of cases through the entire process. An effective system of job placement/employment serves the client, but it also helps the caseload manager to close cases successfully.

FOLLOW-UP REQUIREMENTS

The term *follow-up* may suggest various meanings to rehabilitation practitioners. However, for the rehabilitation counselor, it is essentially an evaluation procedure to acquire feedback about the appropriateness of client placement and the value of services, prior to official closure of the case. Logically, follow-up contacts would primarily occur while a case is in employment. Other definitive follow-up procedures (i.e., attempts to determine outcome of client rehabilitation efforts since termination from a rehabilitation facility) may, of course, negate the above definition. Follow-up should not be confused with the category "post-employment services." The latter implies substantial service delivery to clients. Follow-up may be viewed as research efforts with specific focus on evaluating overall satisfaction with the placement situation and assisting the agency in its information gathering for accountability reports to the federal agency. It is important to the success of the placement process that the client be pleased with

the job situation, but it is critical that the employer be satisfied with the performance of the client. It is the responsibility of the rehabilitation counselor to intervene and attempt problem resolution with any difficulties that occur during the designated follow-up period. As such, follow-up does not assure long-term client employment, but it does suggest to the employer that the client has not been "dumped" and that the counselor is concerned with the outcome of the placement, not just the placement itself.

The number of follow-up contacts with the client or employer is difficult to assign to a general rule because the characteristics of each situation will mandate the appropriate quantity of follow-up interaction. By federal regulation, the minimum time requirement in employment is sixty days, and so follow-up contacts would normally fall within this time period. Therefore when a placement situation is relatively free of crises, one or two such contacts will likely be sufficient. Other situations will require professional judgment as to the required number of contacts.

As a correlative dimension to caseload management, follow-up should be viewed both in terms of *immediate* and *long-term* aspects. The immediate aspects will dictate the counselor functions with each client–employer relationship. Long-term aspects, on the other hand, are more concerned with developing employment opportunities for future clientele. Keeping the doors open to specific employment opportunities clearly assists the counselor in case movement aspects of the management process.

SUMMARY

It is important for the caseload manager to understand that a variety of behavioral dimensions affect the flow of cases through the process management scheme used by rehabilitation agencies. Four of these dimensions are (1) Casefinding, (2) Counseling, (3) Job Placement/Employment, and (4) Follow-up. This chapter treats each as a correlative dimension to the management system advocated throughout this text. Extensive treatment of these four dimensions is beyond the limits of this text. Sufficient content has been developed elsewhere to fill any void noticed by the counselor who might be studying the present text. Though these correlative dimensions are not treated at length here, they can be significant for individuals attempting to develop themselves as rehabilitation professionals. They are included here to support the conclusion that caseload management provides a comprehensive, inclusive base of practices that effectively respond to the identified needs of persons seeking rehabilitation agency services.

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CHAPTER 9

Rehabilitation Caseload Management in the Private Sector

REHABILITATION AND THE PRIVATE SECTOR

Rehabilitation counseling is one of the fastest changing professions. In fact, rehabilitation has been in a transitional state since its inception with the passage of the Smith-Fess Act in 1920. Cassell and Mulkey (1985) describe this transition as "the passage from one state to another . . . transition is change . . . it has become a truism in the profession that the one thing that can be depended on in rehabilitation to remain the same is change" (p. 275). This type of transition and change has been distinctly noted with the emergence of private sector rehabilitation. In 1970, virtually all professionals in the field of rehabilitation practiced within a state–federal vocational rehabilitation agency. The Social Security Administration had arrangements with state agencies to provide rehabilitation for Social Security Disability recipients, but this was limited in scope and impact. In contrast, during the 1970s, benefit levels and costs related to workers' compensation and other disability policies increased to unprecedented levels, leading to the recognition of the costs of disability and the implementation of private rehabilitation services (Havranek, 1995). This private-for-profit movement expanded quickly due to the perceived personal and economic benefits of the field of rehabilitation. These benefits were further expanded by organizations that had been charged with reducing the costs of disability benefits. During the 1990s, these efforts continued to be implemented to ensure that services were more cost effective and efficient.

Rehabilitation in the private sector includes a wide range of services provided by practitioners and other professionals who are employed in private businesses, rather than in public service agencies. As described by Shaw and Betters (2004), the term *private sector rehabilitation* "encompasses the work of a wide array of rehabilitation personnel within both for-profit and not-for-profit

businesses" (p. 236). The services provided in the private sector are similar in many ways to those provided by practitioners regardless of their work settings. These services may include vocational planning and assessment, disability case management, case documentation and reporting, and job placement and development. According to Shaw and Betters, what makes the work of private sector professionals unique is the business environment in which they function. Regardless of their mission or services that may characterize profit as the nature of the business. Private sector rehabilitation is profit producing and without profit would cease to exist. "Consequently, the goals, business practices, and all functions of the business's employees must be attuned to this underlying fact" (Shaw & Betters, p. 236).

Feast or Famine

The rehabilitation field has experienced many legislative and administrative swings as it moved through various transition phases. Recently, rehabilitation in general has moved from the "feast" period of the 1960s, where plentiful dollars, small caseload size, and rapid case movement were prominent, to a "famine" period of this decade in which shrinking dollars, larger caseload size, slower case movement, order of selection, and priority categorization prevail.

McFarlane and Frost (1981) projected that feast and famine might give way to extinction of the rehabilitation professional if key areas of stress were not reduced. The five areas noted by these authors were: (1) outcome standards, (2) compliance, (3) shrinking dollars, (4) changing expectations, and (5) consumerism. All of these areas have implications for the current practice of caseload management, most specifically in the area of private sector rehabilitation. The core of private rehabilitation is the profit producing "bottom line." Although the services provided by private sector professionals are similar to those of the public sector, there are three key differences. Lynch and Lynch (1998) identified these differences, stating that the private sector is (1) more versatile, (2) quicker to initiate services, and, more importantly, (3) cost effective. Overall, the private sector is a world of business whose distinctions enable companies to generate profits (Shaw & Betters, 2004).

Changing Target Populations

The field of rehabilitation has tended to shift its focus from one disability group to another, often misguided by an unwritten philosophy to be all things to all people. At one point a cradle-to-grave continuum of probable service recipients for rehabilitation was envisioned. This constant flux and

shift in caseload management practice was confusing and stressful, further complicating the personal effort to become a competent professional.

The rise of private sector rehabilitation has been attributed to the changing nature of clients served by the public rehabilitation system, caseload sizes, and the extent of the provision of services. According to Matkin (1997), when vocational rehabilitation services became available to civilians in the 1920s, workers' compensation statutes that provided for medical services for federal employed and private workers already existed. Vocational rehabilitation services for these individuals were intended to be provided through the state agency. Therefore, the predominant client population served by the state agency, until the mid 1970s, "consisted of working-age people who reasonably could be expected to return to gainful employment" (p. 140). The characteristics and services in the public sector also changed drastically with the definition and inclusion of developmental disabilities.

With the 1973 Rehabilitation Act and subsequent amendments, the highest priority of clients to be served by the public agency system was extended to include those individuals considered most significantly disabled who acquired their disabilities in life or at birth (Matkin, 1997). Although at that time services could be provided to virtually all citizens with disabilities, rehabilitation professionals in public agencies were confronted with increasing client caseloads to manage and an increase in the average duration per case. As a result of this expansion of the disability population and governmental funds for rehabilitation services, there was an increase in private rehabilitation facilities. "Because rehabilitation units and centers were exempt from the prospective payment system, which characterized health care reimbursement at the time, many tertiary care centers established rehabilitation units" (Shaw & Betters, 2004, p. 237). Many community rehabilitation programs began to focus on issues of service integration and vocational rehabilitation. Simultaneously, a report on cost-containment strategies was brought to the attention of the state workers' compensation boards, which at this time were struggling with cost-containment issues. The thrust behind this report was the idea that by introducing VR services, individuals with disabilities would return more rapidly to work, therefore resulting in cost containment. This idea spread quickly, leading to acceleration in the use of rehabilitation services within the workers' compensation arena. Though most workers' compensation companies relied heavily on the state–federal VR programs to provide services to their clients, they quickly became dissatisfied with the services provided by the public sector. Typically, these services were seen as slow to implement, training focused rather than placement focused, and deficient in cost

containment (Shaw & Betters, 2004; Weed & Hill, 2001). Therefore, private practitioners began to shift from public offered services to private sector services that met the needs of a variety of disabling conditions whose origins most frequently were diseases, accidents, or work injuries covered by workers' compensation insurance.

Without question, the goal of change in target populations in the private sector is to empower clients to return to work and gainful activity. Private sector rehabilitation professionals seek to restore clients as closely as possible to their former level of functioning (Matkin, 1995). In a quest for cost-efficiency, this restoration in the private sector created a total package of services for clients that are more readily available and flexible.

PROCEDURES IN THE PRIVATE SECTOR

Caseload management is the nucleus of the private sector and/or disability management system. Caseload managers may be selected from the internal ranks of human resource management personnel, they may be recruited and hired to complement an already existing disability management team, or they may also be accessed through a consultant from a private rehabilitation vendor in the community. Several professional roles have evolved to meet the challenges faced by practitioners in the private sector. Private sector professionals have become caseload managers, disability management specialists, consultants to business and industry, specialists in the area of workers' compensation vocational rehabilitation, and vocational experts in the legal arena (Brodwin, 2001).

Caseload management in the private sector requires coordination and monitoring of medical and rehabilitation services. Private sector professionals need to coordinate multidisciplinary prevention, rehabilitation, and treatment activities for workers. They collaborate with medical and health care providers, public and private rehabilitation providers, and members of disability management teams (Mullahy, 2004; Shrey, 1995; Shrey, 1995a). These counselors emphasize early intervention, minimize functional limitations associated with disability, control cost-effective services, prevent industrial accidents, are associated with wellness in the workplace, and develop disability management and/or return-to-work programs.

Private rehabilitation professionals formalize disability management programs, which require the development of transitional work plans and a systematic effort to coordinate information in implementation of return-to-work or worker-retention plans. These managers also coordinate an employer's response to an injury and issues directly related to disability through evalu-

ations to determine transferable skills, rehabilitation plans, and transitional programs. According to Shrey (1995, 1995a), along with these duties, private sector practitioners have important functions in recommending corporate policy and procedure. "Therefore, the roles and functions of disability managers must be clearly delineated and thoroughly communicated to other active participants in the disability management process" (Shrey, 1995a, p. 74).

Communication

Case management in the private sector has become an integral part of the medical mainstream, and has made it essential that new dialogues and improved levels of communication be maintained. Disability management is a face-to-face profession, making it essential to maintain open pathways to effective communication. According to Mullahy (2004), "more focused and conscious communication is needed between caseload managers and physicians, patients, families, payer sources, and related legal entities" (p. 167). To communicate more effectively with these select groups, disability managers must recognize the obstacles to communication and strive to eliminate or overcome them.

Communicating with Supervision

Perhaps the most important level of communication in the disability management arena is between the disability manager and the employee's supervisor. "Injuries, subsequent disabilities and work disruptions originate, for the most part, within the work environment" (Shrey, 1995a, p. 74). The work supervisor is generally the individual most familiar with the employee, specific work demands, and the circumstances related to the onset of disability. Therefore, the disability manager will play a crucial role, both in the communication of information to the disabled worker's supervisor and the implementation process of the work-return options for the employee with work restrictions. The return-to-work plan will delineate clearly defined goals, objectives, and responsibilities. For it is through the development and implementation of such work-return plans that the disability manager will enhance communication and service coordination.

Communicating with Physicians

There are stereotypical judgments that can impede positive communication between private sector professionals and physicians. In several ways, these stereotypes stem from personality traits that are inherent to a physician or

practitioner. According to Mullahy (2004), "Physicians tend to be results oriented, trained to diagnose and treat. Caseload managers, on the other hand usually come from traditional caretaker backgrounds, and maintain ongoing patient contact to perform their functions" (p. 168). Therefore, caseload managers tend to view physicians as less interested in the disability management issues of the client, whereas physicians tend to regard private practitioners as overly involved in the case.

A second obstacle to communication between private sector professionals and physicians involves the health-care system. As health care continues to evolve and change, a territorial distance is often created among health-care professionals. Despite a common cause, physicians and private sector professionals are becoming opponents in a system lacking in openness. In a communication system that is collapsing, physicians and private practitioners view one another with caution and mistrust. Therefore, it is critical to combat misperceptions and misunderstandings that stem from lack of effective communication on services and service delivery.

Due to the ongoing and changing relationship between private sector rehabilitation professionals and physicians, transition to full and open communication and collaboration is awkward and at times difficult. "Involved are differences in orientation, training, spheres of influence, and recognition of each group's expertise" (Mullahy, 2004, p. 168). Society sees the physician as the focal point of medicine. Buying into this societal expectation are private sector practitioners who have failed to value their own contributions to the system. As a result, caseload managers may not be confident in handling interactions with physicians. This impediment to communication may be overcome by empowering caseload managers to appropriately esteem their contributions to the field of rehabilitation, and by placing emphasis on the skills that they contribute in health-care management settings.

Communicating with Clients

How and when the case management role is introduced and explained to a client is important. All parties may be more effectively served by early involvement of the caseload manager. According to Mullahy (2004), "Helping to educate clients as to the ideal time for case management intervention should be a constant objective of all caseload managers" (p. 175). However, because caseload managers rarely have influence over when they obtain a referral, they must learn how to establish effective counselor–client communication. To facilitate the best possible exchange, the caseload manager needs to be fully informed about the client and the reason for referral. He

or she also needs to be fully aware of as many facts as possible related to the disability or injury. The medical circumstance may have created financial hardship or other problems for the client. Therefore, by way of an open communication style the client is kept aware of the medical circumstance and the counselor can assist in the rehabilitation process by maintaining empathy.

Communication and Private Sector Burnout

Case managers will often have tragic and difficult cases. Many of these cases result in life altering changes for clients and their families. There seems to be little balance between success and tragedy in more traditional health care delivery systems. Often, caseload managers deal with individuals who are angry at the system and who tend to voice their opinions to their caseload manager rather than to their physician. According to Mullahy (2004), "Caseload managers who try to totally distance themselves emotionally by . . . walling themselves off from the pain their clients feel will lose their ability to be effective because they will stop interacting with that client" (p. 190). Therefore, private sector professionals must develop a balance between successful and tragic cases by finding the appropriate level of involvement between clients and themselves.

Caseload managers must understand where the function of case management begins and where it ends. They must be able to develop a strategic plan that addresses all issues related to the problem, while simultaneously understanding and acknowledging their own limitations. Despite the day-to-day issues that arise, counselors must maintain a state of equilibrium. Otherwise they will become overwhelmed and burned out (Mullahy, 2004).

To circumvent counselor burnout, private sector professionals would do well to understand their attitudes related to their position and its parameters. Counselors' attitudes toward their clients have been shown to be important factors in successful intervention against burnout (Brodwin, 2001). To be effective, rehabilitation professionals must be fully aware of their attitudinal biases toward clients and toward issues related to their job position. Private rehabilitation practitioners also need to be well versed in the parameters of their positions. They need to understand their job positions realistically and not glamorize them. A counselor engaged in a case management role needs to prepare for the role's requirements and understand its expectations. Many professions have undisclosed expectations. However, it is by recognizing and understanding these expectations that counselors combat burnout and find viable solutions to stress in the workplace.

PRIVATE SECTOR SKILL CLUSTERS

As described in chapter 2 (Table 2.1), skill clusters are patterns of actions that concern central themes or axes. A skill is a learned ability for doing an activity in a competent manner. Often, the execution of one skill relies on another prerequisite skill. Thus, skills are often interrelated and occur in clusters (Cassell & Mulkey, 2004). Each cluster gathers together sets of specific actions that the caseload manager uses for consistency of personal practice and for fulfilling organization standards. Whether in the private or public sector, there are skill clusters that may be applied to any rehabilitation setting. Illustrated in Table 9.1 are five major skill clusters that reflect management application in the private sector.

Planning

Caseload management is a process that allows private sector practitioners to identify and solve problems. For private sector rehabilitation professionals, the key issue in any case is to focus on the best and/or most appropriate treatment, as well as the most appropriate setting for the treatment. Caseload managers must use their skills in various situations to appropriately plan effective rehabilitation outcomes. Some information in case files may beyond the expertise of some practitioners. It is then that the caseload manager has a responsibility to become familiar with the area in question, and it is always appropriate to ask or to acknowledge that there is a need for further information.

At this phase of the rehabilitation process case managers need to begin evaluating the funds available for services. With the impact of costs of medi-

TABLE 9.1
Basic Managerial Clusters in the Private Sector

Traditional Managerial Functions	Typical Corresponding Caseload Management Functions
Planning	Establishes a process of identifying and solving problems.
Reporting	Initiates and facilitates an effective communication process with clients.
Obtaining Approval	Serves as adjunctive link to proceeding with the recommendations in the rehabilitation report.
Coordination	Executes the recommended services and puts these services into place.
Follow-Up	Evaluates recommended activities and takes the necessary corrective action within a rehabilitation structure to maintain cost-effectiveness and quality services.

cal equipment, supplies, physician bills, and therapies, case managers must pay close attention to price, quality, and delivery sites. Therefore, it is crucial that the case manager consider the services already in place, look at the overall costs, and reevaluate where and how time may be well spent. Overall, it is the case manager's job to plan an effective rehabilitation program and then, in measurable steps, follow the procedures necessary to ensure that the ultimate goals are attainable and realistic for the client.

Reporting

The nature of the referral source will impact on communication from the initial evaluation through the reporting stage (Mullahy, 2004). The focus needs to remain on the client and the information needs to be balanced to present an accurate picture of the client's overall situation. A report in a disability case should be specific and the medical information complete. The frequency and length of the report should be established by the referral source, and the nature of the report should be pertinent to the specific medical situation. Reports should be written a minimum of once per month, and should contain all pertinent case activity recorded in a specific, standard, or recommended form and clarifying the client's current medical situation. This type of recording (i.e., specific) should continue for the duration of the case and be modified according to the referral source.

Case managers must focus on the situation, the line of insurance, the payer, and the needs of the client. Therefore, case management records need to address medical costs; medical, physician, client, and family issues; the individuals consulted; rehabilitation actions agreed upon and actions taken; and outcomes (Mullahy, 2004). Regardless of the client's situation or need, the report should adequately present the information that captures the general and specific aspects of the case.

Obtaining Approval

After the case management plan has been created and the report has been sent to the client and the referral source, the caseload manager must obtain approval to proceed with the rehabilitation plan as outlined. At this point in the process the caseload manager will communicate directly with the payer regarding the list of recommendations that define the rehabilitation plan. This bi-directional communication process allows the counselor and payer to address cost issues and alternate forms of care.

There will be times when caseload managers will have to use personal judgment and consideration for those they are representing. They may receive direct communication from an employer, referral source, or payer that

prohibits the payment of some aspect of the plan due to cost containment or expense. If the rehabilitation *professional's opinion* is that the client is located in the most appropriate setting and is receiving the most cost-effective treatment, then the caseload manager should not allow the employer, referral source, or the payer to override his or her *professional judgment*.

Coordination

The caseload manager's roles and responsibilities are to coordinate case resolution services, prevention services, medical treatment, rehabilitation services, and evaluation services through direct links with internal and external resources (Shrey, 1995a, 1995b). The caseload manager will often work in collaboration with employer-based human resources departments to coordinate third-party insurance payments for services. For those caseload managers with medical management skills, provision of services to injured clients and important utilization reviews ensure quality rehabilitation and treatment outcomes.

For clients with prolonged work disruptions or for those hospitalized more than two weeks, rehabilitation services and medical management activities should be closely monitored. Case managers may be assigned to coordinate visits to rehabilitation and treatment programs, functioning as the liaison between the client and the community treatment team provider. The case manager may coordinate office visits with physicians, and make visits to homebound clients to monitor recovery processes and facility rehabilitation planning activities (Shrey, 1995a, 1995b).

Shrey (1995a) describes the variation within the coordination of caseload management activities. He states, "The nature of coordination of case management and medical management activities will vary considerably according to the acuity, chronicity and other mediating circumstances surrounding the injury and/or disability" (p. 76). Therefore, it is imperative for caseload managers to expand their coordination beyond basic monitoring skills to include utilization review, evaluation of treatment plans, and promotion of medical opinions. It is the goal of the coordination process to reduce lost time by providing effective health-care services and coordinating realistic and attainable return-to-work options (Shrey, 1995a, 1995b).

Follow-Up

Attention must be given to each detail of the rehabilitation process. Any time a caseload manager becomes responsible for a case, recommendations for services, or implementation of services, the counselor must ensure that what has been put into place is working effectively. Approval to monitor or follow

up a case may be difficult to obtain from the payer or source; yet managing a case without follow-up can lead to disaster.

The monitoring process varies from case to case. According to Mullahy (2004) the monitoring process, "may include semimonthly home visits by the case manager or periodic phone calls placed by the patient to the case manager" (p. 281). When there are multiple services in place, the case manager needs to make on-site or home visits to ensure knowledge of the "true" situation. Continuing follow-up reports are essential because they will assist the case manager in maintaining links to the client when assessing the situation, and will support the case manager's role throughout the case.

Follow-up services are necessary to facilitate the continued implementation of rehabilitation strategies and return-to-work plans for workers with disabilities. These strategies blend the management of information with supportive policies. Mullahy (2004) reflects on the continuity of the case manager's position during the management process and throughout follow-up by stating, "Rather than someone who sets up services or assists with hospital discharges, the case manager is perceived as someone who contributes to the entire treatment plan" (p. 282). Thus, rehabilitation professionals are part of this process from the beginning and follow it through with the client until the end.

PUBLIC AND PRIVATE REHABILITATION: A COMPARISON

Similarities and differences between the private and public rehabilitation sectors are becoming more apparent than they were during early developmental periods. Negative outcomes such as competition and animosity can arise between these two similar professional areas. As these negative outcomes emerge, they must be resolved on a professional, cooperative basis if the field of rehabilitation is to survive and continue the mission of providing quality services to individuals with disabilities.

As growth continues, the key questions become (1) Is this an entirely new rehabilitation profession?, and (2) What continued impact will private rehabilitation practices have on those practitioners in the public sector? Organist (1979) has suggested that public and private rehabilitation have more commonalities than differences. However, this classic observation appears dated, particularly if one puts into perspective the many more current articles written on the services provided and the functions of the rehabilitationist in the private sector (Cassell & Mulkey, 1985, 2004; Diamond & Petkas, 1979; Maki & Riggar, 1997; Matkin, 1985; McMahon, Matkin, Growick, Mahaffey, & Gianforte, 1983; Mullahy, 2004; Shrey & Lacerte, 1995). The public and private sector similarities and differences are considered in Table 9.2.

TABLE 9.2
Similiarities and Differences: Private and Public Sector Rehabilitation

Private or Insurance Sector	Public Sector
Philosophy	
Rehabilitate injured workers to their level of functioning prior to injury (implies focus on short-term goals).	Maximize each client's highest potential level (implies possible retraining, evaluation, long-term goals).
Client Population and Eligibility	
• Worker's Compensation clients (usually not severely disabled). • Insurance policy determines eligibility. • Eligibility based only on need for services. • Serves nondisabled like "midcareer changers," bodily injury, auto nonfault.	• Conforms to Rehabilitation Act of 1973 and subsequent amendments. • Individuals with most significant disabilities are high priority. • Must have a disability. • Disability must constitute a barrier to employment. • Vocational potential must be present.
Functions, Duties, and Services	
• More personalized case management. • Smaller caseloads. • Top five services: 1. Case monitoring and follow-up. 2. Job analysis, placement, and development. 3. Medical case management. 4. Labor-market surveying. 5. Job restructuring consultation. • Fee for service. • Outplacement services (services needed for those losing jobs because of company's reduction in force [RIF] activities, i.e., job-seeking skills). • Flexibility in service selection and flexible in sequence. • Engages in preventative rehabilitation activities. • Vocational expert services.	• Larger caseloads. • Less individualized contact with clients. • Vocational counseling. • Long-term training cases. • Job analysis. • Job development and modifications. • Diagnostic medical evaluations. • Job placement. • Document Individual Plan for Employment. • Services on a non-fee basis. • Marketing. • Mandated sequence of tracking activities.

Potentially positive outcomes for caseload management activities can emerge from this transition, especially for public rehabilitationists. The public sector caseload management system has often been criticized for its uncompromisingly strict structure and over-control of counselors' caseload management practices. However, the practices of counselors in the private sector have brought about transitions in the public sector. Evidence of this was first noted in 1983 with the involvement of the Michigan Rehabilitation Services (MRS), a public agency, in a full-cost recovery rehabilitation program based on services for fees (Smith & Sawisch, 1983). Although vocational rehabilitation services have been offered traditionally to the eligible public on a non-profit basis, MRS recovered service costs from employers through their financial obligation for injured worker rehabilitation. Thus, *for this particular client population,* caseload management practices paralleled those of the private rehabilitationists'. That is,

> public providers became more pragmatic (less comprehensive) to achieve better cost containment. MRS had also demonstrated a willingness to incorporate a service delivery approach that offered flexibility by promoting independence from past practices and federal constraints. This included the options of providing sole services independent of a rehabilitation plan and elimination of eligibility criteria. [Smith & Sawisch, 1983, p. 11]

Thus we see a public agency initiating caseload management practices that provide services independent of governmental support. The final projected result was high-quality, high-intensity services that established private and public sector rehabilitation professionals as peers in the competition for injured-worker and third-party liability rehabilitation cases. The end result for rehabilitation is a continued transition toward cooperative relationships between the public and private sectors. The rehabilitation field will profit greatly from these professional interchanges.

In summary, private and public rehabilitation professionals share basic philosophies that attempt to establish goals for individuals with disabilities that are attainable based on functional capacities and consistent with the disabling condition and requirements for independent living. However, both areas must have high levels of management skills in order to manage their caseloads effectively and efficiently, and to assist their clients in emerging out of the rehabilitation process successfully.

CREDENTIALING

One of the greatest challenges faced by professionals in the field of rehabilitation is to understand counselor credentialing. Credentialed individuals

have an indicator that they are legitimate professionals. According to Remley and Herlihy (2005), "Credentialing comes in many forms, which is the basic reason people are so confused by it" (p. 28). In addition, some credentials are regarded as essential to the profession, others are desirable but not necessary for practice, and still others are of questionable value.

In the field of rehabilitation, there are diverse opportunities for credentialing. However, the following section will address the most common credentials in the rehabilitation counselor credentialing process. These areas include (1) Certified Rehabilitation Counselor (CRC), (2) Certified Case Manager (CCM), and (3) Nationally Certified Counselor (NCC).

Certified Rehabilitation Counselor (CRC)

The CRC credentialing process is the oldest and most established certification process in the counseling field (Leahy, 2004). Offered by the Commission on Rehabilitation Counselor Certification (CRCC), this credential is designed for professionals practicing rehabilitation counseling, a specialty that assists individuals with disabilities. There are several rehabilitation disciplines and related processes integral to this credential, including vocational evaluation, job development and placement, work adjustment, and case management (Mullahy, 2004). "Created with a number of eligibility levels to sit for the exam, the CRC, its certification standards, a Code of Professional Ethics, its certification guide, and application can be viewed on its website, www.crcccertification.com" (Mullahy, 2004, p. 527).

According to Leahy (2004), since the inception of CRCC in 1973, over 30,000 professionals have participated in the CRC certification process. Currently, there are more than 15,000 certified rehabilitation counselors in the United States and throughout the world. The certification standards and content for the examination have been validated empirically and represent the education, experience, and knowledge competencies required of qualified rehabilitation professionals (Leahy, 2004; Remley & Herlihy, 2005).

Certified Case Manager (CCM)

The Certification of Insurance Rehabilitation Specialists Commission (CIRSC) was the credentialing agency selected by the National Case Management Task Force to develop the case management certification process (Mullahy, 2004). This group defined what is now known as case management and announced the credentialing process for case managers. "The CCM credential brought into existence a nationally accepted standard for case management practitioners" (Mullahy, 2004, p. 523). In early 2002, case management professionals

from a wide variety of backgrounds were surveyed. The results of this study indicated that the majority of certified professionals hold the Certified Case Manager (CCM) credential. The second largest group was noted as having some "other" form of certification. Overall, the CCM examination is intended to be the tool for the evaluation of the skills necessary for case management in private and public sectors.

The Nationally Certified Counselor (NCC)

The National Board for Certified Counselors (NBCC) (n.d., ¶ 1) developed the first general practice counseling credential that was national in scope. NBCC began credentialing National Certified Counselors (NCCs) in 1983. Currently, more than 36,785 mental health professionals throughout the United States and in more than 40 other countries hold this voluntary professional credential. Although the NCC credential is seldom required for independent practice and is not a substitute for the legislated state credentials, those who hold it appreciate the opportunity to demonstrate that they have met national standards developed by counselors, not legislators.

The three basic components of the requirements for the NCC credential are education, supervised experience, and examination. Candidates for the NCC credential must hold an advanced degree with a major study in counseling from an accredited college or university. They also must meet specific semester or quarter hour requirements and content area requirements. Candidates for national certification must meet the supervised experience requirements specific to the option under which they qualify and apply. These professionals must also achieve a national passing score on the National Counselor Examination for Licensure and Certification (NCE).

Other Credentials

As explained in this section, credentials vary significantly among rehabilitation practitioners. The previous section detailed three common credentials noted in the rehabilitation services profession (i.e., CRC, CCM, and NCC). However, there are a number of credentials that have emerged due to changes in private sector rehabilitation and case management. Examples of these certifications include (1) Certified Disability Management Specialist (CDMS), (2) Continuity of Care Certification, Advanced (A-CCC), (3) Case Manager Certified (CMC), (4) Case Management Administrator, Certified (CMAC), and (5) Certified Professional in Health Care Quality (CPHQ). Due to the nature of case management and cross-disciplinary practice, there will continue to

be variations in the credentials of rehabilitation professionals. As more agencies and companies specify a credential to their employees, some credentials will move to the top as those most desired and recognized as indicators of established professionals (Mullahy, 2004). Therefore, it is crucial that private sector practitioners become aware of which credentials will meet their needs and the needs of their clients.

In summary, attaining a credential in the area of case management should be the goal of professional rehabilitation practitioners. Once the credential is attained, a professional should maintain both competency and credential through continued education and training. "Taking the time to obtain the credential demonstrates both a professional and personal commitment to the case management process and serves to validate its importance for ensuring quality outcomes" (Mullahy, 2004, p. 531). As numbers of qualified and credentialed rehabilitation practitioners continue to increase in the United States and around the world, the profession of rehabilitation counseling will be positioned firmly for the future, assisting clients, agencies, private payers, and service providers. Private practitioners know the value of their work. The credentialing process will underscore and further complement professional contributions to the field of rehabilitation.

SUMMARY

The future of rehabilitation counselors in the private sector is unclear. Rehabilitation counselors and other private practitioners must focus on demonstrating cost effectiveness in their case management practices while maintaining critical partnerships within the private sector. Managing the personal and economic costs of injury and disability in private sector rehabilitation requires active partnerships, including all those participating in the development, implementation, and evaluation of individuals with disabilities. In addition, these partnerships must be client centered with the client having access to valuable multidisciplinary resources and services throughout the entire process.

Although it may be difficult to note day-by-day changes in the process, rehabilitation practitioners have historically been accustomed to shifting trends and they react quickly to signals of change in the workplace (Shaw & Betters, 2004). Counselors will vary their roles and functions depending on the needs and requests of their referral sources, and will continue to provide effective case management services within the private sector. Rehabilitation professionals in the private sector have proven to be tenacious throughout

all of the changes within the health-care and medical care settings. For it is "rehabilitation counselors' broad skill set, their demonstrated outcomes, and professional flexibility that seem to point to a future filled with possibilities for rehabilitation counselors within the private sector" (Shaw & Betters, 2004, p. 251).

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CHAPTER 10

Using Technology in Caseload Management

TECHNOLOGY

Today's technological advances have the same purpose: to facilitate the transfer of information. They have had a significant impact on the rehabilitation counseling profession. Specifically, research on the work role and time spent in caseload management activities reveals that rehabilitation counselors have a diversified work role and expend the larger portion of their work day on managerial activities, a major part of which consists of paperwork (Rubin & Emener, 1979; Zadny & James, 1977). Paperwork and other data-collection activities have long been perceived as major barriers to effective performance and job satisfaction. However, several authors have noted "new age" changes wherein organizations are undergoing profound technological advancement (e.g., personal computers, lap-top computers, "virtual offices," and palm pilots), resulting in supportive aids for professionals in the field of rehabilitation (Bruyere & Vandergoot, 1982; Clarcq, 1983; Crimando & Sawyer, 1983; Gephart, 2002; Grosick & Greb, 1980; Stensrud & Ashworth, 2002). Professionals are engaging in "telework" to accomplish ever-increasing objectives, while diminishing personal and in-house resources. Both rehabilitation professionals and clients are beneficiaries of the electronic age in the management of a caseload (Sarno & O'Brien, 2002). With the client electronically involved in the rehabilitation process, the caseload manager is freed for more actual counseling/planning . Sarno and O'Brien note that the client has access to (1) all program publications and details regarding eligibility, (2) information about vendors, service options, the rehabilitation process, and agency policies, (3) guidelines on developing effective resumes, and (4) accurate primary and secondary labor market information. All of these facilitate informed choice in the rehabilitation process.

Telephones

Counselors use telephones as an essential means of communication with clients and other professional. However, the use of telephones raises several issues for rehabilitation professionals. Counselors must be cautious in discussing confidential information with anyone over the telephone, as there is no way to be sure who is on the other end of the conversation. Also, there are ways that the telephone conversation may be monitored or intercepted without the counselor or the client's awareness. "Even when you talk to individuals frequently and know their voices well, you still are taking a chance when you assume that you know who you are talking to or that your conversation is private" (Remley & Herlihy, 2005, p. 273). Therefore, rehabilitation professionals must be cautious when referring to confidential information over the telephone, and must also educate staff members in their agencies concerning appropriate telephone usage.

Cellular Telephones

Cellular telephones (i.e., cell phones) operate the same way as telephones connected by wires (land lines), except that the conversations are transmitted via airwaves. As a result of this transmission style, there may be a greater likelihood that an unauthorized person can intercept, accidentally or purposefully, a conversation on a cellular phone. In addition, cellular phones are more mobile than land line phones, making them readily accessible. The wise assumption is that the client is not in a private place and not fully free to discussissues directly related to the rehabilitation plan and/or program.

COMPUTER-BASED TECHNOLOGY

According to Niles and Harris-Bowlsbey (2002), "the sequence of development and use of computer systems from the late 1960s to the present—spanning the generations of the mainframe, minicomputer, and microcomputer—has identified and confirmed the strengths of computer technology related to assisting people in the career planning process" (p. 212). These strengths include (1) test and inventory administration and interpretation, (2) database searches, (3) crosswalking (database interrelating), (4) standard delivery, (5) monitoring progress of the user through vocational planning, (6) delivering instruction, and (7) linking resources. These strengths are important to the field of rehabilitation as the question is no longer whether or not to learn about technological advances, but how to *catch up* with this ever-changing and evolving resource. Certainly, professionals in the field of rehabilitation

will want to maximize their effectiveness by utilizing as many forms of technology as possible. It is also important that counselors become familiar with the ways in which their clients' privacy may be compromised by the use of technology. The recent revised code of ethics for rehabilitation professionals makes it an ethical violation to use technology in an inappropriate manner.

"For rehabilitation counselors, use of computers and access to the Internet are essential tools for assessment, job exploration, resource development, record keeping and communication" (Scherer & Sax, 2004, p. 271). As rehabilitation professionals begin to work with clients in exploring the vast array of resources on the World Wide Web, they reap the benefits of a growing knowledge of online accessibility standards. Mandated by years of disability legislation (The Rehabilitation Act of 1920 [and subsequent amendments]; The Americans with Disabilities Act, 1990; the Assistive Technology Act, 1998; the Individuals with Disabilities Education Act, 2004) technology enhances the abilities of individuals with disabilities, and provides a better means of assisting them to achieve greater levels of independence and employment. The following discussion will address several areas in which technology has impacted the field of rehabilitation, and will provide some brief guidelines for ensuring the privacy of clients.

Where's the Start Button?

Reinforcing the key elements of the manager aspects of a caseload in the electronic age, Brooks, Barrett, and Oehlers (2002) distinguish between information literacy and computer literacy. Information literacy is "defined as the ability to access, evaluate, organize, and use information from a wide variety of sources" (p. 30). The authors of the current text might add to this list the ability to plan, coordinate, direct, and control. The reader should recognize that these concepts fall within the general paradigm of management discussed in chapter 2 of this text. It should be clear by now that the professional who commands high-quality information will be in the best position to provide the highest quality of services.

Brooks and colleagues (2002) call for rehabilitation professionals to be "computer literate." Their definition of the computer literate rehabilitation professional is "one who has acquired the knowledge and experience necessary to utilize computers intelligently and efficiently within his or her discipline" (p. 30). One of the authors of the current text has been engaged in training rehabilitation professionals on the use of the Internet in serving the caseload. At one session, when participants were instructed to "hit the Start button," one participant gazed stupefied at the keyboard and asked, "Where's

the Start button?" Professionals in rehabilitation should be far beyond "the Start button."

Computer Literacy

Computer literacy should be a prerequisite to employment in an agency or organization. The practitioner must have "*found the start button*" before accepting employment. Basic computer skills, other than the operating software used by the agency, are rarely taught to rehabilitation professionals. As was stated in chapter 1, the expectation is that rehabilitation personnel acquire a wide array of skill clusters to be proficient and effective in their practices. Brooks and colleagues (2002, p. 36) describe the rudimentary prerequisite competencies important to the rehabilitation professional:

1. knowing and using basic computer terminology,
2. operating various pieces of hardware and software, particularly the operating system, to handle basic maintenance,
3. being able to connect and operate the computer to access information networks and to read and follow guides and manuals of operation,
4. demonstrating a basic understanding of computer programming syntax,
5. understanding the impact of information on careers, society, their own lives, and the lives of others,
6. continuously improving personal technology skills to be an effective VR professional.

The Value of Computers

Few inventions have received as much attention as the computer. Although the impact of the computer may be argued, it has certainly changed the ways in which we talk, think, and work (Crimando, 1997). Computers and computer software have appeared in literature since the 1980s, and discussions have included their relevance and use in working with rehabilitation clients. There has also been a sequence of studies (Taber & Luzzo, 1999) indicating that the most effective means of providing career planning assistance to clients is by a combination of computer and counseling. These same studies indicate that assistance from computer-based systems provides better outcomes than no assistance at all, but significantly better gains are achieved when counselors can add specific competencies to the overall counseling relationship. Pyle (2001) identifies a list of five necessary counselor competencies

in relation to technology: (1) knowledge of computer-assisted software and websites, (2) ability to diagnose, (3) ability to motivate, (4) ability to help the client process data, and (5) ability to move the client to an action plan. These competencies may be applied in combination with different working models within the rehabilitation service delivery system that combine technology and counselor support.

"In one-to-one counseling plus use of technology, the counselor gives the clients specific assignments to use a computer-assisted system or websites between sessions" (Niles & Harris-Bowlsbey, 2002, p. 219). It is crucial that these assignments be outlined specifically as they will incorporate areas of exploration, personal "homework," and implementation of rehabilitation goals as they directly relate to employment. Patterson, Knauss, Lawton, Raybould, and Oehlers (2002) note that by using directories and locators on the Internet, the rehabilitation professional can enhance development of individualized plans for employment. Electronic applications also have multiple benefits in the rehabilitation process. For example, almost all disability groups have websites or web pages to assist individuals who may be adapting to a recent disability. Also, support groups can assist the rehabilitation professional in providing services for clients' adaptation to their disability.

Even more than twenty years ago, the value of electronic caseload management was recognized. Downing and colleagues (1981) recognized the value of the computer for the rehabilitation professional when they stated, "A counselor is the recipient, processor, interpreter, and dispenser of information. The computer is an excellent filing cabinet, a manipulator, and organizer of information but it cannot interpret or use the information" (p. 47). Thus, the effectiveness of rehabilitation professionals may be linked to their skills in using the computer.

Electronic Mail Communications

Electronic mail is commonly referred to as e-mail. This system is fast becoming the preferred method of communication by individuals who have access to personal computers in their work or home environments. Usually, individuals will use this method to send, receive, or perform work assignments, as e-mail allows them to send and receive messages from their personal computers. "These messages seem secure because a secret password must be used to send or read messages" (Remley & Herlihy, 2005, p. 276). Messages are typed, but written documents, video images, or audio messages may be attached to e-mail messages and sent to another person through the e-mail system. However, the use of the e-mail system may create problems for both

the counselor and the client. Those who use e-mail type their messages, press a button, and then the messages simply disappear. Although it appears that the message is private between the sender and the receiver, in reality there are numerous opportunities for e-mail messages to be intercepted and read by unauthorized users (Remley & Herlihy, 2005).

There are several advantages, as well as disadvantages, of using an electronic mail communication system. A primary advantage is that it is *free* once accessed through an e-mail system and secured through a local subscriber. Also, many employers provide e-mail access to their employees. Other advantages of e-mail include (1) retrieval of messages at a convenient location, (2) lack of interruption by telephone calls, (3) copies of messages are easily printed out to retain for case file documentation, and (4) messages may be returned quickly and efficiently. However, there are disadvantages of e-mail communication when compared to telephone conversations for both the client and the counselor. These include (1) communication is usually one-way, (2) communication is not complete until the recipient actually accesses the message and reads it, (3) messages once sent cannot be retrieved, (4) recipients may misinterpret messages, and (5) messages may be altered before being sent to another person (Remley & Herlihy, 2005).

The primary concern to counselors who use e-mail is that a record exists in the computer for every message that has been sent to the client. Each message is recorded in several computers and may be retrieved by unauthorized users. A message creates a record that is vulnerable to exposure and may be retrieved by individuals who operate the computer system through which the message is being sent. As a result, counselors must be extremely cautious when disclosing confidential information to clients or to other professionals through e-mail communications, and they should warn their clients about the possibility that e-mail messages may be compromised.

Use of the Internet

Hahn & Stout (1994) discuss the Internet as an information superhighway. It may also be identified as a group of worldwide information resources consisting of text, sound, graphics, databases, and software residing on computer networks around the world. They may be accessed through e-mail or by other means. In terms of Internet use in rehabilitation agencies, access is available with special software by anyone with a computer and a connection to the client network.

Recently, Paterson (2000) described how the Internet can be incorporated into each stage of the rehabilitation process. Further, the report in

the 26th Institute on Rehabilitation Issues entitled "Using the Internet as a Resource to the Work of the State VR Counselor" (Dew, McGuire-Kuletz, & Alan, 2002), has sweeping implications for electronic caseload management.

Because of the electronic surge, rehabilitation professionals have far greater control over information flow than ever before (Billingsley, Knauss, & Oehlers, 2002; Brooks et al., 2002; Patterson et al., 2002). Giving added focus to electronic caseload management, Patterson and associates (2002) state that, "all phases of the rehabilitation process, from case-finding to post-employment services" (p.10) are involved in creative and practical applications of professional practice.

One of the most common uses of the Internet in the field of rehabilitation is information retrieval. Three sources of information are bulletin board systems (BBSs), gopher servers, and the World Wide Web (WWW) servers. Each of these systems allows both the client and counselor to access messages, files, and textual information, and conduct searches upon which network links may be obtained related to specific subject areas. However, it is important to note that counselors who send their clients to the Internet for information must understand the nature of the material found there. "Sites on the Internet are not monitored for content or quality. As a result, clients must be cautioned to keep in mind that what they are reading or reviewing may not be accurate or helpful to them" (Remley & Herlihy, 2005, p. 279). In addition, sites that have been reviewed by counselors may have changed by the time clients view them.

SUMMARY

Advances in technology have had a significant impact on the field of rehabilitation. Oehlers and Billingsley (2002) emphasize telecommunications-based approaches and their implications for saving caseload service funds with the reduction of spiraling costs of specialty services. The authors state that their findings "suggest that Internet, telephone, and videoconferencing may be effective and efficient modes of treatment for people with chronic, disabling conditions" (p. 25). Also, the rehabilitation organization itself is strengthened by inclusion of the new technology. Luthans (2002) calls for a proactive, positive approach to emphasizing strengths in organizations rather than attempting to fix weaknesses. Patterson and colleagues (2002) note that with the advent of intranet communication in rehabilitation organizations job satisfaction and counselors' sense of belonging to their agencies is enhanced. Within this latter context, organizations gain with the advent of distance education when counselors spend more time in the office, and clients gain by experiencing more quality time with their counselors (Dew et al., 2002).

Patterson and associates (2002, p. 9) compiled an extensive list of benefits to be drawn from electronic caseload management in the 26th Institute on Rehabilitation Issues 2002. They noted that this list has advantages for counselors, clients, and the rehabilitation organization. A brief scan of the list highlights important issues relative to caseload management:

1. leads to faster communication for counselors, consumers, and VR management,
2. researches employers for counselors and consumers,
3. enhances consumer choice for counselors, consumers, and VR management,
4. provides information on assistive technology devices for counselors, consumers, and VR management,
5. provides information on careers for counselors and consumers,
6. identifies community resources.

This has been a brief excursion into electronic caseload management. The implications of computer technological advances for caseload management purposes are more far reaching and have more depth than can be given in this chapter. The information base, techniques, and technologies continue to emerge as important components in the caseload management process. Driven by client and practitioner involvement, these technologies are paving new roads in this area. As client empowerment and streamlining issues continue to emerge, more advanced technological approaches will become incorporated into rehabilitation caseload management practices. Certainly, service delivery demands and client-informed choice will continue to shape electronic approaches in the field of rehabilitation, and with this technological influence and continued enhancement of rehabilitation, there will be an answer provided for the longstanding question "Caseload management is. . . ."

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