PRINCIPLES AND PRACTICES OF CASE MANAGEMENT IN REHABILITATION COUNSELING

ABOUT THE EDITOR

E. Davis Martin, Jr., Ed.D., C.R.C., N.C.C. is professor, Department of Rehabilitation and Special Education, College of Education, Auburn University, where he serves as the coordinator of the Rehabilitation Counseling Program. He was formerly executive vice president of Sinsabaugh Consulting Services, PC, Richmond, Virginia; emeritus professor of rehabilitation counseling, professor of rehabilitation counseling, interim chairman, and director of clinical practice, Department of Rehabilitation Counseling, Virginia Commonwealth University (VCU); collateral professor of special education, School of Education, VCU; acting dean, School of Community and Public Affairs, VCU; and director of continuing studies, School of Allied Heath Professions, Medical College of Virginia, VCU; and has served in various rehabilitation counseling, supervisory, and administrative positions in the state-federal vocational rehabilitation program. He has served as a fair hearing officer for the Virginia Department of Rehabilitative Services and for the Virginia Department for the Blind and Visually Impaired. Dr. Martin has authored/co-authored/edited five major textbooks and has been a frequent contributor to the rehabilitation literature. He currently serves as the editor of the *Journal of Forensic Vocational Analysis,* a leading journal for the forensic vocational expert. Dr. Martin previously served as a vocational expert for the Office of Hearings and Appeals, Social Security Administration for 25 years and has provided expert testimony in numerous civil suits involving occupational injury, accidental injury, disability retirement, and issues of product liability involving injury. Dr. Martin's primary research interests have focused on advocacy, leadership, inclusion, and empowerment for persons with disabilities. He has consulted with local, state, and federal agencies as well as with organizations in the private sector. Dr. Martin has been repeatedly recognized for his outstanding leadership and service by the receipt of many awards and commendations from professional, governmental, and private agencies including appointment to significant state boards and councils. He served as a member of both the Statewide Independent Living Council and the State Rehabilitation Council, which he chaired, in Virginia, and currently serves on Alabama's State Rehabilitation Council. Dr. Martin is a licensed professional counselor (Virginia), certified rehabilitation provider (Virginia), certified rehabilitation counselor, and national certified counselor and has attained Diplomate status with the American Board of Vocational Experts.

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Edited by

E. DAVIS MARTIN, JR., ED.D., CRC, NCC

Professor of Rehabilitation Counseling
Auburn University

With a Foreword by

PHILIP BROWNING, PH.D.

Wayne T. Smith Distinguished Professor and Head
Department of Rehabilitation and Special Education
Auburn University

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

CONTRIBUTORS

Philip Browning, Ph.D.: Dr. Browning received his B.A. degree in psychology from Howard Payne University in Texas and an M.A. degree from Texas Tech University in counseling psychology with a major in rehabilitation. He earned his Ph.D. degree in 1969 in rehabilitation and special education from the University of Wisconsin and then spent the next 21 years at the University of Oregon. He initiated and directed an interdisciplinary doctoral program in rehabilitation, mental retardation, and research that produced 23 Ph.D. graduates. In addition, at different times, he served as both the training and research director for the national Rehabilitation Research and Training Center in Mental Retardation. In 1989, he joined Auburn University as head of the Department of Rehabilitation and Special Education. Since his arrival at Auburn, he has received several honors, including the College of Education's *Outreach Award* (1994) and *Research Award* (2002), Alabama's *Outstanding Special Educator of the Year Award* (1996), and Auburn University's annual *Excellence in Faculty Outreach Award* (2005). In 2000, he co-founded the Auburn Transition Leadership Institute and became its first director. Dr. Browning, who holds a Wayne T. Smith Distinguished Professorship in Education, was honored in 2003 with the National Council on Rehabilitation Education's *Distinguished Career Award in Rehabilitation Education.*

Rebecca S. Curtis, Ph.D., C.R.C.: Dr. Curtis is assistant professor of rehabilitation counseling, Department of

Rehabilitation and Special Education, Auburn University. She formerly was assistant director in the Andrew Young School of Policy Studies at Georgia State University, Rehabilitation Continuing Education Program for Community Rehabilitation Providers for the Rehabilitation Services Administration, Region IV. She has served as an adjunct faculty member for San Diego State University and the University of North Texas in association with the Consortium for Distance Education in Federal Rehabilitation. Dr. Curtis has served with the Rehabilitation Research and Training Center in Learning Disabilities, University of Georgia/Roosevelt Warm Springs Institute for Rehabilitation and has worked as a behavior specialist at Roosevelt Warm Springs Institute for Rehabilitation and as a psychiatric specialty counselor at the University of Pittsburgh Medical Center, Western Psychiatric Institute and Clinic. Dr. Curtis was a Mary Switzer Memorial Scholar, one of twenty persons from the United States chosen for the twenty-third annual Switzer Memorial Seminar, a think tank on issues in vocational rehabilitation. She is a certified rehabilitation counselor.

J. Chad Duncan, M.S., C.P.O., C.R.C.: Mr. Duncan is coordinator of clinical practice and a doctoral student, Department of Rehabilitation and Special Education, Auburn University. Formerly, Mr. Duncan worked in the field of prosthetics and orthotics, where he distinguished himself as client-focused practitioner. His rehabilitation research interests are in assistive technology, distance education technology, life care planning, and crisis management. Mr. Duncan has presented at many national professional conferences on such topics as the O*NET, ethics and supported employment, assistive technology, and distance education as well as prosthetics and orthotics.

Gerald L. Gandy, Ph.D., C.R.C., N.C.C.: Dr. Gandy is emeritus professor of rehabilitation counseling, Department of Rehabilitation Counseling, Virginia Commonwealth University (VCU). Formerly, he was professor, Department of Rehabilitation Counseling, VCU; president of the faculty, School of Community and Public Affairs, VCU; Director, Rehabilitation Services Education Program, VCU; chief, Counseling and Rehabilitation Services, Veterans Administration Regional Office, Columbia, South Carolina; counselor, University of South Carolina Counseling Center; and captain, United States Army Medical Services Corps. Dr. Gandy has either authored or co-authored/co-edited five major textbooks and contributed numerous articles to the professional literature. He has been active in local, national, and international professional activities and has received various awards and recognition for his service. Dr. Gandy is a licensed professional counselor (Virginia), licensed clinical psychologist (Virginia), certified rehabilitation counselor, and national certified counselor. He is registered with the National Register of Health Service Providers in Psychology and holds the Association of State and Provincial Psychology Boards Certificate of Professional Qualification in Psychology. Dr. Gandy is also a Fellow and Diplomate in Professional Counseling of the International Academy of Behavioral Medicine, Counseling and Psychotherapy.

Richard E. Hardy, Ed.D.: Dr. Hardy is emeritus professor and chair of rehabilitation counseling, Department of Rehabilitation Counseling, Virginia Commonwealth University. Formerly, he was chief psychologist and supervisor of professional training, South Carolina Department of Rehabilitation; rehabilitation advisor with the Rehabilitation Services Administration, Washington, DC; and rehabilitation counselor with the Virginia Commission for the Visually Handicapped. He also served on the South Carolina Board of Examiners of Psychology and taught part-time in the Psychology Department at the University of South Carolina. Dr. Hardy has consulted extensively internationally on mental health and rehabilitation. He has published many books and articles used worldwide, and over 100 reviews of them have been published thus far in professional journals of other countries. Several national organizations have named him a Fellow, and he has received both national and international awards.

George R. Jarrell, Ph.D.: Dr. Jarrell is emeritus professor of rehabilitation counseling, Department of Rehabilitation Counseling, Virginia Commonwealth University (VCU). Formerly, he was professor and coordinator of the Work-Study Program, Department of Rehabilitation Counseling, VCU; assistant dean, School of Community and Public Affairs, VCU; and rehabilitation counselor, South Carolina Department of Vocational Rehabilitation. Dr. Jarrell previously served as vocational expert consultant with the Office of Hearings and Appeals, Social Security Administration. He has written a number of articles on the role of the vocational expert. He is widely known in the legal profession and is frequently asked to lecture on the utilization of vocational experts in personal injury cases. Dr. Jarrell was a licensed professional counselor (Virginia), certified rehabilitation counselor, and national certified counselor.

Karen Rabren, Ph.D.: Dr. Rabren is an associate professor in the Department of Rehabilitation and Special Education and director of the Auburn Transition Leadership Institute, Auburn University. She has devoted most of her career to an area of study known as transition, which focuses on the preparation practices and supports needed for youth and young adults with disabilities. Dr. Rabren's research interests are in postschool outcomes for students with disabilities, secondary curriculum, and transition program development, implementation, and evaluation. Prior to joining Auburn University, Dr. Rabren directed Alabama's five-year systems change grant project in transition. Her university responsibilities include teaching undergraduate and graduate courses in areas of disability, as well as conducting research and training through the Auburn Transition Leadership Institute.

Allison E. Shipp, M.B.A., M.Ed., C.R.C., A.T.P.: Ms. Shipp is assistive technology associate, Program for Students with Disabilities, Auburn University, and doctoral student, Department of Rehabilitation and Special Education, Auburn University. Ms. Shipp coordinates the alternate format services for the Program for Students with Disabilities. She reviews documentation to determine eligibility, supervises workers in the Assistive Technology Lab, and trains college students with disabilities to use assistive technology. Ms. Shipp travels extensively, providing training to other postsecondary disability support services on topics such as accessible Web design, electronic text production, making distance education accessible, producing Nemeth Braille and tactile images, and developing accessible electronic training materials. Ms. Shipp also conducts assistive technology assessments and consultations for primary and secondary school systems.

Larry L. Sinsabaugh, Ph.D., C.R.C.: Dr. Sinsabaugh is chief executive officer of Sinsabaugh Consulting Services, PC, specializing in private sector rehabilitation and forensic practice. Dr. Sinsabaugh has extensive rehabilitation counseling experience in both state (Virginia, Maryland, North Carolina, West Virginia, and Ohio) and federal (Veterans Administration and Department of Labor) rehabilitation programs. He served for many years as an adjunct faculty member, teaching career development, occupational analysis, and placement courses in the Department of Rehabilitation Counseling, Virginia Commonwealth University; and has previously served in various managerial positions in the private sector of rehabilitation. He currently serves as associate editor of the *Journal of Forensic Vocational Analysis,* a leading journal for the forensic vocational practitioner. Dr. Sinsabaugh is member of the board of directors for the American Board of Vocational Experts, where his service has been acknowledged with the receipt of the President's Award twice. He has previously been awarded the Outstanding Rehabilitation Counselor Award from the Virginia Rehabilitation Counseling Association. In addition to Dr. Sinsabaugh's forensic practice, he is an adjunct professor with Bluefield College, and Central Michigan University. Dr. Sinsabaugh is a Licensed Professional Counselor (North Carolina, Virginia, and West Virginia), and a certified professional counselor (Maryland), certified rehabilitation counselor, national certified counselor, certified disability management specialist, certified case manager, and certified employee assistance professional. He has attained Diplomate status with the American Board of Vocational Experts.

Keith C. Wright, M.S.: Mr. Wright is emeritus professor of rehabilitation counseling, Department of Rehabilitation Counseling, Virginia Commonwealth University (VCU). Formerly, he was professor, Department of Rehabilitation Counseling, VCU; research analyst, West Virginia Division of Vocational Rehabilitation; and counselor and research analyst with the United States Public Health Service. Professor Wright served for many years as chair of the Board of Professional Counselors for the Virginia Department of Health Regulatory Boards. He also served as president of the Virginia Rehabilitation Association, president of the Virginia Easter Seals Society, and president of the Faculty of the School of Community and Public Affairs at VCU. He has received many awards and honors for his distinguished community service. Professor Wright has contributed numerous articles and book chapters on a variety of topics to the rehabilitation literature. He previously was a licensed professional counselor (Virginia), certified rehabilitation counselor, and national certified counselor.

FOREWORD

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

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

The year 1970 was a significant year for people with disabilities in that the Developmental Disabilities Act was signed into law and, five years hence, became the "bill of rights" for their integration into our communities. This national declaration set in motion the dismantling of our institutions while building for these individuals a foundation for normalization. Alongside this was the Rehabilitation Act of 1973 that provided them, including those with *severe* limitations, many employment services and civil rights mandates. Within the same time frame, the passage of the All Handicapped Children Act would permanently change this country's educational philosophy, programs, and practices for students with disabilities. The year 1990 was yet another dramatic year in that an amendment to the earlier education act, now known as the Individuals with Disabilities Education Act, provided all students with disabilities equal educational opportunities and the most appropriate services in an inclusive setting with students without disabilities. A final cornerstone was laid that same year with the passage of the Americans with Disabilities Act, which extended the federal civil rights laws that apply to women and minorities to all Americans with disabilities. In the words of President George H. W. Bush, who signed the Act on July 26, 1990, ". . . every man, woman and child with a disability can now pass through once closed doors into a bright new era of equality, independence and freedom." In summary, these five legislative landmarks ensured people with disabilities of the rights and opportunities entitled to all U.S. citizens. They provided a foundation of permanent social change by safeguarding rights to education, to the workplace, and to the community.

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

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

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

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

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

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

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

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

Chapter 2 is a much-welcome addition to the book's second edition. Both education and rehabilitation legislation recognize the nature and importance of the transition-age group, which represents some 2 million students with disabilities between the ages of 14 and 22. In 1984, Madeleine Will, then assistant secretary of the U.S. Department of Education, set in congressional motion transition from school-to-work as a national priority. While in office, she wrote the "bridges model," in which she identified three optional bridges for the successful crossing from school to adult roles. Of these, Bridge Two requires "time-limited services" that lead to eventual employment, and partners rehabilitation counseling services with the educational system. Interestingly, the idea for this partnership is over forty years old. In the 1962 National Action to Combat Mental Retardation Report prepared for President John F. Kennedy, one of the recommendations was: "It is clear that the first line of attack is through the educational system, and that vocational rehabilitation for the mentally retarded must be coordinated with our secondary education system" (p. 125). Rehabilitation must have a partnership role with education to provide time-limited services to assist many of our nation's youth with disabilities in becoming responsible and productive citizens.

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

I suspect that the readers of this book are rehabilitation counselors in-the-making. Therefore, they should find Chapter 4 to be especially germane to their career aspirations. While counselors are at the heart of the rehabilitation profession, it is important to note that they represent more than just service providers who simply assist people with disabilities to enter, or re-enter, the world of work. In essence, they manifest a belief in the spirit of the human being, a value in their independence, and a commitment to the ideals of inclusion in all walks of life. While best practices are the tools to be applied in our rehabilitation practice, best values should serve as a decision-making foundation for their application as discussed in Chapter 7. The values of *independence* (having choice and control of one's life), *productivity* (working in the primary labor market), and *inclusion* (to live, work, and play in one's community of choice) drive the ideals of rehabilitation counseling and that of its practitioners. It is through this legislative, philosophical, and best practices window that the counselor must be prepared to assist persons with disabilities toward a more complete and satisfying life. The counseling itself is expressed in the dialogue between the client and counselor, in the trust that emerges from the relationship formed between the rehabilitation counselor and client, and in the nonintrusive manner in which men, women, and youth learn to become independent, self-sustaining members of our American democratic society.

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

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

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

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

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

PHILIP BROWNING, PH.D.
Wayne T. Smith Distinguished Professor and
Head Department of Rehabilitation and Special Education
Auburn University

REFERENCES

Parent, W. S. (1993). Quality of life and consumer choice. In P. Wehman (Ed.), *The ADA mandate for social change* (pp. 19–44), Baltimore: Paul H. Brookes.

Report to the President. (1962). *A proposed program for national action to combat mental retardation.* Washington, DC: The President's Panel on Mental Retardation. Author.

PREFACE

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

The new *Principles and Practices of Case Management in Rehabilitation Counseling* contains some material from the previous edition, although new material regarding the vocational rehabilitation process is reflected in the various chapters in Parts 1 and 2 of the text relative to transition, adaptation to disability, vocational evaluation, assistive technology, and ethics. Within this edition, the reader will find significant updating of original material and expansion and reorganization of material related to service priority and legislation, the rehabilitation process, and career and occupational information. Part 3 of the text contains thirteen case situations, although not exhaustive of all disabilities, they are, however, representative of major disabilities. The case studies in this section of the text are composites of various individuals representing reality concerning the challenging circumstances that people with disabilities, family members, and others close to the person with a disability confront daily.

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

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

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

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

Special recognition and appreciation are extended to my colleagues at Auburn University, particularly to Dr. Phil Browning, Wayne T. Smith Distinguished Professor and head of the Department of Rehabilitation and Special Education, for his support of this project and his insightful foreword, and especially to Dr. Becky Curtis, Dr. Karen Rabren, Ms. Allison Shipp, and Mr. Chad Duncan for their participation and involvement in the development of this edition of the text. Drs. Rabren and Curtis' chapter on the partnership between special education and vocational rehabilitation regarding the transition of youth with disabilities from the secondary school system is particularly relevant and timely given the emphasis placed on this group within current federal legislation. Dr. Curtis provides an insightful perspective on the nature of values in the chapter on ethics she coauthored. Ms. Shipp provides a very useful and insightful perspective on assistive technology in the chapter focusing on disability assessment. Ms. Shipp and Mr. Duncan each provide a narrative approach to case resolution and a sample case resolution that are highly instructive and illustrative for use by readers and students.

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

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War Eagle!

E. DAVIS MARTIN, JR.
Auburn, Alabama

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Chapter 1

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

E. DAVIS MARTIN, JR.

Disabilities that are regarded as significant have been given increasingly greater emphasis since the passage of the historic 1973 Rehabilitation Act and, in fact, selection priority in the delivery of vocational rehabilitation services. The Rehabilitation Act amendments in 1992 and 1998 have continued and expanded this mandated priority. Programs and activities created by these legislative events have moved the delivery systems toward a client or consumer perspective with greater control vested in the person with a disability regarding choice. The Americans with Disabilities Act (ADA), for instance, mandated that educators, employers, businesses, and governmental agencies were to provide goods and services to persons with disabilities from a posture of anti-discrimination. The major difference articulated in the ADA when compared to Section 504 of the 1973 Rehabilitation Act is its effect on the private sector of the economy. Similarly, the education of children and youth with disabilities has moved from segregated self-contained classrooms to mainstreaming to full inclusion through passage of P.L. 94–142 to the now entitled Individuals with Disabilities Education Improvement Act (IDEA 2004). IDEA 2004, for example, calls for greater coordination in the transition of youth with disabilities from secondary schools to that of further education or work through a partnership with vocational rehabilitation for those students who meet the vocational rehabilitation agency's eligibility criteria (note Chapter 2 for a detailed discussion of transition programming and vocational rehabilitation).

The purpose of this chapter will be to review the historic legislative events that originated during the 1970s, most notably the 1973 Rehabilitation Act and its subsequent amendments, denoting the changes over the course of the past three decades. The human service delivery systems, principally the vocational rehabilitation program and the public educational systems that were mandated to provide services as a result of these legislative events, will be analyzed from the perspective of the consumer of those services. The decade of the 1970s produced three of the most significant legislative accomplishments of the twentieth century: the Developmental Disabilities Services and Facilities Construction Act (P.L. 91–517), the Rehabilitation Act of 1973 (P.L. 93–112); and the Education for All Handicapped Children Act (P.L. 94–142). Each of these legislative events and subsequent amendments continuing to the present represented a paradigm shift that signaled an increased voice and influence for persons with disabilities regarding vocational, educational, and independent living choices.

Developmental Disabilities Legislation

With the passage of P.L. 91–517, the Developmental Disabilities Services and Construction Act of 1970, the term *developmental disability* first came into use (Kiernan & Schalock, 1995). The term *developmental disability* was defined to include the following specific disabilities: mental retardation, epilepsy, and cerebral palsy. Onset of the developmental disability was to have occurred at birth, or prior to age eighteen, and have imposed severe limitation in the child's or person's ability to function. The act established a formula grant program in which the states were encouraged to develop coordinated services for persons labeled as having a developmental disability. Braddock, Hemp, Parish, and Westrich (1998) noted that the ". . . states were required to establish interagency councils representing numerous state government agencies relevant to the delivery of developmental disabilities services . . . [that would develop] . . . every three years . . . formal state plans to set goals and improve the delivery of services" (p. 7).

In 1975, amendments to the Developmental Disabilities Services and Construction Act re-titled the act as the Developmental Disabilities Assistance and Bill of Rights Act (P.L. 94–103). Categorical groupings of disabilities were maintained and the disabilities of autism and dyslexia (with some qualifications) were added. The 1975 amendments also specified essential services that should be available as basic rights to persons defined as having a developmental disability. Those services specified, among others, were residential services, employment services, treatment, transportation, and leisure services. These services were considered to be basic rights. These amendments were greatly influenced by ". . . a series of class-action law suits in which the courts ruled that the mentally retarded [*sic*] in institutions had constitutional rights to treatment, services, and habilitation that 'maximize the developmental potential of the person and are provided in the setting that is least restrictive of the person's personal liberty'" (Berkowitz, 1987, p. 207). Most notable of these class-action suits were *Wyatt v. Stickney* (344 F. Supp. 378, M.D., Alabama, 1972) and *New York State ARC v. Rockefeller* (357 F. Supp. 752, 1973), often referred to as the *Willowbrook* case.

The 1978 amendments, now titled as the Rehabilitation, Comprehensive Services, and Developmental Disabilities Act (P.L. 95–602), broadened the definition of developmental disability from the existing categorical basis to a functional basis; that is, a definition that no longer specifically denoted a particular mental or physical condition, e.g., mental retardation and epilepsy, but a chronic and lifelong mental or physical condition that impeded substantial functional limitations in the performance of major life activities. Of the seven characterized major life activities, at least three must present substantial limitations to the person:

1. Self-care
2. Receptive and expressive language
3. Learning
4. Mobility
5. Self-direction
6. Capacity for independent living
7. Economic self-sufficiency

Braddock et al. (1998) moreover, reported that the 1978 amendments established the Protection and Advocacy Program ". . . thus completing the triad of Developmental Disabilities Act funded organ-