1995

Caseload management: An annotated bibliography for rehabilitation counselors

Geraldine Peggy McKay

CASELOAD MANAGEMENT: AN ANNOTATED BIBLIOGRAPHY FOR REHABILITATION COUNSELORS

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Masters of Arts

in

Rehabilitation Counseling

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ABSTRACT

Caseloads are a very important issue in the work place today. This project looks into caseload management as it applies to the rehabilitation counselor. The caseload managers perform many job functions. The project will explore such areas as the definition of caseload management, maintenance of caseload management, burnout regarding caseload management and different types of clients regarding caseloads. Levels of staffing for various types of caseloads for clients are variable, and even at best, hinder counselors in delivering the recommended standard of caseload management for many types of clients.

ACKNOWLEDGMENTS

I would like to thank both Dr. Joseph Turpin and Dr. Thomas Gehring for all of their invaluable assistance in the preparation of this research project.

Most of all I would like to thank my family for all of the love and support that they gave me continuously while I studied to obtain my masters degree.

I am sending a special thanks to all of my friends, classmates and peers who always had encouraging words for me and who gave me the strength to go on.

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DEFINITIONS OF CASELOAD MANAGEMENT

For this study the following definitions apply:

ADJUSTMENTS - to settle rightly, adaptation.

ANTECEDENTS - going before, prior; preceding.

ARTICULATION - pronounced distinctly; expressed clearly.

BASELINE - specified quantity used as a point of reference.

BELIEF - conviction that certain things are true. Alleged facts, on the grounds of evidence.

CASE MANAGEMENT - methodology based in professional training, knowledge and skills.

COUNSELOR - one who gives advice.

DISABLED - to make incapable of physically unfit. To deprive of competent strength or power.

DRUG ABUSE - learned deviant behavior resulting primarily from environmental influences.

FRAGILE - brittle; easily broken.

GENERALIZATION - a broad or general concept.

HANDICAP - the actual obstacles the person encounters in the pursuit of goals in real life. The disadvantage or advantages.

HANDICAPPED - persons who have functional limitations from a disability. Physical or mental disadvantage.

LANGUAGE - any means of communication.

LOCUS - a place; locality.

MULTIDISCIPLINARY - a variety of fields of study.

POPULATION - all of the people inhabiting a specified area.

REHABILITATION - to bring or restore to a state of health or constructive activity.

INTRODUCTION

Caseload management is very different than the recently popularized term case management. 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 decision making for functional control of self, client, setting and other relevant related factors for anchoring a proactive practice. In caseload management the rehabilitation counselor should be able to manage all aspects of his caseload. However, without the perspective and skills founded in effective caseload management practices overall competency will elude the counselor (Roessler, 1982).

Success for effective caseload management guided this writer's efforts in completing this project. It is perceived that the findings and recommendations of this project will be of some value to the many rehabilitation counselors as it pertains to the management of their caseloads. This writer saw caseload management as an area that needed further research and exploration. As more and more studies of caseload management are being carried out more definitive conclusions can be made.

Anglin, Linda T., (1990) Caseload Management. A model for agencies and staff nurses. Home Healthcare Nurse, 10, 26-31.

MAINTENANCE OF CASELOAD MANAGEMENT

The key to having effective caseloads is caseload management. Roessler (1982) stated that

> Caseload management is a systematic process merging counseling and managerial concepts and skills through application of techniques from intuitive and researched methods, there by advancing efficient and effective decision making for functional control of self, client, setting, and other relevant related factors for anchoring a proactive practice.

To be an effective counselor the rehabilitation counselor should be able to manage clients within a given amount of time and then to be able to provide optimum service to the clients. This concept also includes being able to prioritize the sequence of service that is delivered to be within the framework of the agency's philosophy. The goal is therefore to be able to work with the client so that the client is able to achieve independence in the most effective way.

Anglin stated that there are six steps involved in the process of maintaining caseload management, The six-step process includes:

1. Clarifying the agency philosophy

2. Planning
3. Prioritizing the caseload
4. Selecting an approach
5. Monitoring services
6. Evaluating the results

One example of this six-step process can be illustrated by nurses who work in home healthcare. The first step in this process would be to provide the nurses that are working in an agency a clear understanding of the philosophy of the agency. Whether the agency is voluntary, public proprietary, or not-for-profit, a careful explanation of the agency's philosophy early in the employee orientation process is important to gain a philosophical commitment of the nurse to agency goals. The second step in the process is to guide nurses through at least one planning simulation that allows for questions and help in identifying common concerns when actual visits are made. The third step estimates the desirability of the service and whether it could be adequately provided for the needs of clients. The fourth step focuses on selecting an approach by determining the time available and services offered. The fifth step is to monitor services and resources. The last step selects the cases and activities necessary by consulting with staff and administrators before final decisions or evaluations were made. This process is a loop; even though it ends with evaluations, the process is continuous and requires

monitoring to establish continued effectiveness.

Caseload management is very useful but is often overlooked. Travel time is the most costly, however, telephone time, documentation, actual home visits, and scheduling time are often overlooked in the evaluation process. Industry has always analyzed these costs very carefully. However, in home care, the total expenses for these items may be identified and presented as part of the cost per visit to be helpful to the nurse in caseload management. The nurse makes five or six home visits per day. The home visits are recommended to last at least 45 minutes for each visit. The time spent carefully planning the home visit is often omitted. Nurses were informed about the current reimbursement rate and also knew the costs of some of the items of a visit. For example, this included their hourly salary, mileage and medicare reimbursement, and what charges they submitted for each visit. They were unable to identify accurately planning time or record keeping time.

Another area that is under used is the home visit plan. The time needed to carefully plan a production, a home visit of 45 minutes, is not taken and this may result in additional visits, the need for longer interventions, more frequent supervision, increased calls by the clients, or ineffective use of nurse time. To enhance caseload management by nurses, a review of the essential concepts

necessary for a successful home visit may be helpful, including a written plan for the nurse who is new to home care. The steps in developing a contract with the client could be included in this plan. Again, many home health care nurses lack the community health concepts on contracting, which have been proved successful in community health nursing, mental health nursing, and other areas of nursing practice. A workshop on critical features of a contract would give the nurses additional skills in delivering a more effective home visit.

Dipcot, S., Dipcot, J., (1989) A method of caseload management. British Journal of Occupational Therapy. 52, 380-383.

MAINTENANCE OF CASELOAD MANAGEMENT

This article by Dipcot and Dipcot outlines a caseload management system which they developed and introduced for trained staff in the occupational therapy department of King's College Hospital in South East London. The purposes of this article, which have proved effective in monitoring referrals to the department and staff caseloads, aim to avoid stress on staff and helps to ensure a quality service for those patients receiving occupational therapy.

In the system design, the information on caseload numbers was being collected for Korner statistics, but it does not give an immediate picture of the weight of a therapist caseload. Realizing this, the following guidelines were established for the grouping of the authors' patients. In order to give an idea of the amount of input required, a weighting system or score of the patients currently being seen was used. (see Table 1)

Straight forward patients who only needed minimal input would be graded as a 1. Patients needing short term rehabilitation with no complications would be graded as a 2, and the heavier, more complicated patients needing daily input would be graded as a 3.

Table 1. Guidelines on Grouping of Patients

Type of Case/Input Required	Group
• Orthopaedic inpatients, for example, fractured neck or femur • Heart and chest (medical) • One-off assessments which may include a home visit but not treatment implications • One or two sessions + home visit • Simple splints (1-2 sessions)	1
• Short-term rehabilitation, for example, amputees • A set period of time • Reasonably straight forward • No complications • Orthopaedics (frail/confused) • Minor strokes - making quick recovery	2
• Strokes (dense) • Head injuries • Neurological conditions - advanced, for example, multiple sclerosis • Complicated cases • Need daily input • Intensive rehabilitation • Multiple diagnosis	3

A sample data collection sheet was deigned for therapists to record the weight of their caseload, which would be collected on the same day of each week. (see Table 2) The grouping scores would be added to give a total score of the weight of their caseload. A column was included to give a 3 point pressure of work score:

1. One point if the therapist feels underworked.
2. Two points if the therapist feels they have an adequate manageable caseload.
3. Three points if the therapist feels overworked and stressed.

A final column was included to record details affecting pressure of work score because it was realized that many other factors affect the therapist size of caseload and feelings of pressure. A newly qualified occupational therapist cannot be expected to take on as much work and responsibility as an experienced senior occupational therapist.

The head or senior clinical occupational therapist with management duties will have a number of staff to supervise, teaching commitments to fulfill, meetings to attend and more administration tasks to perform. Therefore, having all of these responsibilities has an effect on the senior therapist.

The monitoring method stated the therapists keep their own sheets and every Thursday each therapist recorded the

Data collection sheet (example from a newly qualified basic grade occupational therapist)

Name of occupational therapist: ..... MSB..... Grade: .....Basic grade.....
To be completed on Thursday of each week.

Date	Current caseload groupings	Total	Pressure of work score *	Other relevant factors for score
25.8.88	1, 1, 1, 1, 2	6	2	First week's work after qualifying in July
1.9.88	1, 2, 1, 1, 2, 1	8	2	Still settling into routines and learning procedures
8.9.88	1, 1, 2, 2, 1, 1, 3	11	2	Building up caseload, off sick one day
15.9.88	1, 2, 2, 2, 1, 3, 1	12	2	Caseload growing, more written reports needed and liaising with other staff
22.9.88	1, 2, 2, 1, 3, 1, 3, 3	16	2	More complex cases, more need for good time management
29.9.88	2, 2, 3, 3, 3, 2, 3, 1, 1	20	3	Senior occupational therapist on leave, complicated caseload
6.10.88	3, 3, 2, 1, 1, 1, 2, 2	15	2	Senior back from leave

Table 2.

caseload held on that day. They decided which grouping the individual patients were placed into. The grouping scores were totaled, a pressure of work score was noted and supporting comments were written.

With all qualified staff keeping weekly records of the weightings of their caseloads and their pressure of work or stress levels, it was envisaged that a cut off point could be estimated for each grade of therapist's caseload. For example, a senior occupational therapist may have an adequate caseload when the total weighting comes to 20 points, and should not take on a new patient until the weighting has dropped. Over time, it is envisaged that this system could be used to determined staffing levels.

This system, which had been developed to manage and monitor the caseload in a general physical department, has proved to be valuable and should continue to be used in the future. The principal of grouping patients according to how much input is required and the complexity of the case could easily be applied to other specialties, especially those working with patients on an individual basis.

Brennan, J., Kaplan, C., (1993) Setting new standard for social case management. Hospital and Community Psychiatry. 44, 219-222.

CASELOAD MANAGEMENT IN SOCIAL WORK

The roots of case management lie in the early days of social casework and public health nursing. In 1863, the Massachusetts Board of Charities established a program to coordinate public services and conserve public funds. Traditional social case workers maintained a dual focus on the client and the social environment. They worked both directly with clients and their families who needed social services and indirectly on their behalf.

The use of case management as a method of coordinating services grew during the 1940s as part of workers' compensation programs that focused on rehabilitations. With the rapid expansion of social programs in the 1960s, coordination of services for individual clients became increasingly necessary as well as more complex. There were a number of demonstration programs in service. Coordinations were established by the federal government in the early 1970s with significant success reported.

Based on the results of these programs, case management and service coordination programs have been included in federal statutes such as the Education for All Handicapped Children Act and the Older Americans Act and the subsequent reauthorizations. Recent demonstrations funded by the

Health Resources and Services Administration have shown the efficacy of employing case management in the delivery of services to person with HIV disease.

The primary goal of case management is to optimize client functioning by providing high-quality services in the most efficient and effective manner to individuals with multiple complex needs. Case management is a methodology based in professional training, knowledge and skills used to attain treatment or service goals established in conjunction with the client. These goals include enhancing the problem-solving and coping capacities of clients and improving the delivery system and social policy.

At the client level, case management begins once the client has been identified and asked for services. The social work case manager conducts a face to face assessment of the client. This assessment includes the client strength and limitations and the social, financial and institutional resources that are available to focus on the essential problems identified in the assessment. On the basis of the assessment, the case manager works with the client to develop an individualized service plan that identifies priorities, desired outcomes, strategies and resources to be used in attaining the outcomes.

To address issues for the social work profession, the National Association for Social Workers (NASW), formed a case management work group in the spring of 1991. This

group consisted of 11 expert practitioners and administrators representing diverse areas of social work practice including mental health, health, social services, aging, education, and substance abuse. The group was charged with reviewing the professional's existing standards and guidelines for social work case management for the functionally impaired and to develop a recommend up-to-date standards for the profession.

The work group's final recommendations were approved by the NASW board of directors in June 1992. The ten new standards for social work case management, replacing the previous standards, are as follows:

Standard 1: Qualifications. The first standard defines the qualified social work case manager as one who has a baccalaureate or graduate degree in social work.

Standard 2: Primacy of client interest. The primary responsibility of the social work case manager is to serve the client.

Standard 3: Client self-determination. The social work case manager should ensure that clients are involved in all phases of case management practice to the greatest extent possible.

Standard 4: Confidentiality. The fourth standard addressed the case manager's responsibility to ensure the client's right of privacy.

Standard 5: Client-level intervention. This standard outlines the responsibility of the social work case manager in providing and coordinating the delivery of direct services to clients and their families.

Standard 6: System-level intervention. The social work case manager is responsible for intervening at the service system level to support existing case management services.

Standard 7: Fiscal responsibility. This standard confirms the case manager's responsibility to be knowledgeable about resource availability, service costs, and budgetary parameters.

Standard 8: Quality assurance. The case manager and the agency administration are responsible for monitoring the appropriateness and effectiveness of the service delivery system and the case manager's own services.

Standard 9: Caseload. This standard discusses the need to establish reasonable caseloads that allow the case manager to effectively plan, provide, and evaluate case management services related to client and system interventions.

Standard 10: Professional cooperation. in recognition of the interdisciplinary and interagency nature of case management, the final standard calls on social work case managers to treat colleagues with courtesy and

respect and to strive to enhance interprofessional and interagency cooperation on behalf of the client.

The development of the NASW standards for social case work management reaffirms the role of social workers as key providers of case management services. The application of standards by individual providers, agencies, policy makers, and insurers will provide a basis for the development of outcome measures and realistic quality assurance programs. In turn, those developments will help assure consistent and appropriate services for clients receiving case management services.

Raguepaw, J. and Miller, R. (1989) Psychotherapist burnout: A componential analysis. American Psychological Association. 20, 32-36.

BURNOUT

Another important aspect to a caseload is its size. If there are too many caseloads, this can result in burnout. Burnout is a syndrome of emotional exhaustion and cynicism that frequently occurs among individuals who work directly with people (Miller & Raquepaw 1989). It can be the result of constant or repeated emotional pressure from intense involvement with people over long periods of time. Victims of burnout lose their idealism, energy and purpose. Although burnout is possible in many professions human service professionals may be at a particular risk. In such settings burnout involves a loss of concern and a loss of positive feelings for one's clients and consequently a decline in the quality of service that clients receive. The person who experiences burnout may develop low morale, exhibit poor job performance and absenteeism, and eventually change jobs.

Physiologically, burnout is no small matter. Its symptoms have been well documented and include constant fatigue, insomnia, frustration, and depression. The Maslach Burnout Inventory (MBI) is a frequently used measure of the burnout syndrome (Miller & Raquepaw, 1989). The MBI consists of three subscales for measuring separate aspects

of burnout. The emotional exhaustion subscale concerns feelings of being emotionally drained. As emotional energies are depleted, people are no longer able to give themselves fully as they once did. The depersonalization subscale deals with the development of negative, cynical attitudes and feelings toward people with whom one works. Lastly, the personal accomplishment subscale concerns feelings of competence and success in working with people. When people feel they are no longer accomplishing what they want or making a meaningful contribution through their work, they evaluate themselves negatively. (see Table 3) Higher scores on the emotional exhaustion and depersonalization subscales and lower scores on the personal accomplishment subscale reflect a higher degree of burnout (Miller & Raquepaw, 1989).

In a study conducted by Miller & Raquepaw (1989), a random sample of 68 practicing psychotherapists in Texas completed surveys that included the MBI, demographic questions designed to assess their intent to leave the profession, their treatment orientation, and their perceived ideal caseload. The results indicated that demographic variables and treatment orientation were not accurate predictors of therapists' burnout. However, it was found that psychotherapists who worked for agencies had more symptoms of burnout than their colleagues who worked solely in private practice. The therapists' actual caseload was

Table 3.

Maslach Burnout Inventory Norms and Burnout

Subscale	Moderate burnout range[a]	Scores	
		M	*SD*
Emotional Exhaustion			
Frequency	18–29	18.5	8.9
Intensity	26–39	28.0	11.0
Depersonalization			
Frequency	6–11	5.5	4.5
Intensity	7–14	7.9	6.1
Personal Accomplishment[b]			
Frequency	39–34	42.9	3.7
Intensity	43–37	43.4	5.1

not associated with burnout, but satisfactions with their caseload was. The therapists who indicated their ideal caseload would be smaller than their current caseload were more burned out than those who were satisfied with their caseload. In addition, burnout was predictive of the therapists' reported intentions to leave psychotherapy for other professions.

Studies in which researchers assess the effectiveness of interventions designed to prevent or reduce are still badly needed, but there may be several things that over-burdened psychotherapists can do to improve their situations. At the individual level, expressing one's feelings about his job and obtaining a social support system may lead to a reduction in feeling of burnout. Suggestions for dealing with burnout are to engage in physical exercise, take regular vacations, take breaks on the job, proper diet and to be able to separate their work life from their private life.

In addition, because burnout is more likely among those who work for agencies, interventions at the institution level may be particularly important. Decreasing time spent on paperwork and administrative duties may minimize the risk of burnout. Other suggestions include shortening work hours, allowing time-outs during the workday and changing the function of staff meeting from a setting in which to simply discuss clients and get support. Another important

issue is to improve work relations between staff members and to create a good social support system which may reduce the risk of burnout. The differences in practitioner burnout observed in this study deserve further investigation.

Shefler, G. and Greenber, D. (1991). Improving case management and caseload management at a community mental health center. Hospital and Community Psychiatry. 42, 748-750.

COMMUNITY MENTAL HEALTH CENTERS

In recent years the number of psychiatric hospital beds has continued to decline, while the number of referrals to community mental health centers (CMHC) has grown. Increased public awareness of the availability of psychotherapy and a willingness to seek help have also resulted in a greater variety of referrals to the centers. Patients now seen at CMHCs present a broad spectrum of psychological problems, including acute and chronic psychotic disorders, personality disorders, adjustment disorders, and neurotic disorders. Traditional psychodynamic therapy is appropriate only for a minority of these patients. Most are in need of medication, rehabilitation crisis intervention, or other brief, focused interventions.

These kinds of services required have placed new demands on CMHC professionals. The CMHC must often interact with other professionals and agencies, such as family practitioners, social services, insurance agencies, and the courts, acting as the patient's advocate and providing clinical assessments and reports. Faced with these new and increased responsibilities, CMHC professionals may feel inadequately trained, overworked, and unfulfilled. Symptoms

of fatigue, irritability, and an inability to enjoy one's work have been associated with burnout and have been noted particularly among CMHC professionals.

These changes also place demands on CMHC administrators, who must ensure not only that new and increased services are available, but also that they are delivered to people who need them. Because of their larger and more problematic caseloads, CMHC professionals require more administrative support and greater supervision. Effective administrative methods are needed to facilitate the operation of the CMHC under these changing conditions at the Ezrat Nashim CMHC. Administrative changes occurred over a four year period. They are presented here in 5 phases.

Phase 1: Service availability. The administrative changes began with an effort to improve the availability of services. The center established a daily walk-in clinic during which CMHC professional performed immediate initial interviews.

Phase 2: Standardization of information. To standarize the information obtained during the initial interview, a questionnaire was devised with three sections. The first section, completed by the patient, elicited demographic data. In the second section the interviewer summarized the presenting complaint, developmental history, and mental health status and presented a brief formulation. The third section

included the diagnosis, the levels of functioning, and the selected therapy and therapist.

Phase 3: Increasing efficiency. Instead of daily clinics, two mornings each week were set aside for walk-in clinics. The benefits of these changes were clear: since only two mornings a week were devoted to initial interviews, professional were better able to use their time.

Phase 4: Shared decision making. While some professionals doggedly accepted each new case assigned to them, the caseloads of other professionals were inexplicably always full. This created tension within the teams. An administrative solution was needed.

Phase 5: Caseload administration. These statistics provide important documentation requested for additional staff and funds.

These phases are the administrative changes that occurred over four years. The developments were in chronological order describing the new problems and solutions that emerged at each phase.

Some effective administrative solutions for the rising number of CMHC referrals were discussed. CMHC professional need increased administrative support and supervision in order to manage heavy caseloads and treat difficult cases. At CMHCs a team approach to problem solving has contributed to a general sense of coping, engendered mutual support, and

the sharing of difficult clinical problems. CMHC professional indeed have a demanding job to perform.

Kantorowski, Laura, (1992). Issues of early professionals in counseling psychology: Community mental health centers. The Counseling Psychologists, 20, 61-66.

COMMUNITY MENTAL HEALTH CENTERS

An adequate example of mentally disabled client caseloads are in community mental health centers (CMHC). A counseling psychologist faces many challenges when choosing to work in the CMHC setting. During the early 1960s CMHCs were deinstitutionalized (Kantrowski 1992). This happened because of the cost of long-term hospitalization. As a result, there were thousands of patients released back into society from these institutions. During this time the drug thorazine had been researched and was thought to be a wonder drug for mentally ill people. By using this drug with the clients they would no longer require 24 hour supervision. Kantrowski stated that the Short Doyle Act (Barten & Bellak 1972) legislated the means to care for the previously incarcerated in the least restrictive way. Psychologists gathered together to focus on helping the previously incarcerated and to formulate a theory of community psychology. There were centers set up for patients. Funding was available for social service programs. Sliding scale fee systems allowed fundless patients to receive the help they needed.

Within the agency, morale was exceedingly low. There was no money for pay raises, and the decision had been made

to decrease the work from 40 to 36 hours per week. Kantorowski stated no work reductions were put into action. Passive aggressive behavior seemed to be the coping strategy of choice.

The role of the practicing psychologist in the agency became limited. assessment was a particularly useful skill. Crises intervention skills were used. Any developmental issues were not seen as critical and were therefore relegated to waiting-list status. Clients were only the indigent poor. Treatment became impossible and case management became reality. The major psychological skill was survival.

Satcher, J. and Dooley-Dickey, K. (1990). Rehabilitation counselor selections of service options for persons with learning disabilities. Journal of Applied Rehabilitation Counseling. 22, 34-36.

THE LEARNING DISABLED CLIENT

This study investigated how general caseload carrying rehabilitation counselors and counselor supervisors would rate the appropriateness of selected service categories when presented with a description of a client as a learning disabled. Satcher and Dooley-Dickey stated that specific learning disability (SLD) represents a relatively new disability category served by vocational rehabilitation. In 1981, the Rehabilitation Services Administration (RSA) determined that persons with learning disabilities could be determined eligible for vocational rehabilitation assistance solely on the basis of their learning disability.

Since the inclusion of specific learning disability as a disability category, increasing numbers of individuals with learning disabilities have been served by vocational rehabilitation, with on the job training and vocational training being the service option most frequently provided. One service option for persons with learning disabilities that has received little attention in the rehabilitation literature is college training.

Section 504 of the Vocational Rehabilitation Ace of 1973 prohibited agencies and institutions receiving federal

funds from discriminating against persons with disabilities in the provision of services. The colleges and universities must provide services for students with learning disabilities who are otherwise qualified. To meet this requirement, many colleges and universities have developed special programs for students with learning disabilities while others have provided accommodations to facilitate the success of these students in higher education settings.

Rehabilitation counselors and counselor supervisors are often not aware of services and accommodations available for students with learning disabilities in higher education settings. Without proper knowledge of these services and accommodations, rehabilitation counselors and counselor supervisors may be reluctant to assist persons with learning disabilities to attend college. They may fear that the student will not be provided with the support necessary to succeed in a college setting.

The literature indicated that a growing number of persons with learning disabilities are seeking services from vocational rehabilitation agencies. If members of this population are to achieve their full vocational potential, stereotypical attitudes toward this group need to be addressed. However, further research is needed to investigate attitudes toward persons with learning disabilities and the impact of these attitudes as determinants of case services for this population.

American Speech-Language-Hearing Association (1993). Guideline for caseload size and speech language service delivery in the schools. ASHA, 35, 33-39.

SENSORY DISABLED CASELOADS

The sensory disabled caseload is the guideline for caseload size and speech-language service delivery in the schools. Caseload issues are one of the major ongoing concerns of speech-language pathologists across the country. There is a continuing concern over caseload issues fueled by conditions that are prevalent across the country. In spite of shortages of qualified personnel, school speech language pathologists serve high numbers of students while faced with budget constraints and cuts that expand their work responsibilities and paperwork demands.

Nationwide speech-language pathologists provide services for almost 25% of school aged children who are eligible under part B of the Individual with Disabilities Education Act (IDEA) and chapter I of the Elementary and Secondary Education Act which is a State operated program. Speech-language pathologists also provide related services to an estimated 50% of other children with disabilities. Overall, speech language pathologists serve more than two million school aged children in addition to many of the half million pre-schoolers who are eligible for speech language services.

The purpose of this particular article is to provide

guidelines for caseload size and to assist the speech language pathologist in determining which service delivery model best meets the needs of eligible students. The speech-language pathologist is the professional primarily responsible for the speech-language programs for pre-schoolers and students with communications disorders. This includes evaluation of all pre-schoolers and students with suspected or identified communication disorders and the development, management, and coordination of a speech-language program. The speech-language pathologist has the expertise to make decisions regarding the student's communication program, but may not be the person to make all the decisions. Decisions regarding a student are based on the multidisciplinary team's evaluations. Speech-language pathologists are required to perform duties other than direct services that are essential to the appropriate management of each student. These duties may include, but are not limited to the following: (see Table 4)

Each student added to the caseload increases the amount of time needed not only for diagnosis and service, but also for paperwork. Forms for multidisciplinary conferences and parent and teacher contact are other responsibilities. Multiplying the number of students on the speech-language caseload by the number of forms that must be completed per student and the number of meetings that must be attended gives an initial indication of the workload. The number of

Table 4

Roles and Responsibilities Affecting Caseload Contact Time
• Conducting speech-language-hearing screenings
• Writing reports
• Participating as a member of multidisciplinary teams and conferences
• Completing required documentation
• Participating in continuing professional education
• Coordinating assistive technology support services
• Planning curricular/instructional changes
• Serving on teacher assistance teams
• Carrying out comprehensive diagnostic evaluations
• Developing IEPs
• Participating in on-going teacher and parent conferences
• Providing in-service documentation
• Participating in annual review conference(s)
• Participating/leading child study committees
• Supervising support personnel/CFYs
• Serving as a mentor teacher
• Meeting other school responsibilities

students on the caseload must be considered in light of the number ofcontact hours per week. The amount of time for service must be based on student service needs.

The funding issue is another important factor. High caseloads can be the result of special education students generating federal funds. Higher caseloads reduce the need for additional speech-language pathologists. There is also a growing trend toward school districts seeking funds from third party payors, such as medicaid or private insurance companies, adding to an overload of paperwork.

Two more important issues for the speech-language pathologists are caseload sizes and caseload guidelines. Certified speech-language pathologists employed on a full-time basis have an average monthly caseload of 52 individuals. Certified speech-language pathologists employed in a school facility reported that 68.1% of the caseloads were composed of individuals between the ages of six and seventeen, and only twenty-five point seven percent in the three to five year old range, and three point four percent in the birth to two year old range. Speech-language pathologists employed in a school facility reported that fifty point nine percent of their caseloads were composed of individuals with moderate impairments; twenty-six point five percent with mild impairments, and twenty-two point five percent with severe impairments.

The speech-language pathologist has to consider

carefully the amount of time available in each school day, week, or month. The time has to be divided in order to service the students. It is also important to consider that the role and responsibilities of speech-language pathologists have a major impact on the caseload size. The caseload must reflect a balance between the amount of time available for appropriate services and the amount of time needed to complete other required responsibilities.

Service delivery is a dynamic concept and should change as the needs of the students change. No one service delivery model needs to be used exclusively during treatment. Service delivery models should be combined within a caseload if the speech-language pathologist believes that a combination of models will be more effective than a single model. The types of service delivery models are as follows:

1. Collaborative Consultation. The speech-language pathologist, regular or special education teacher, and parents voluntarily work together to facilitate a student's communication and learning in educational environments.
2. Classroom based. There is an emphasis on the speech-language pathologist providing direct services to students within the classroom and other natural environments.
3. Pullout services are provided to students individually

and in small groups in the speech room.

4. Self-Centered Program. The speech-language pathologist is the classroom teacher responsible for providing academic instruction and intensive speech-language remediation.

ASHA guidelines allow trained speech-language support personnel to assist in the delivery of speech-language services and the augment program and treatment activities under the direct supervision of American Speech-Language-Hearing Association Certified speech-language pathologists. Although the speech-language pathologist may delegate specific tasks to support personnel, the legal, ethical and moral responsibility for all services provided to the students cannot be delegated.

Koegel, R. and Ingham, J. (1986) Programming rapid generalization of correct articulation through self-monitoring procedures. Journal of Speech and Hearing Disorders. 51, 24-32.

SENSORY DISABLED CASELOADS

Koegel and Ingham stated a number of techniques have been used effectively to modify articulation. The changes these methods produce are often clinic bound and limited to structured speech task. Generalization of a newly learned response beyond the treatment setting on into spontaneous speech is identified as a serious problem by most speech clinicians. However, Koegel and Ingham have discussed the fact that many treatment techniques do not include systematic programming to promote clinical gains outside of the treatment environment. Therefore, without programming carry-over activities, the clinician must simply hope that generalization will occur. Although some children begin using correct sound spontaneously after the implementation of an intervention, many do not.

There are a number of interesting suggestions for promoting generalization that have been made. Some of the procedures are designed to be used in clinical settings. These include the use of over practice with increased speech, reducing differences between the treatment and natural environment, the use of natural reinforcers and intermittent reinforcement and delayed but contingent

reinforcement procedures. There are other methods that can be done to produce generalization outside of the clinical setting. These include the use of paraprofessionals or parents as therapists and treatment in multiple environments. Although methods done in a clinical setting or outside a clinical setting have been effective to some degree, they have limitations. They are time consuming and logistically difficult to arrange. Therefore, these methods may not always be practical for clinicians with large caseloads or who otherwise have time to work with individual clients.

Researchers have suggested that including the child as an active participant in the instructional program by utilizing self-monitoring procedures may promote generalization. Self-monitoring use as a target behavior involves two stages. First, the child must recognize an occurrence of the target behavior. Second, the child must record the occurrence.

The authors use a self-monitoring activity in a clinical and natural setting. This method was to promote rapid generalization of a target speech sound to beyond treatment conditions. There were 13 children, seven girls and six boys, who attended three different elementary schools and were enrolled in speech therapy. They all demonstrated consistent misarticulation of one to three consonants during unstructured spontaneous speech outside of

the classroom. The children lateralized (s) and (z), substituted (o) for ((s) and (q) for (z) and/or substituted (w) for (r). They were in session either individually or in small groups and attended the sessions twice each week for 15 to 20 minutes. Table 5 shows detailed information about each of the children in the investigation.

The program had a baseline condition, which consisted of administration of the regular treatment program without any self-monitoring activities. The children had to meet the one sentence level before self-monitoring could begin. The steps to reach self-monitoring were as follows:

1. Speech-language pathologist demonstrated a correct and incorrect target sound and then the child was required to produce a correct and incorrect target sound.
2. Children were taught to record correct responses during conversation.
3. Children were asked to continue talking with the clinician. Every time the child produced a correct response, he or she recorded a plus (+) on the data sheet.
4. Children were instructed to produce and record the target sound correctly all of the time. The children had to carry the data sheets and record responses in all environments.
5. When the child attends speech therapy, he or she self-monitored and recorded data during the unstructured

Table 5

The age, sex, target sound(s), and treatment format for each child in the investigation.

Child	*Sex*	*Group (G) or Individual (I) treatment*	*Grade*	*Age at start of study*	*Target error sound(s)*	*Previous treatment*
1	F	G	3	7:9	/s,z/ dentalized	none
2	F	G	3	8:7	/s,z/ dentalized	none
3	F	G	2	7:10	/s,z/ dentalized	none
4	M	G	2	8:0	/r/ w/r all types	none
5	M	G	2	8:6	/r/ w/r all types	none
6	M	I	2	7:10	/s,z/ dentalized /r/ w/r all types	none
7	F	G	2	7:1	/s,z/ dentalized	none
8	M	I	4	10:9	/s,z/ dentalized	none
9	F	G	2	7:2	/s,z/ dentalized	none
10	F	G	2	7:9	/s,z/ dentalized	8 months (I)
11	M	I	2	8:3	/s,z/ lateralized	8 months (I)
12	F	I	1	6:6	/r/ w/r all types	9 months (I)
13	M	G	2	7:3	/s,z/ dentalized	16 months (I)

spontaneous speech with the speech-language pathologist.

6. After the children began to show a level of success outside of the clinic, the requirement for the children to carry the data sheets were terminated.

The results of this study demonstrated that articulation improved after children were taught to self-monitor their correct articulation in their natural environments. The results were also valuable for clinicians with large caseloads or otherwise limited time to spend with individual clients.

Piette, J., Fleishman, J., Mor, V., and Dill, A. (1990) A comparison of hospital and community case management programs for persons with AIDS. Medical Care. 28, 746-755.

AIDS CASE MANAGEMENT

The issue of how effective case management is as a means of increasing access to care or client well-being remains unresolved. Some studies have documented increases in the number of services received, as well as occupational functioning and social integration associated with case management.

The financial benefits of case management are also unclear. Some experiments have demonstrated a decrease in inpatient utilization and total costs, while others have demonstrated longer inpatient stays and more frequent clinic visits associated with service receipt.

Despite the lack of empirical evidence for the cost effectiveness of this service, case management systems for people with Human Immunodeficiency Virus (HIV) infection are being implemented in most communities with the continuing wide spread growing of Acquired Immune Deficiency Syndrome (AIDS). The goals of these programs are to insure that clients receive needed services, in addition to decreasing unnecessary utilization of expensive acute care beds.

A number of public and private funding sources have encouraged the increasing of case management for AIDS

patients. The New York State AIDS Designated Centers, a hospital based system of AIDS care, are mandated to provide case management in order to receive the enhance reimbursement offered by the state's medicaid program. Case management is an essential part of the demonstration funded by the Robert Woods Johnson Foundation to encourage community service to associates in large cities nationwide. Case management is an accurate component of two major projects through which the Health Resource and Service Administration is funding programs in 31 cities across the country. Therefore, it appears that case management will remain a central component of the AIDS service system for many years to come.

Two organizational settings employ the vast majority of AIDS case managers. The two organizational settings are the community based organization (CBO) and the public hospital. Many case managers work within the CBOs that initially provide volunteer support that have become hallmark of AIDS care. Within the CBOs, clients are identified either through self-referral or interagency networking. Public hospitals provide the bulk of medical care for persons with HIV infection. The public hospital also use case management as a means of facilitating service coordination. These case managers identify clients as they come for medical care and medical case management model.

The authors conducted a survey of case managers in

cities of high AIDS prevalence. The goal of the report was to describe the activities in which these professional are mostly involved, and compare them across organizational types. Data is also presented that compares the difficulty case managers in the two settings face linking clients with needed financial, paramedical, and social services.

The author used the following methods:

I. Sampling: A list of target agencies was complied from three sources.

1. All agencies providing case management as part of the Robert Wood Johnson AIDS Health Services program were identified through site visits and phone contacts.
2. CBOs serving persons with AIDS in the 50 cities of highest AIDS prevalence as of May 26, 1988 were identified through the Resource Guide.
3. Public acute and chronic care facilities in each city were identified through the American Hospital Association member directory.

II. Questionnaire: Questions addressed caseload characteristics, case management philosophy, and organizational policies. Questions were also included to determine the frequency in which case managers were involved in various traditional case management activities.

III. Analysis: The analysis addressed three major issues:

1. Case managers and caseload characteristics were examined across setting type.
2. The frequency with which case managers performed functions such as client advocacy and service linkage was compared.
3. Case managers were asked to rate the degree of difficulty they experienced linking clients with a variety of key services.

IV. Results: One hundred seventy-one case managers returned completed questionnaires. Data from 75 CBO case managers and 93 hospital case managers were analyzed.

AIDS case management continues to be the focus of intense discussion and a central factor of most service networks in the United States. In conclusion, the relative role of hospital and community-based programs should be determined by rational grounds rather than on the characteristics of funding decisions. Shifts in the size and composition of the client pool will require continual re-evaluation of the role of the case management within public hospitals and CBOs. The authors speculate that today's solutions may not be the answer for tomorrow's problems and clients.

Trupin, E., Tarico, V., Low, B., Jamelska, R., McClellan, J. (1993) Children on child protective service caseload: Prevalence and nature of serious emotional disturbance. Child Abuse and Neglect. 17, 345-355.

WELFARE CASELOADS

Trupin, Tarico, Low, Jamelka, and McKlellan stated, "there were nationally 2.2 million children referred to child protective services in 1986." Referrals have continued to increase constantly in the last two years. Although rates vary from state to state, statements of abuse have been substantiated in approximately 40% of cases investigated. Child Protective Services (CPS) investigated 47% of the cases that are receiving some preventive or remedial service. However, three quarters of these children are in substitute care settings because of maltreatment or neglect, and an estimated 270,000 children nationwide are in foster care.

The National Family Violence Study in the United States reported that children were victims of severe violence, defined as being kicked, punched, beat up, threatened with a weapon, or assaulted with a weapon. The study also reported that a large scale of sexual abuse lasts an entire lifetime.

Developmentally-oriented research indicates victims of assault manifest disturbances that vary according to the child's age and the nature of the assault. Physically abused infants play less than other infants, are less

focused, show less positive affects and patterns of disorganization or anxious attachment. Evidence shows that abused children lag in play development and have a higher number of behavior problems. Incest has been linked to depression, nightmares, bedwetting, clinging and anxiety as well as sexually acting out. Neglect has been associated with emotional withdrawal and intellectual delay. Studies have been done to indicate there is a high amount of abuse found among adjudicated adolescents, drug abusing adolescents, and psychiatrically hospitalized children.

The authors of this article composed a survey of children served by CPS in the state of Washington focusing on the specific intent of assessing mental health status. The study was completed as part of a larger community survey. System analysis was conducted through the Washington State Child and Adolescent Service System Program (CASSP). The CASSP system analysis was an experimental study of children in Washington State that generated estimates of the current serious emotional disturbance, data relevant to children's service history, needs and barriers to appropriate services. Public school children and children in difficult state-funded social service programs were surveyed independently. This study reported data on children sampled through the Department of Child and Family Services who were receiving protective services at the time of the survey.

PREVALENCE OF SERIOUS EMOTIONAL DISTURBANCE

The children taken in the survey were classified as Serious Emotional Disturbance (SED).

CHILDHOOD PSYCHOPATHOLOGY CORRELATES

Children being served by the CPS had experienced a number of events that might be considered antecedents of childhood emotional behavior disturbance or indirect indicators of such disturbance.

PSYCHIATRIC CLASSIFICATION

The Achenbach Child Behavior Checklist (CBCL) Total Behavior Problem Score and specified clinical scale scores provide dimensional indices on which psychiatric classification might be based.

MALADAPTIVE BEHAVIOR

The presence of emerging antisocial and other maladaptive behavior in many of the sampled children was confirmed by specific CBCL items.

SERVICE HISTORY

Children were more likely to begin manifesting problems between ages two and five, but were more likely to begin obtaining mental health services between 6 and 11.

NEEDED SERVICES

Current receipt of mental health services as well as services not met were examined to reflect the status of children at the time of the study.

SERVICE BARRIERS

From the perspective of service providers factors pertaining to the families' motivation appeared to be the primary barrier preventing children from receiving needed mental health services.

There are several factors that must be kept in mind while regarding the research findings. Limited information was obtained concerning the abuse histories of the children. This made it impossible to assess severity of abuse or to differentiate subtypes such as neglect, physical abuse, and sexual abuse. The population was defined only in terms of the receipt of services through CPS. There was no psychiatric interview conducted to verify symptom or diagnostic information obtained from respondents. Future research will need to address these limitations in order to provide a more precise clinical profile of children served by CPS and to identify subgroups within this population.

Table 6 shows that case management and foster home placements are the most commonly prescribed interventions for those children. Although they are perceived as needed in a relatively small proportion of cases. Table 6 also indicates that other needed services are often not received. The results of this study demonstrate the need for a comprehensive show of mental health and social services for a large percentage of children on CPS caseloads.

Table 6

Current Services and Service Needs (N = 191)

Service	Received	Needed
Psychiatric evaluation	02%	12%
Eval. for psychotropic medication	01%	02%
Psychological testing	04%	15%
Case management	75%	07%
Outpatient mental health treatment	35%	24%
Outpatient alcohol/drug treatment	01%	08%
Mental health day treatment	05%	05%
Therapeutic preschool or daycare	13%	06%
School-based mental heatlh services	12%	19%
Intensive in-home services	04%	08%
Family reconciliation services	09%	09%
Family support group	21%	30%
Crisis residential/receiving home	07%	02%
Foster home placement	38%	06%
Group home placement	01%	03%
Psychiatric residential treatment	00%	01%
Psychiatric hospitalization	00%	01%
Inpatient alcohol/drug treatment	00%	03%

Thompson, A., (1988) Young offender, child welfare, and mental health caseload communalities. Canadian Journal of Criminology. April, 135-143.

WELFARE CASELOADS

Thompson matched records of individuals charged under the Young Offenders Act in order to determine the extent of caseload overlap. The records of 2,539 individuals charged in Alberta were matched with records of the Provincial community mental health service and Provincial Child Welfare System to determine the overlapping caseload. Selected file data were also retrieved in order to provide a descriptive profile of the sample. Forty-seven percent of young offenders had been previously assigned child welfare status and eighteen percent had been on the caseload of Alberta Mental Health Services. Although the overlap is convincing, the following differences need to be considered in service planning. The author stated, "there were three differences to be looked at very carefully." The differences were as follows:

1. Individuals who had also been on the mental health and/or child welfare caseloads were more likely to have been involved in crimes against persons.
2. Natives were over represented in the young offender sample in comparison to the general population. The proportion was about one-half of that found in the general child welfare caseload.

3. Young offenders were more likely to have received a diagnosis of conduct disorder than those on the general mental health services caseload.

The most remarkable finding in this study was the high level of caseloads among the three services delivery systems. Nearly one-half of the subjects had records of previous child welfare status, while the figure for utilization of the mental health system under study was a lower proportion of nearly one in five. The existing use of mental health services in general is much higher. The child welfare is the only agency providing child protective services, although there were a number of agencies other than Alberta mental health services that provided services for the psychiatric and emotionally disturbed.

The extent of caseload overlap that was found to support the view that there was a large number of separate services unattached to similar social or human problems, that may be dealing with a smaller number of high risk groups. These groups may exhibit behavior that bring them to the attention of many other agencies.

The data indicated that children receiving child welfare and mental health services were at risk for later juvenile delinquency. This early identification of high risk groups creates the potential for early intervention, which, if carried out effectively, could reduce the likelihood of later incarceration.

The other major difference in this study to be considered is in regard to services to native children. Mental health provides services to a relatively low proportion of Natives in comparison to the Young Offender Program. Child welfare serves the highest proportion. The data suggests that Native children are nonetheless over-represented in the Young Offender population. A more detailed examination of the respective roles of cultural, individual or circumstantial influences. These differences, coupled with low utilization rates of mental health services, suggests that planned prevention and intervention programs for Natives are likely to going to have to be different from those created for non-Natives.

CONCLUSION

The roots of case management lie in the early days of social casework and public health nursing. Traditional social case workers maintained a dual focus on the client and the social environment, working both directly with clients and their families who needed social services and indirectly on their behalf.

With the increasing emphasis in the health and mental health care delivery system in shortened inpatient stay and reliance on outpatient services, it has become essential to offer patient services that are coordinated and cost-effective. One of the most frequently used methods of achieving these goals is case management.

Case management has been defined as methodology based on professional training, knowledge, and skills and used to attain treatment or service goals established in conjunction with the client. The primary goal of case management is to optimize client functioning by providing high quality services in the most efficient and effective manner to individuals with multiple complex needs.

Professionals are using the concept of case management more than ever before. For example, employing case management in the delivery of services with persons with HIV disease, mental health, social services, aging, education and substance abuse have become the most important issues. in many managed care and insurance programs, the focus of

case management is to prevent the unnecessary or unreasonable use of reimbursable services.

Caseloads are an important factor in the professional's work load. Caseload management is very different than the recently popularized term case management. The concepts and skills needed for effective caseload management are vital professionals who work in different settings. Caseload management requires the ability to manage a number of clients within a given amount of time and provide optimum services. The concept also includes being able to prioritize the sequence of the service delivered within the framework of the agency philosophy.

The size of the caseload is another important factor in a professional's workload. If the case load is too large, the professional will have a difficult time achieving goals and will experience the syndrome referred to as burnout.

Burnout is a syndrome of emotional exhaustion and cynicism that frequently occurs among individuals who work directly with people. Although burnout is possible in many professions, human service professionals may be at particular risk. In such settings, burnout involves a loss of concern and a loss of positive feelings for one's clients and, consequently, a decline in a the quality of service that the client receives.

Therefore, for clients to receive the most efficient and effective services, it is important to consider the size

of the caseload. If the caseload is too large, this can be overwhelming for the professional's ad the professional will experience burnout.

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