

A Team Approach to Rehabilitating Recipients of Aid to Dependent Children

by ELLARENE L. MACCOY, M.D., AND HARRY I. FRIEDMAN*

To explore the extent and nature of disability among parents in families receiving payments under the State program for aid to needy children and to determine what can and should be done to restore to self-maintenance the largest possible number, California developed the project described in the following pages. The philosophy on which the project was based, its methods of operating, and its values are outlined here.

IN September 1951 the California Legislature showed its concern over mounting relief costs by enacting two statutory provisions amending the State Welfare and Institutions Code. The amendments were designed to encourage self-support among the families receiving assistance under the program for aid to needy children. One of the amendments states in part: "It is the intent of the Legislature that the employment and self-maintenance of parents of needy children shall be encouraged to the maximum extent and that this chapter shall be administered in such a way that needy children and their parents will be encouraged and inspired to assist in their own maintenance. The State Department of Social Welfare shall take all necessary steps to implement this section."

The other amendment provides that "each County shall, in administering aid under this chapter, refer to the Bureau of Vocational Rehabil-

* Dr. MacCoy was State Medical Director of the Bureau of Vocational Rehabilitation at the time of the project described; she was also a member of the Los Angeles area committee on the project. Mr. Friedman, an assistant supervisor in the vocational rehabilitation program in the Los Angeles district, was the project's field supervisor.

The article is based on Dr. MacCoy's paper presented at the National Conference of Social Work, May 10, 1954. For a detailed report on the project, see *Rehabilitation of Disabled Parents in the Aid to Needy Children Program: An Experiment in Cooperative Relations* (California Department of Education), August 1954, 80 pages.

itation of the State Department of Education each [disabled] parent of a needy child to determine the feasibility of rehabilitation for such person. The State Department of Social Welfare and the State Department of Education shall jointly develop plans for the orderly processing of such cases. Priority shall be given to cases for which rehabilitation is determined to be most feasible."

Implementing the amendments, the *Aid to Needy Children Manual* states that "primary responsibility for developing and following through plans for achieving as complete self-maintenance as possible . . . rests with the family. The County's function is to encourage, inspire, and assist parents towards this end. The case record shall reflect both the family's and the County's efforts in this respect."

It was recognized immediately that the invoking of these laws, in accordance with the manual instructions, would in all probability swamp the Bureau of Vocational Rehabilitation with a mass of case referrals that, with its limited staff and funds, it was not prepared to accept. A pilot project seemed the answer.

Aware that such legislation offered an undeniable challenge to a State rehabilitation agency, and at the same time convinced that substantial savings could be effected by intensive application of rehabilitation services to certain individuals receiving assistance, the Federal Office of Vocational Rehabilitation granted the State \$33,000 for a demonstration project to run approximately 18

months. Several planning meetings were held in November 1951. They were attended by regional representatives from the Federal Office of Vocational Rehabilitation, the State Department of Employment, the State Department of Social Welfare, the State Bureau of Vocational Rehabilitation, the State Department of Finance, and the Legislative Auditor's office. Some area directors of the Department of Social Welfare, district supervisors of the Bureau of Vocational Rehabilitation, and directors of several county welfare departments also took part in the meetings. The meetings led to a formalized project agreement between the State departments of education, social welfare, and employment.

Scope and Aims of the Study

The four most populous counties in the State, Belvedere district of Los Angeles County, Alameda County (Oakland), Sacramento County, and San Francisco County, were selected as demonstration areas so that a true cross section of the program's population would be studied.

The specific aims of the project were (1) to assess the probable number of disabled parents presently receiving aid under the program for needy children; (2) to determine what portion of this load could become self-maintaining through the services of the Bureau of Vocational Rehabilitation and/or the services of the State Department of Employment; (3) to determine the proportion who probably could not be rehabilitated to a point of acceptance for competitive employment; and (4) to learn the effectiveness of exceptionally well-qualified counselors in rehabilitating disabled clients, drawn from a group believed to be more severely disabled and frequently having concomitant emotional problems of greater intensity than would be

found in an average group of referrals. It was also the purpose to bring to the attention of appropriate State, county, and Federal officials and of the State Legislature definite information, as soon as it was available, on what might be expected from such efforts in reducing dependency and effecting self-maintenance for persons receiving this type of public assistance.

The regional representative of the Federal Office of Vocational Rehabilitation strongly urged that the project have as one of its major purposes the development of improved methods and skills that later might be adopted by the State's entire rehabilitation staff. Accordingly it was agreed that the caseloads of the project counselors would be limited to a size that would permit as intensive casework as might be required. High standards were also stipulated in the selection of Bureau personnel to be assigned to the project and in the services to be provided to clients.

This pilot project, as conceived by its planners, was an opportunity to develop workable cooperative relationships among several State and local agencies. The degree of success achieved was found to depend not only on the type of client and disability but also, to a large extent, on the personalities of the team members, their professional capacities, their philosophies regarding the need or value of such a project, and their willingness to undertake and implement the arrangements necessary in each of the areas chosen.

Sampling method.—Approximately 1,000 cases receiving aid to needy children were selected by the public assistance agencies in each area. They were then screened by the caseworkers for families receiving aid because of the incapacity of the wage earner. Later, in some of the areas, absent-parent cases were rescreened for disability in the parent remaining at home. Such information had frequently been unrecorded, and clients therefore had to be reinterviewed and questioned. In one area the project rehabilitation counselor was of the opinion that the referring caseworkers were strongly conditioned in their selections by the conceptions they had already formed of the

services rendered by the Bureau of Vocational Rehabilitation. Undoubtedly this was an influence in all areas, and interpretation was necessary to ensure a new approach and a special effort. Occasionally there appeared names of clients who had been previously known to the Bureau of Vocational Rehabilitation; the cases of some of them had been closed out as "nonfeasible." Such names were processed routinely with the rest, in the hope that a new look might produce worthwhile results.

Out of the original sample of approximately 4,000 cases, 871 persons were finally selected as having a disability that was either the basis for a public assistance grant or seemed to stand as an obstacle to self-maintenance. The local screening committees in each district then went to work reviewing these cases. First, the counselors of the Bureau of Vocational Rehabilitation and the casework supervisors of the welfare agencies, working together, excluded from further consideration those cases for which obviously no rehabilitation plan could be entertained. Among the cases that could readily be ruled out were persons confined to institutions: patients in sanatoriums and hospitals; those in prison or in custody; the senile, the decrepit, and the alcoholic; those who were greatly retarded mentally; and those with serious, far-advanced diseases. Eventually the 871 possibilities were reduced to a working sample of 519 cases, which had to be carefully weighed in the light of all the information that could be brought to bear.

Identification of disability.—At this stage public assistance workers undertook to compile summaries of the pertinent information from each case file, bringing together all the medical information available to them, with as many further personal observations and other data as they could add. In view of the legal criteria for substantiation of incapacity, it is not surprising that this information was meager. In the past it had not been mandatory to obtain extensive medical information as a basis for eligibility. All that was legally required was a diagnosis or statement from a physician, clinic,

hospital, or health department; receipt of disability benefits; a medical report from a psychiatrist, a recognized hospital, or a physician in cases of mental illness; or even a caseworker's observation in the case of a visible impairment. Moreover, the files generally contained only the minimum.

Only a few of the clients had been receiving private medical care, and there was therefore only a scattering of reports from private physicians. The majority of the reports came from State mental hospitals, county general hospitals and tuberculosis sanatoriums, the University of California Hospital, and the hospital clinics; a few were from clinic facilities where part-pay patients are cared for at reduced rates. There were also reports from public health clinics on patients with tuberculosis and venereal disease. No matter what the source of the report, incompleteness was the rule. It was at this point that problems immediately presented themselves.

Screening committees.—Although the actual procedures varied from area to area, the general format of the screening committees was the same. In each district one rehabilitation counselor was assigned by the Bureau of Vocational Rehabilitation. A casework supervisor from the local welfare department was given overall responsibility for that agency's share of the project and supervised the individual caseworkers, who presented detailed reports on their cases. A placement officer was assigned by the local employment office.

These representatives met, at first frequently and later once or twice a month, to discuss in round-table conference the accumulated information. They were joined later by others, including doctors and medical-social workers from public health departments, occasionally by officials of the local welfare agencies, and, at least once, by one of the members of the local board of supervisors. It became evident almost immediately that medical advice was needed and that the medical consultants from the local office of the Bureau of Vocational Rehabilitation should become part of the team. Unfortunately this method could not be worked out

fully in all districts, but in one district the State medical consultant, who was also the district case consultant, attended nearly every meeting of the screening committee. In this district so much local interest developed in the methods that were being explored that professional personnel from many other official and voluntary health and welfare agencies asked to sit in and observe. There were many out-of-State visitors. The State field supervisors, both from the State Department of Social Welfare and the Bureau of Vocational Rehabilitation, visited all four area committees from time to time, as did representatives from that Bureau's central administrative office.

The working pattern that developed proved most practical and effective. The public assistance caseworker presented all the pertinent information available; the medical consultant discussed and clarified what medical information was at hand; and all others who had knowledge of the client or of the family offered their contribution. Since this was, in fact, a pioneer project, it was felt that the time taken in learning the intricacies of the new approach was by no means wasted; in fact, caseworkers who had been somewhat resistant at first to the work entailed in preparing case summaries began to vie for the privilege of presenting cases to the committee. Many of these workers had felt for years that something ought to be done to help their clients but did not know how to go about it. They were greatly heartened by this evidence of interest in helping them help their clients.

Case Determination

From the first it was clear that the kind of medical information available in the welfare case files would not be sufficient to permit the screening committees to make a ready determination on whether the client could be prepared for employment or, indeed, on just what constituted the disability. Even the existence of physical disability, on which eligibility for services from the Bureau of Vocational Rehabilitation hinges, could not be determined immediately.

There were many cases in which the diagnosis that had been given

was so unclear and the medical information so poor that it became imperative to go back to the medical source for more material. As the committees in their efforts to reach decisions sought further clarifying facts regarding the reported disabilities, they found a wide variety of medical information that had been provided, either on a private or clinic basis.

The project committees recognized early that official medical summaries from hospital records and other sources were essential to produce the best results in the shortest time, conserving costs and avoiding duplication of medical care. Urgent requests were made to hospitals and clinics, through established administrative channels, that these summaries be provided as expeditiously as possible, but obtaining the medical data needed proved a difficult hurdle, even though understanding and a cooperative spirit were not lacking. Overloads of work in the medical records departments, staff shortages, and insufficiently trained personnel, together with the sheer thickness of the records to be reviewed, made an almost impossible situation. Often, therefore, when the résumés arrived they had been long delayed, represented cursory reviews of the files, and were sometimes actually frustrating in their lack of necessary explanations for conditions (often serious in nature) hinted at or tentatively diagnosed. Similarly, letters from private physicians were often of little help because of the superficial nature of the information given.

On the other hand, specific information on medical conditions already ruled out by appropriate diagnostic tests was most helpful, as was exact information on surgery performed and on the pathological diagnoses, which often made it possible to disregard hearsay or reported conditions that had no basis in fact. The difficulties encountered in getting medical résumés existed throughout the State, varying only in degree, and undoubtedly were directly related to the overload of casework and to the rapidity with which all the facilities have had to expand their services. As a result, nowhere was there sufficient personnel to do

the kind of a job one would like to see done.

Findings

As would be expected in these days of high employment, persons who can readily solve their own medical or health problems generally do so. Applicants for aid to needy children who were referred to one of the project committees usually presented one of the following situations:

(1) Serious, proven disease, evidently far advanced and not susceptible to improvement or cure.

(2) A complex health problem with proven diagnosis—such as diabetes, tuberculosis, hypertension, and central nervous system lues—for which the worker did not have sufficient amplifying information about the extent of the illness to determine if the client could hold a job.

(3) A relatively simple medical problem—such as the need for dentures, glasses, or specific surgery—the medical implications of which had probably been insufficiently understood by the worker who misjudged these as constituting true vocational handicaps.

(4) Problems presented by clients who, after recovery from an acute illness or surgery, have had no reevaluation of their ability to work.

(5) Obscure and ill-defined complaints and symptoms, sometimes sounding not very severe or disabling, of which no thorough differential or definitive diagnosis had ever been completed, even if undertaken.

For many of the cases reviewed by the committee there had been plenty of medical care. Most of the clients selected for the project had been carried for years on various free clinic rolls. All too frequently, however, the treatments provided had been piecemeal and palliative. Many of the patients still retained the same complaints over the several years of clinic care that ran concurrently with the assistance payment. In several instances competent diagnosis had been made, but appropriate, recommended treatment, for a variety of reasons, had not been provided. Sometimes it was the patient who did not follow through or return for the appointment. In some cases it was because

of hospital policies that had to be adopted because of patient overload. Elective surgery, for example, often had to give way to acute surgery, sometimes indefinitely. When such problems were called to the attention of the hospital administrators, it sometimes became possible to expedite elective rehabilitative surgeries. In one instance a family composed of a man, his wife, and nine children had been receiving aid to needy children for 3 years because the father had a diagnosed inguinal hernia. Assistance payments totaling \$11,000 had gone to this family while it was waiting for surgery to be provided. When special attention was called to the situation, the service was provided within 3 weeks.

For the cases judged potentially employable, probably the single service rendered by the Bureau of Vocational Rehabilitation that gave the most striking result was a thorough diagnostic workup. Many of the patients, after new diagnostic studies and interpretation to them of the findings, went out—often without further treatment—and found employment, either through their own efforts or with the help of the California State Employment Service.

Essentials in Motivation

While everyone working on the case committees recognized certain irrefutable facts concerning the difficulties involved, working with these relief clients would have been useless without an optimistic approach. For years, rehabilitation workers have considered public assistance cases as among the most difficult to serve. They have pointed out that the longer a person is on relief, the harder, generally speaking, is the selling to the client of a rehabilitation program or goal.

However, at least from the viewpoint of personnel of the Bureau of Vocational Rehabilitation, it seemed essential to hold to certain definite hopeful convictions regarding men and women and their motivations, in order to make sound and worthwhile attempts to help them. These convictions are:

(1) That more persons really want to be self-supporting and self-suffi-

cient than want to be parasites and failures, and that therefore it is risky to make judgments regarding any individual until it is certain that he has had his fair chance.

(2) That relatively few human beings in our culture are satisfied for long with a dependency role.

(3) That more people want to be well and feel good than want to "enjoy poor health"; therefore, when complaints of pain, fatigue, and ill health persist over long periods of time, it should be seriously questioned if adequate examinations and diagnoses have been provided.

(4) That often the varying weights of the "last straws" in a long series of misadventures and unfortunate circumstances cannot well be measured by another individual more comfortably situated, and so the current situation may not represent the client's possibilities for independence.

(5) That years of discouragement often create a psychic trauma that prevents the real personality and worthwhileness of the public relief client from being recognized by any but the most discerning and sympathetic; as a result, special treatment in the form of understanding psychological or psychiatric help is often needed before other rehabilitation plans can be offered or accepted.

(6) That individuals are made of better stuff than is apparent on the surface or to the casual or prejudiced observer.

Since the project was designed to do the greatest justice possible to each client's problems, the consensus was that they should be approached with open-mindedness and be reevaluated whenever necessary. When it could be ascertained that adequate total diagnosis had been followed up by appropriate and competent medical care for the disabling condition, the committees sought only to document the facts and consider rehabilitation in the light of the medical recommendations obtained. However, adequate medical information for understanding of the many physical and/or mental problems could rarely be obtained from any of the past medical care sources, and a new evaluation, therefore, had to be undertaken in most cases.

Diagnostic Procedures

It is customary in the California Bureau of Vocational Rehabilitation to provide a general medical examination for every eligible applicant as a step in establishing the presence of a disability, and to study his present health status. Usually conditions detected here are studied in more detail by internists or other specialists when it is deemed advisable. In the majority of the cases in the sample, however, the physical complaints and symptoms were so manifold and the medical care so long drawn out that, for the most part, the more general type of examination was omitted, and a thorough diagnostic workup was immediately arranged.

Generally the procedure was as follows. All important and pertinent medical information that was available was assembled. Top-flight diagnostic specialists were asked to cooperate in accepting these patients as "diagnostic challenges." They were asked to take a new look, medically speaking, at the whole person in the most objective manner possible, to determine (1) whether there were real physical or mental disabilities present; (2) the degree of influence that each exerted on the total health of the individual; and (3) what, if anything, could be done to cure, improve, or ameliorate the condition. Whatever diagnostic laboratory tests seemed necessary were authorized.

By the use of this method and by pooling all possible skills, in many cases a new understanding of the patient's difficulty was brought about. A 35-year-old woman, for example, had complained over a 7-year period of shortness of breath or difficulty in breathing upon hurrying, working, or getting emotionally upset. She had been considered as having an anxiety neurosis. An examination by an internist and a laryngologist revealed a paralyzed larynx (abductor muscles), leaving her a breathing space of only a 3-millimeter chink. When the medical problem was adequately understood and interpreted to her, she was enabled to adjust more adequately to her domestic responsibilities. No restorative program was undertaken, although it would have been medically sound, because social

factors compelled her withdrawal from the labor market and because she could function as a homemaker as she was.

A 47-year-old man complained of severe back pain. He also had a multitude of other pains and symptoms of a somewhat bizarre pattern. Detailed orthopedic examinations revealed that he had pathology of his lower back—a symptomatic spondylolisthesis. All the consultants agreed, however, that surgery would not cure this client, since he would still have the other disabling complaints and pains. Probing of his past history finally revealed that he had been a long-time alcoholic, although for the past 10 years he had not been drinking. An internist was asked to study this client for possible deficiency disease. With his cooperation the indicated treatment was undertaken, and a month later all previous consultants, as well as the client, were astounded at the improvement that had occurred. Pain due to his peripheral neuritis was relieved, and the client was able to bear the back pain when it recurred.

Conclusions

The problems encountered in identifying the disability in order to determine eligibility for services and rehabilitation prospects have been explained in some detail. The team continued to function throughout the rehabilitation process. It would be difficult to do justice to the patience, skill, and ingenuity that the

counselors brought to the job, but they all needed and received continuous help and encouragement from the welfare caseworkers, who ironed out socioeconomic problems and helped with achieving motivation. Cases were rediscussed in committee meetings when crises arose, and solutions were finally reached by a joint effort. The "team approach" became a way of life.

It was not expected that the concrete successes of this project would be necessarily startling. The main interest was in learning what might be accomplished and in pointing the way. Nevertheless the values were remarkable in many respects. There is no good way to measure the fine interagency relationships that have been established and the new understanding of mutual endeavors; it is obvious, however, that many daily problems have been made easier to approach and solve through these new methods.

Other results speak for themselves. Of the 519 cases referred to the Bureau of Vocational Rehabilitation by the screening committees, 300 cases received no services beyond diagnosis. Some were shown not to have disabilities, for others the disabilities were too great. Some remarried, became pregnant, went to work, or otherwise disqualified themselves. Seventy-three of the 219 who received some type of service were successfully rehabilitated, and their cases closed. Forty-seven more cases were worked with just as conscientiously but were not successfully terminated.

Another 99 cases were still (at the time of the report) receiving training and other rehabilitation services.

When the total number of persons (more than 300 in the 73 families) removed from the relief rolls is considered, the human values begin to be evident. These 73 cases were rehabilitated at an expenditure (including administrative and counseling costs) of \$46,000, an inconsiderable amount—the equivalent of assistance for slightly less than 5 months. Their average earnings were almost double the amount their grants had been. A few clients actually took work paying less than the assistance grant—a situation that some thought would not be a possibility. Most of the clients, however, were earning substantially more, and their economic status had materially improved.

The experiment has demonstrated effectively that by pooling community skills and efforts great strides can be made in solving long-established and difficult community problems. Only in this way can the enormous costs of community services (costs often contributed to by solitary and duplicated efforts) be reduced and minimized. Intelligent interagency cooperation may accomplish what even expanded agency budgets sometimes fail to achieve—the promotion of increased and improved benefits for the citizens they serve.

Notes and Brief Reports

The Team Approach in Rehabilitation*

The California project described in this issue of the *Bulletin* (pages 11-15) used the team approach in going to the heart of one of the most perplexing problems in rehabilitation

* Based on discussion paper presented by Dorothy T. Pearse, medical social consultant, Bureau of Public Assistance, Division of Program Standards and Development, at the National Conference of Social Work, May 10, 1954.

programs today—that of motivation toward independence and a willingness to give up the security of the known public assistance for the satisfaction of self-support. Social workers and vocational rehabilitation counselors alike accept, in theory, the idea that many disabled adults—even those with long histories of dependency—can achieve an increased measure of self-sufficiency if "only they can be motivated." From Dr. MacCoy's outline of the philosophy on which the Cali-

fornia project was based and the methods used, certain principles emerge—principles that may well prove to be essential components in that illusive concept labeled motivation:

(a) The team must have a full determination and an understanding of the full medical facts before attempting a constructive program for a person who is disabled or thought to be disabled.

(b) All members of the team must have an unshakeable belief in the worth of each individual, coupled with the knowledge that basically he wants more than anything else to be