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 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 California 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

* 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.

a healthy, contributing member of society.

(c) There must be evaluation of the person as a whole, through joint consideration by experts of several different but related professions.

(d) There must be adequate study —both of the individual and of the group of which he is a part.

(e) There must be, for the client's effective movement toward independence, action by professionally trained caseworkers and counselors with a high degree of competence.

These five principles seem to be basic to any program aimed at increasing positive motivation. Helping men and women to achieve and keep the wish to work toward a socially desirable goal is clearly not a simple process, nor something accomplished quickly. There is no magic. There can only be hard work, applied by truly sensitive, intelligent, and cooperative persons.

Undertakings similar to the California project described by Dr. MacCoy have been tried in one or two other communities. In New Orleans a psychiatrist and a psychiatric social worker undertook a direct approach in the vocational rehabilitation of a group of 25 chronically unemployed psychiatric patients.[1] Twenty of the group had been supported during their illness and unemployment by public assistance. They were not incapacitated parents, although some of them were receiving aid to dependent children. During the time between the decision to focus on the problem of employment and the patient's return to work, from four to 30 interviews were held; the average was 10. Twenty of the patients could be considered successfully rehabilitated. They had been employed for periods ranging from 4 months to 3 years at the time the report was presented. Sixteen of the successfully rehabilitated patients had received public assistance payments averaging $54 a month during their illness. Following their rehabilitation, these patients earned an average wage of $132—140 percent more than their payment. Instead of costing the State $10,000 annually, their combined income of about $25,000 returned many tax dollars to the community. Even more important, all of these patients improved their standard of living and their enjoyment of life.

The results of another intensive approach, made not by a team but by an extremely well-qualified social worker with strong convictions about the innate strengths of people, were made known in 1952.[2] Kermit T. Wiltse reported then on a 3-month experience in which he worked with 27 incapacitated fathers whose illnesses, it was believed, were partly emotional in origin. The purpose of the project was to demonstrate the importance of professional casework methods and skills in public assistance. The study deserves a high place among the meaningful efforts made to correct some of the negative elements in current practice in the aid to dependent children program. However, medical consultation for these 27 men would undoubtedly have provided a sounder base than the medical information in the case records for the work directed at removing the cause of unemployment. Special studies directed at helping incapacitated parents in families receiving aid to dependent children have been started in West Virginia and Oklahoma as cooperative ventures of the rehabilitation and welfare agencies.

California has also recently completed a joint study by the State Department of Social Welfare and the State Department of Public Health.[3] Funds had been allocated by the 1953 legislature for this study, which was designed "(a) to determine whether eligibility for Aid to Needy Children in incapacitated father cases is being properly established, and (b) to evaluate the medical information found in case records and to make recommendations for improving the sources, quality and use of such information."

What do these various studies tell us about aid to dependent children in general? Do they show us something specific about the part of the program that relates to deprivation of a child or children due to the incapacity of a parent? They seem to show in broad strokes that improvement is needed. The results of such projects as that described by Dr. MacCoy emphasize the value of making expenditures for remedial efforts instead of assistance. Assistance payments, of course, need never be thought of as wasted money. It is not wasting money to feed children or to make possible for them some semblance of a home. Assistance payments being made month in and month out, however, to a family of growing children without some regard to the needs other than that for money can be a damaging social act.

Any social worker worth his salt knows that a chronically ill father, unemployed and deprived of his place as a contributing member to society, must have a harmful influence on the growing child in the home. The aim in work with such a child should be clear. Assistance payments should be made when need is determined and other eligibility factors met, including that of the parent's incapacity. At the time eligibility is being determined, however, the total needs of the family must be recognized, and treatment processes started even as eligibility is established. Through competent medical methods, the existence of a true incapacity must be established. Too much reliance is now placed by most social workers on the importance of medical reports, regardless of their adequacy or omissions. Social workers should have access, through help from administration, to competent consultation from professional personnel, including physicians, medical social workers, qualified supervisors, and rehabilitation counselors. Moreover, they cannot do a constructive job with the disabled person, even knowing the significance of his diagnosis, when the number of cases they carry prohibits them from seeing the family as often as is necessary.

[1] Thais Morris and Ian Stevenson, M.D., "Psychiatry and Social Work in the Vocational Rehabilitation of Psychiatric Patients" in the *Social Welfare Forum, 1953,* Columbia University Press, 1953, pp. 148–157.

[2] California Department of Social Welfare, *Social Casework in Public Assistance,* 1952.

[3] California Department of Social Welfare, *A Medical Study of Incapacitated Fathers Receiving Aid to Needy Children in California,* March 1954.

Welfare administrators also need to attack the overall problem through a different avenue. They must, in addition to searching critically and fearlessly their own administration, join with all organized medical groups and health facilities in the community in seeing that adequate medical services are available to recipients of assistance. Such efforts need not and should not be carried by the welfare agency alone.

Nationally, the caseload in aid to dependent children has changed rather significantly in recent years, as an increasing number of children of deceased fathers are supported through old-age and survivors insurance. At the time of Dr. MacCoy's report, 5 out of 6 families receiving aid to dependent children were eligible because of the incapacity or absence of the parent. Two and a half times as many children were eligible because of a parent's absence as because of his incapacity. However, the figures for November 1953 show that nearly 109,000 families were eligible because of incapacity. About a quarter of a million children thus look hopefully for a guarantee that the family deprivation due to incapacity will not go on indefinitely—look for the father's restoration, as soon as possible, to his rightful place as father in every sense of the word.

Employers, Workers, and Wages Under OASI, January-March 1954

The contraction in business activity early in 1954 is reflected in the first-quarter estimates of the number of employers and workers and the amount of wages taxable under old-age and survivors insurance, shown in the accompanying table. (The quarterly estimates exclude the self-employed, who have been covered since 1950, and their earnings.) While the number of employees with taxable wages, the amount of taxable wages, and the amount of wages in covered employment in January–March 1954 varied from the levels in the preceding quarter in accordance with seasonal patterns observed in the past, they each showed a de-

Estimated number of employers [1] and workers and amount of earnings in employment covered under old-age and survivors insurance, for specified periods, 1940–54 [2]

[Corrected to Nov. 10, 1954

Year and quarter [3]	Employers reporting wages [4] (in thousands)	Workers with taxable earnings during period [4] (in thousands)	Taxable earnings [4]		All workers in covered employment during period [5] (in thousands)	Total earnings in covered employment [5]	
			Total (in millions)	Average per worker		Total (in millions)	Average per worker
1940	2,500	35,393	$32,974	$932	35,393	$35,668	$1,008
1941	2,646	40,976	41,848	1,021	40,976	45,463	1,110
1942	2,655	46,363	52,939	1,142	46,363	58,219	1,256
1943	2,394	47,656	62,423	1,310	47,656	69,653	1,462
1944	2,469	46,296	64,426	1,392	46,296	73,349	1,584
1945	2,614	46,392	62,945	1,357	46,392	71,560	1,543
1946	3,017	48,845	69,088	1,414	48,845	79,260	1,623
1947	3,246	48,908	78,372	1,602	48,908	92,449	1,890
1948	3,298	49,018	84,122	1,716	49,018	102,255	2,086
1949	3,316	46,796	81,808	1,748	46,796	99,989	2,137
1950	3,345	48,283	87,498	1,812	48,283	109,804	2,274
1951 [6]	4,440	58,000	120,700	[7] 2,080	58,000	149,000	[7] 2,570
1952 [6]	4,450	60,000	128,800	[7] 2,150	60,000	161,000	[7] 2,680
1953 [6]	4,350	61,000	137,000	[7] 2,250	61,000	175,000	[7] 2,870
1946							
January–March	2,287	36,038	16,840	467	36,038	17,397	483
April–June	2,416	38,055	17,845	469	38,153	19,079	500
July–September	2,478	39,670	17,709	446	40,228	20,222	503
October–December	2,513	37,945	16,694	440	39,930	22,562	565
1947							
January–March	2,509	38,765	20,805	537	38,765	21,497	555
April–June	2,587	39,801	20,655	519	40,175	22,245	554
July–September	2,617	40,255	19,555	486	41,155	23,035	560
October–December	2,609	37,448	17,357	463	40,748	25,672	630
1948							
January–March	2,588	39,560	23,080	583	39,560	23,923	605
April–June	2,690	40,245	22,708	564	40,524	24,668	609
July–September	2,699	40,585	21,150	521	41,675	25,700	617
October–December	2,661	36,790	17,184	467	41,540	27,964	673
1949							
January–March	2,639	38,162	23,376	613	38,162	24,254	636
April–June	2,693	38,591	22,571	585	38,864	24,570	632
July–September	2,697	38,333	20,160	526	39,601	24,971	631
October–December	2,692	34,529	15,701	455	39,477	26,194	664
1950							
January–March	2,671	37,393	23,490	628	37,393	24,316	650
April–June	2,766	39,264	24,052	613	39,557	26,210	663
July–September	2,768	40,486	22,382	553	41,923	28,165	672
October–December	2,741	35,609	17,574	494	41,792	31,113	744
1951							
January–March [6]	3,552	43,600	30,336	696	43,600	31,000	[7] 710
April–June [6]	3,658	45,200	30,693	679	45,500	33,000	[7] 730
July–September [6]	3,635	45,800	27,815	607	46,800	33,000	[7] 710
October–December [6]	3,638	42,000	22,702	541	46,000	36,000	[7] 780
1952							
January–March [6]	3,595	45,000	33,159	737	45,000	34,000	[7] 760
April–June [6]	3,670	46,800	32,627	697	47,000	35,000	[7] 740
July–September [6]	3,645	46,700	29,166	625	48,000	36,000	[7] 750
October–December [6]	3,640	42,600	24,067	565	48,000	40,000	[7] 830
1953							
January–March [6]	3,590	47,000	36,300	772	47,000	37,000	[7] 790
April–June [6]	3,660	48,300	36,000	745	48,500	39,000	[7] 800
July–September [6]	3,650	47,800	31,000	649	49,500	39,000	[7] 790
October–December [6]	3,630	41,700	22,800	547	48,500	42,000	[7] 870
1954							
January–March [6]	3,550	45,000	35,000	[7] 780	45,000	36,000	[7] 800

[1] Number corresponds to number of employer returns. A return may relate to more than 1 establishment if employer operates several separate establishments but reports for concern as a whole.

[2] Excludes joint coverage under the railroad retirement and old-age and survivors insurance programs.

[3] Annual totals for 1951–53 include the self-employed and their earnings (covered beginning 1951); quarterly totals exclude the self-employed and their earnings.

[4] For quarterly and annual data for 1937–39 see the *Bulletin*, February 1947, p. 31. Quarterly data for other years were in the August 1947, February 1948, and January 1953 issues.

[5] For a description of the series and quarterly data for 1940 see the *Bulletin*, August 1947, p. 30. Quarterly data for other years were in the February 1948 and January 1953 issues.

[6] Preliminary.

[7] Rounded to nearest $10.