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A PROJECT DEMONSTRATING THE EFFECTIVENESS OF VOCATIONAL  
REHABILITATION SERVICES IN A TOTAL PSYCHIATRIC CARE PROGRAM.  
GEORGIA STATE DEPT. OF EDUCATION, ATLANTA  
GEORGIA STATE BOARD OF HEALTH, ATLANTA

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DESCRIPTORS- \*VOCATIONAL REHABILITATION, INTERAGENCY  
COORDINATION, \*EMOTIONALLY DISTURBED, MENTAL ILLNESS,  
ADJUSTMENT (TO ENVIRONMENT), PSYCHIATRIC HOSPITALS,  
VOCATIONAL EDUCATION, FOLLOWUP STUDIES, COMPARATIVE ANALYSIS,  
EXPERIMENTAL GROUPS, CONTROL GROUPS, \*DEMONSTRATION PROJECTS,  
PROGRAM DEVELOPMENT, \*WORK EXPERIENCE PROGRAMS, MILLEDGEVILLE  
STATE HOSPITAL, GEORGIA,

A COOPERATIVE PROGRAM OFFERED A COMPLETE RANGE OF  
INTEGRATED MEDICAL, PSYCHOLOGICAL, SOCIAL, AND VOCATIONAL  
SERVICES TO REINTEGRATE MENTAL PATIENTS INTO THE LIFE OF THE  
COMMUNITY. THE PROGRAM PROPOSED TO DEMONSTRATE THE  
EFFECTIVENESS OF CERTAIN REHABILITATION PROCEDURES TO EXTEND  
AND IMPROVE REHABILITATION SERVICES, AND TO ESTABLISH  
EFFECTIVE COMMUNICATION BETWEEN THE HOSPITAL AND THE  
COMMUNITY TO INSURE ADEQUATE AFTERCARE AND OTHER  
REHABILITATION FOLLOWUP SERVICES. SIXTY-EIGHT PATIENTS IN AN  
EXPERIMENTAL GROUP AND 71 IN A CONTROL GROUP WERE DRAWN FROM  
THE TYPE OF PATIENT USUALLY ADMITTED TO A STATE MENTAL  
HOSPITAL. A TREATMENT TEAM COMPOSED OF PSYCHIATRIC RESIDENT,  
PSYCHOLOGIST, SOCIAL WORKER, REHABILITATION COUNSELOR, NURSE,  
WARD ATTENDANTS, AND OCCUPATIONAL THERAPIST WORKED WITH EACH  
PATIENT IN IMPLEMENTING A PLAN OF ACTION. A LOCAL COUNSELOR  
PROVIDED FOLLOWUP SERVICES WHEN THE CLIENT WAS RETURNED TO  
THE COMMUNITY. A FOLLOWUP SURVEY AT THE END OF 3 YEARS SHOWED  
A 70 PERCENT SUCCESS RATE (CLIENTS EITHER WORKING OR IN  
TRAINING) FOR EXPERIMENTALS AND 46 PERCENT FOR CONTROLS. WITH  
VARYING DEGREES OF SUCCESS ALL PROGRAM GOALS WERE  
ACCOMPLISHED. THE NUMBER OF MENTALLY ILL ACHIEVING  
REHABILITATION STATUS INCREASED FROM 252 TO 24 DURING THE  
PROJECT. NEW METHODS AND TECHNIQUES OF REHABILITATION WERE  
INTRODUCED INTO A STATE HOSPITAL AND FOUND TO BE EFFECTIVE  
AND A SATISFACTORY WORKING RELATIONSHIP WAS DEVELOPED BETWEEN  
THE COOPERATING AGENCIES. PROGRESS WAS MADE IN INCREASING  
STATE AND COMMUNITY RESOURCES AVAILABLE FOR REHABILITATION,  
BUT FURTHER DEVELOPMENT WAS NEEDED. (JK)

ED016105

**VOCATIONAL REHABILITATION SERVICES  
IN A TOTAL PSYCHIATRIC CARE PROGRAM**

**FINAL REPORT  
PROJECT NO. RD - 778  
1964**

**DIVISION OF VOCATIONAL REHABILITATION  
ATLANTA, GEORGIA**

VT004113

**U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE  
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**A NARRATIVE FINAL REPORT**

**TO**

**Department of Health, Education, and Welfare  
Vocational Rehabilitation Administration  
Washington 25, D. C.**

**PROJECT NO. RD 778**

**A PROJECT DEMONSTRATING THE EFFECTIVENESS  
OF VOCATIONAL REHABILITATION SERVICES  
IN A TOTAL PSYCHIATRIC CARE PROGRAM,**

**Period: July 1, 1961 through June 30, 1964**

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Atlanta, Georgia**

## TABLE OF CONTENTS

<b>ACKNOWLEDGEMENTS</b>		<u>Page</u>
<b>I. THE GENERAL GOALS OF THE PROJECT</b>		<b>1</b>
Statement of the Problem		
General and Specific Objectives		
The Setting of the Project		
Review of Relevant Literature and Related Projects		
<b>II. THE PROJECT PROGRAM</b>		<b>6</b>
Introduction		
Development of Program		
Services Rendered Study Subjects		
Team Composition and How it Functioned		
<b>III. RESEARCH METHODOLOGY</b>		<b>12</b>
Introduction		
Population Sample		
Description of the Evaluation Data		
Data Collection and Analysis		
<b>IV. PROCEDURES, TREATMENTS, AND THERAPEUTIC FACTORS</b>		<b>15</b>
Introduction		
Case Finding		
Criteria for Feasibility		
Yarbrough Rehabilitation Center		
<b>V. RESULTS</b>		<b>51</b>
Introduction		
Analysis of Pilot Studies		
Analysis of Final Study (No. 4) of all Experimental and Control Subjects		
Summary of Findings		
<b>VI. IMPLICATIONS OF FINDINGS</b>		<b>56</b>
Introduction		
Appraisal of Problems in Providing Follow-up Services -		
Problems of Change Required as Hospital Staff Adjust to the Idea of Vocational Rehabilitation in a Program of Integrated Services		
<b>VII. SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS</b>		<b>61</b>
Summary		
Conclusions		
Recommendations		
<b>Appendix</b>		<b>68</b>
<b>Bibliography</b>		

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Various other state and local resource groups rendered invaluable service to the Project and are due our thanks. Local public health nurses provided valuable follow-up services to clients. State and local Mental Health Association groups provided consultation to the Project staff and mental health education and leadership in the development of follow-up resources for Project clients. The Georgia Jaycees spearheaded a drive to encourage employers to employ the mentally restored and also gave assistance in the development of needed community resources.

We wish to express appreciation to the Vocational Rehabilitation Administration at both the Central and Regional Office levels for the opportunity to make this contribution to the rehabilitation of the mentally ill and for the guidance given throughout the operation of the Project.

Finally, our own Project staff deserve an expression of gratitude for services rendered. Dr. Louise Marshall, Psychiatric Consultant, not only provided high quality professional consultation but gave effective moral support to other staff members during trying circumstances. Dr. Robert W. Wildman, Research Consultant, worked tirelessly in research design and data analysis. Mr. James H. Miller, Program Supervisor, gave efficient program supervision. Also, to him we are indebted for the data collection and the structure and composition of this report. The counseling staff, the evaluation and work adjustment staff, the vocational training staff, and the clerical staff all comprise a group of individuals who have, with great initiative, worked efficiently, cheerfully and enthusiastically to give this Project every possible chance to succeed.

W. C. Petty  
Project Coordinator



## I. The General Goals of the Project

### A. Statement of the Problem

Recent decades have seen a steady broadening of the goals of progressive state mental hospitals. Although the custodial and protective features continue to be important, they are no longer the central functions of the hospital. Treatment is replacing custody as the center of interest. More recently, mental hospitals have begun to recognize that treatment of the illness and the return of the patient to his former community are not enough. Not until the patient is able to integrate into the life of the community is the real purpose of the hospital being accomplished.

Prior to 1960, most patients leaving the Milledgeville State Hospital had been out of contact with the outside world. Suddenly being faced with the need for finding work in a competitive market resulted in stresses which the patients were unable to cope with at the time. Job finding was left to the initiative of the patient upon discharge, with only occasional direct assistance by the hospital Social Service Department. This assistance was usually restricted to the immediate geographical area of Milledgeville State Hospital, which, although in the center of the state, is somewhat isolated from urban areas.

Studies had shown the effectiveness of interagency cooperation in small state mental hospitals (1), in psychiatric wards of general hospitals (2), and with Rehabilitation House Programs (3). Further investigation revealed not only that "traditional treatment of the illness and return of the patient to his former community was not enough," but, likewise, vocational rehabilitation services, alone, were inadequate when working with the post-hospitalized mental patient. As a result of these findings, the Georgia Division of Vocational Rehabilitation and the Georgia Department of Public Health, sought to enter into a cooperative working relationship aimed at offering a complete range of integrated medical, psychological, social, and vocational services with the goal of reintegrating the patient into the life of his community.

In 1961, application was made to the Vocational Rehabilitation Administration for a research and demonstration grant to study the feasibility and effectiveness of a rehabilitation program in a large state mental hospital. A grant was awarded for a three year period for this purpose. Vocational Rehabilitation Administration Demonstration and Research Project No. RD-778-P-65-C3, "Vocational Rehabilitation Services in a Total Psychiatric Care Program," began July 1, 1961.

### B. General and Specific Objectives

The general goals of the project were (1) to apply new knowledge, methods, and techniques partially developed through other studies, including the Vocational Rehabilitation Administration Georgia Project (RD 297), to more effectively increase the number of mentally ill persons being prepared for gainful employment and "independent living," (2) to demonstrate the effectiveness of coordinated services between two state agencies in providing comprehensive vocational rehabilitation services as a vital

part of total psychiatric care, (3) to demonstrate how private citizens, private groups and agencies, and public agencies could be stimulated in mobilizing their resources to provide substantial support to treatment and aftercare programs, and (4) to introduce modern psychiatric rehabilitation concepts and processes in a large state mental hospital.

The specific objectives were (1) to demonstrate and confirm the major factors believed to promote success in the rehabilitation of the hospitalized mentally ill through the comprehensive treatment team approach, (2) to test, extend, and improve the rehabilitation services necessary for the preparation of the hospitalized mental patient for successful adjustment and remunerative employment in a competitive society, (3) to establish effective communication between hospital and community, and (4) to arouse community interest and concern for the post-hospitalized patient to insure adequate aftercare and other follow-up rehabilitation services.

### C. The Setting of the Project

Georgia's lone state hospital for the mentally ill is in Milledgeville, a community having a total population of 12,000. Milledgeville, located in the geographical center of the State is 97 miles southeast of Atlanta and 32 miles northeast of Macon. Formerly the capitol of Georgia, the town boasts of the preserved governor's mansion and many antebellum homes. The Woman's College of Georgia is located here as is the Georgia Military College. Industries include two woolen mills, a brick and tile plant, a coach company, and others. A boys' reformatory is also located here. At the edge of town, sprawls the world's largest hospital (4).

In 1959 a reporter for the Atlanta Constitution, Jack Nelson, wrote a series of stories regarding certain alleged irregularities at Milledgeville State Hospital. As a result of this publicity, the Medical Association of Georgia, at the request of Governor Ernest Vandiver, appointed a committee headed by Bruce Schaefer, M.D., of Toccoa, Georgia, to investigate the charges.

On the recommendation of the Schaefer Committee, Georgia State Hospital was transferred from the Department of Public Welfare to the Department of Public Health, and, in 1959, a qualified administrator, Irville H. MacKinnon, M.D., experienced in psychiatry and hospital administration, was hired as superintendent.

Dr. MacKinnon found that, except for a three month rotating internship in cooperation with the Medical College of Georgia, the hospital had no program in psychiatric training. There were no qualified social workers or music or occupational therapists, only one clinical psychologist, and one accredited recreation therapist. Psychiatric aides received no inservice training, and there was no department of public relations. There was no resident chaplain, much less a clinically trained one. There was no department of vocational rehabilitation,

no department of biostatistics. While the medical records department was functioning reasonably well, it had no professionally trained medical records librarian. There was no department of volunteer services.

Public confidence in the institution was practically nonexistent. To be sent to Milledgeville was to lose the last vestige of hope. The physical facilities were inadequate in all treatment areas. Little effective treatment was being done and the institution resembled what Karl Menninger once described as "a warehouse for humans."

The population of Milledgeville State Hospital on June 30, 1964 included 12,097 residents and 8,049 patients on convalescent leave for a total of 20,146. During the year the hospital accepted 10,826 readmissions, new admissions, and returns from furlough. (This is an increase of 6,208 or 134% in the total gain figure over the year ending June 20, 1961, at which time the Vocational Rehabilitation Project began). The 1964 gain figure was balanced by 1,580 direct discharges from the hospital, 8,049 patients placed on convalescent leave, and 1,114 deaths. During the year 3,512 patients were discharged from convalescent leave, making a total of 5,092 patients discharged. The average length of stay remained at about 80 days.

The average per diem cost, per patient per day, was \$4.027 with \$3.83 being contributed by the State. In the 1964 Milledgeville State Hospital Annual Report (5), Dr. MacKinnon pointed out that significant additions had been made in psychiatric, general medical, nursing, and paramedical staffs. It was hopefully anticipated that adequate financing in the future would make possible an effective staffing pattern thereby making the utilization of new advances in treatment and patient care available to all patients in the hospital. Many improvements and advances were noted:

"Accredited residences and internships are now available in psychiatry, clinical psychology, social work, ophthalmology, hospital administration, clinical chaplaincy, music therapy, recreation, and occupational therapy. A three year accredited residency training program in psychiatry was approved in January 1964 by the American Medical Associations Council on Medical Education and Hospitals. This program is now functioning in addition to those in cooperation with Emory University and the Medical College of Georgia. There are psychiatrists in training in all three programs."

"The organization of the hospital into the unit system is proving successful, and the new building program is completed and in operation. This includes the staff dormitory and apartment complex, the 600 bed Arnall Building addition, the central kitchen, and the Yarbrough Rehabilitation Center which recently played host to a six state conference demonstrating the use of vocational rehabilitation techniques in the treatment of mental illness."



"The new children's rehabilitation center is rapidly nearing completion and will be open for operation in 1965. A re-motivation program is bringing new enthusiasm and treatment techniques to the psychiatric aide staff. A special disability program for the blind, deaf, and patients with speech defects in cooperation with the University of Georgia Speech Clinic was commenced in March 1964 and is now in operation."

In concluding the overview of a rapidly advancing state hospital, it is noted that numerous experimental and clinical research studies are being conducted at Milledgeville State Hospital. Some of these studies are expected to make a significant contribution to our knowledge and understanding of the use of drugs in treatment, the use of unilateral electro-shock therapy, psychotherapy problems in a large state mental hospital, the critical factors in aftercare and follow-up.

#### D. Review of Relevant Literature and Related Projects

The Milledgeville State Hospital Rehabilitation Project has attempted to incorporate proven methods and techniques demonstrated in other state hospital programs (1) (3) (6). More important however, may have been the influence of Georgia's own General Hospital Program (2). A review of similar studies revealed agreements on approaches to vocational rehabilitation of psychiatric patients. One study (1) did not employ an experimental design and thereby had to work toward the attainment of general goals of rehabilitation. Thus the theoretical formulations and explanations for success were derived by another technique, in this case, "Participant Observation (7)." The concern here, as in similar studies, however, was to demonstrate and research rehabilitation techniques rather than to prove methodological superiority. The Vermont Story attributed several key factors as being responsible for the positive results in that particular study: (1) The Effective Utilization and Organization of Ancillary Personnel, (2) The Blending of change with Continuity and Commitment, (3) Reduction of Anxiety and Panic, (4) Reacquainting the Patient with His World, (5) Providing Economic and Social Security for Patients, (6) Maintaining Commitment of Staff to Patients and Patients to Staff and (7) Compassionate Relationships in a Family Setting. Working primarily with a chronic group of schizophrenics, the Vermont State Hospital Project demonstrated that a comprehensive rehabilitation program could function in a modern state hospital. Although a small hospital (population about 1,100), it was significant that they could organize their staff to effectively function in this rehabilitation effort. They discovered that, but with a few additional persons, the existing staff could do effective work using the equipment on hand. This finding should have particular interest for hospital superintendents and vocational rehabilitation directors in the several states.

Most research studies on the need for and operation of vocational rehabilitation programs in mental hospitals are favorable to the new, comprehensive approach to treatment problems. There is agreement also on the need for "client selection criteria." The criteria themselves, however, remain controversial and under close scrutiny. Holbert (8) believed nine factors to be critical in the vocational success of the mentally ill; he made note that much time and effort could be spent in attempting to rehabilitate those who have little desire or potential for rehabilitation while excluding many who have the desire and potential.

(See Criteria for Feasibility in this report.) Vocational Rehabilitation personnel, however, are haunted by the possibility of being accused of accepting only the "healthy cases, those who could rehabilitate themselves." This is not uncommon to the counselor working with the mentally ill. If he chooses, however, to rigidly adhere to proven selection guidelines, he might possibly avoid and refuse service to many patient for whom he might be most needed. This is his unfortunate dilemma.

Most studies emphasize what was found to be most helpful in the rehabilitation of mental patients. Institutional emphasis is on practical referrals, thorough assessment of each individual accepted for services (9), communication between all persons knowing the patient, and full implementation of planning before the patient is released. Goldwin (10) gives consideration to selection criteria, but also discusses transitional work placements as being very significant in the continuum of services for post-hospitalized patients.

The Georgia Vocational Rehabilitation Research and Demonstration Project 297 found in addition to what has already been said, that hospital programs and services were futile without adequate community resources and explicit responsibility for follow-up (2).

There has been some controversy among hospital administrators that vocational rehabilitation has no place in a state mental hospital. A few feel that the very nature of the department (or agency) keeps the patient in the hospital too long. They feel this is contrary to the principle of releasing the patient to the community as soon as the mental condition warrants. It sounds reasonable therefore that a mental hospital should be utilized only for those patients who require hospital care, and that as soon as the acute symptoms have subsided, they could be returned home with continued treatment at the community level. This argument is sound, providing there are facilities available in the community. In some state hospital systems, the issue was not whether to have a Vocational Rehabilitation Department or not to have one, but instead the concern was focused on the question of who should do the job. Historically, social service departments have attempted to provide a wide range of services in state hospitals, sometimes making vocational placements in the immediate vicinity of the hospital. A forced function, it obviously distracted from the ever increasing demands on their departments. In some hospitals, the Occupational Therapy Departments have attempted to incorporate vocational rehabilitation goals into their activities. And, although a remarkable job has been accomplished through improvised means, pertinent studies and current trends seem to suggest that a distinct program of services should be established in order to emphasize the process and goals of vocational rehabilitation and to assure competency of services.

## II. The Project Program

### A. Introduction

The Project Coordinator was assigned to Milledgeville State Hospital for the year preceding commencement of the Project with the objective of defining and clarifying roles and services of vocational rehabilitation, as well as learning more about the hospital and its resources and needs. Particular concern was given to the hospital's changing treatment philosophy and to the task of identifying wards where the team concept was or could be implemented. Once the desired wards were located, the Coordinator familiarized himself with the operation by attending screening, planning, and staffing conferences on intake and treatment wards. He worked with selected cases from a limited number of wards while communicating the objectives and services of the forthcoming Project. Particular emphasis was given to introducing modern concepts of psychiatric rehabilitation. Attention was focused on making better use of hospital jobs and other activities for vocational evaluation, training, and work conditioning. For the first time, concern was appreciably given to the patients' psychological and vocational needs in work assignments and in many other activities.

In addition to frequent planning conferences with Milledgeville State Hospital Superintendent, Assistant Superintendent, and Departmental Chiefs, the Project Coordinator also met with State Vocational Rehabilitation personnel to develop lines of communication between hospital and field counselors, thus encouraging a continuum of services. Cooperation and followup with every vocational rehabilitation client seemed crucial to the success of the Project. Also, of major consideration was the recruitment of Project staff.

### B. Development of Program

The Project was officially launched July 1, 1961 with a staff of Project Coordinator, three rehabilitation counselors, a part-time psychiatric consultant, five one-fifth time clinical psychologists, a part-time research psychologist, and two clerical workers. Three months later, a fourth counselor was hired, but one of the original three was assigned to Metropolitan Atlanta to work exclusively with clients returning there after release from the hospital. The original narrative called for the hiring of a social worker who would "assist the counselor interpret social data" and also, focus attention on social and environmental problems to be dealt with prior to the patient's furlough from the hospital. A qualified person was not located, however, and the rehabilitation counselors filled this particular need through their own resources and with the cooperation of the hospital social workers.

Original planning also called for the provision, by the hospital, of a 500-bed intensive treatment center. It was expected that most of vocational rehabilitation's clients would be products of this special facility. Later, however, it was decided to make this proposed building a rehabilitation center. Only vocational rehabilitation clients would



reside there. Construction of the Yarbrough Rehabilitation Center, as it was eventually named, began in 1961. The first patient was admitted in December of 1963. Due to the delays involved in getting the Center ready for operation, few of the study subjects were served there. The Vocational Rehabilitation staff were provided temporary office space in the Administration Building and, from here, rendered services to the study subjects and other patients. With but few exceptions, the subjects were selected from wards where the "team approach" attempt was implemented. Two counselors worked with males, and the third counselor worked with females. The following section describes vocational rehabilitation services rendered prior to completion and operation of the Center.

### C. Services Rendered Study Subjects

Initially, the counselors confined their activities to screening and ward conferences in the Administration Building. There were six wards - three for males and three for females, all closed. Each side had an intensive treatment ward, an admitting ward, and a chronic ward. Most of the patients on the intensive treatment wards were in either individual or group therapy. A treatment team consisted of a psychiatric resident, psychologist, social worker, rehabilitation counselor, nurse, ward attendants, and occupational therapist. Each team was responsible for approximately 45 patients. (The counselors very quickly discovered that they were relating to several such teams in the Administration Building and elsewhere).

1. Selection of clients was a "team function," but only the rehabilitation counselor had authority to make decisions regarding eligibility for vocational rehabilitation services. The counselors, participating in admission, diagnostic, and screening conferences saw each new admission to Milledgeville State Hospital. Assisted directly by the physician, patients were sometimes selected for vocational rehabilitation services primarily on the basis of their performances in the admissions conference.

Patients were also referred from "intensive treatment wards," as well as from "chronic wards." In all cases, however, the counselor reviewed the hospital files before a tentative decision was made. And in most cases, the counselor had one personal interview with the prospective candidate. (It was quickly discovered that lengthy or additional interviews with the referred patient resulted in frustration for everyone if the individual was not eventually accepted for vocational rehabilitation services).

The counselors prepared lists each week of all referrals who appeared to meet eligibility requirements. (See Chapter IV for selection criteria, as originally developed). The lists, prepared for the research psychologist, contained only the patient's name, age, ward, county, and type of admission. The research psychologist arbitrarily assigned Experimental and Control groups. Except in unusual circumstances, the Control group was completely avoided thereafter. The counselors worked with only the patients assigned to the Experimental group.

2. Evaluation by each team member and the team as a unit was a continuous process for each client from the time of screening to the end of the rehabilitation period. After a patient was assigned to the



Experimental group, the counselor conducted a vocational evaluation, employing data gathered from other team members and from his own techniques of interviewing, testing, observation of client activity, and careful study of past employments. Trial work experiences were recommended for many patients who needed this service as a means of job sampling or evaluation. The utilization of the hospital's many trades and industries was very effective in assisting some patients who needed physical conditioning to a full day's work and to those who had demonstrated unacceptable work habits and attitudes as employees in the community. In a few cases, the hospital work experience was revealed to be actual apprentice training, as some heretofore untrained patients made enough gains to enter directly into employment after release from the hospital.

3. Personal adjustment counseling and vocational guidance services were rendered to all clients on a continuous basis as needed. The rehabilitation counselors worked with the individual clients in identifying and evaluating vocational problems which were apparently interfering with job adjustment. Client participating in test interpretation and in examination of other information was encouraged only to the extent he was ready for and able to accept it. In general, his vocational choices were respected if they were practical in terms of appraised abilities, interests, psychological needs, and available training and/or employment opportunities.

4. Ward services included (a) psychotherapy, (b) administering and adjusting of drugs, (c) basic patient care, (d) recreational activities and (e) medical and nursing services. The transformation from custodial care to rehabilitation was still in process, and a conscious effort by all was required to maintain the desired perspective. Although the psychiatric residents rotated every three months, and each new one had to be oriented to the vocational rehabilitation process, their eagerness from the classroom brought idealism onto the ward and gave new understanding and purpose to the "old time" attendant staff. Their vigor also challenged the rehabilitation concepts and goals held by other team members.

Therapy groups were conducted by physicians, psychologists, and social workers with but little departure from the traditional approach. There were no special groups for vocational rehabilitation clients, and some clients were considered poor candidates for group therapy. These persons, however, received intensive counseling services from the vocational rehabilitation counselors. Recreational activities on the ward included movies, dances with student nurses and infrequent coed dances, bingo, birthday and other special parties initiated by the student nurses, and, of course, TV viewing. When the weather permitted, patients also played softball and went on an occasional picnic. For the entire hospital, the Recreation Department staged dances, plays, concerts, etc., in the main auditorium. Other activities available for selected patients included music therapy, occupational therapy, garden therapy, remedial and special education. A system of graded privileges had not been developed beyond the stage of the patient earning "walk-outs" or campus freedom.

#### D. Team Composition and How It Functioned

1. Introduction. Referral to the "team" in this report means simply that nuclei of staff relating to and working closely with a particular individual. Within this small group, the patient had an opportunity to select the most meaningful relationship. During the weekly ward conference, relationships were discussed in terms of their effect on the patient's overall treatment and rehabilitation program. By way of this more or less objective examination of relationships, and ward, work, and school activities, the patient's progress was appraised and plans modified as needed. The authors recall instances where staff-patient relationships were positive and supportive, but, under group analysis, shown to be contributing little, if any, to the patient's need to get well. In other words, the patient's conflicting desire to stay sick was being reinforced by the staff member's unsophisticated siding with him against the parents and the employer. Getting together each week helped the staff preserve objectivity and authenticity to the therapeutic goals of the ward. Here, the team was made aware of the patient's progress in group therapy, the degree and nature of his participation in ward and social activities, and his attitudes, achievements, and goals with vocational rehabilitation.

Every staff member (as well as patients, family members, friends, and others) was recognized as having substantial influence on the patient's hospitalization, but with greater or lesser significance. For those with primary responsibility for patient care, however, it appeared that the following representatives formed the nuclei of staff referred to as the "team."

2. The Psychiatrist is mentioned first because he was the authority figure on the ward. It was he who coordinated all medical services on the ward, presided over staffings, and set the tempo for ward activities. The staff saw him as the leader, and the patients did likewise. Medications were prescribed, changed, or terminated by the physician. He had final responsibility for walk-out privileges, temporary visits to home or to another town to visit relatives, or to be interviewed for a job. It was he who gave final approval for furlough or discharge. More important, however, was the physician's role as teacher. This concept streamed down from the psychiatrist in charge (of the wards being discussed), and a climate for security in self-assertiveness and exploration was eventually established. The idea of using the physician as teacher and consultant was not new, but was a substantial development in getting all of the staff involved in psychiatric treatment. The importance of each member's contribution was recognized.

3. The Nurses (RN's) were primarily confined to administrative responsibilities whereas the attendants implemented most of the ward activities. The general acceptance of the attendant as an active participant on the psychiatric team has done much in the struggle to change the emphasis from custodial care to rehabilitation. The attendants care for minor physical irritations, arrange for patients to see staff not accessible otherwise, make appointments for optometry or music therapy, etc. They give prescribed medications and emphasize their usefulness. Besides meeting these and other material demands of the patients, the attendants function as surrogate mothers and/or fathers in the real sense. While

praising the patient for a good day's work or for completing his homework, the attendant must also sometimes rather firmly remind the patient to shower before going to bed. During long nights or weekends, the attendant must call on all his resourcefulness to deal with each unique problem, or blessing, that occurs. In ward conferences, his contribution to the patient's staffing is invaluable.

4. Occupational Therapy workers played an active role in the treatment and rehabilitation process when the project commenced. Several withdrawn and depressed patients were referred to Occupational Therapy in the early stages as this was a tested area for (a) appraisal of work tolerances and attitudes, (b) investigation of artistic talents, and also (c) as a means to activate the patient who was not ready to engage himself in work adjustment or school.

5. Clinical psychologists performed a dual role of hospital employee and vocational rehabilitation consultant. As before the project began, the psychologists led therapy groups, conducted and directed research, and offered diagnostic impressions when asked. With the initiation of vocational rehabilitation in the hospital, new demands were made of the psychologists. Furlough planning was now being considered for chronic patients who had no welcoming home or family. In planning for hospital and follow-up services it was important to know these patients a little more thoroughly. On selected patients, psychological or personality evaluations were requested and this data were interpreted in their vocational implications. Individual personality traits were appraised for the team's (and the counselor's) use in casework and planning. The psychologist made the team aware of his findings through written reports, as well as through participation in the weekly ward conference and, like other therapists, he reported to the team on each patient's progress.

6. Many duties of the rehabilitation counselors have already been suggested, but for emphasis, it should be repeated that from the beginning of the Vocational Rehabilitation Project, they were active participants on psychiatric treatment teams. They were present and participated at all ward conferences in which the treatment and progress of patients were covered. The counselor contributed to the planning for each patient-client in terms of the vocational significance of the activity. He observed and selected patients prior to their readiness for personal counseling and vocational guidance. He evaluated each client's personality characteristics, skills, abilities, aptitudes, interests, talents, and goals in their full implications for the outside world of work. Using all available data, he helped the client to form a realistic appraisal of his present capacities and job potentialities. Job requirements and employment opportunities were studied, and counseling sessions dealt with selecting job objectives and carrying through a plan that would lead to employment that was best suited to the client's personal qualifications. In addition to keeping the team current on vocational rehabilitation planning, the counselor maintained contact with the field counselor serving the client's home community.

7. Social workers have been concerned with many types of



"social problems" recognized on the ward. Their role has not greatly departed from the traditional role of the social worker, in general. However, their approach to psychiatric treatment has been reflected by the different methods of practice as dictated by the needs of a particular ward or by a certain patient. On the "intensive treatment wards," under discussion here, the social worker attempted to obtain complete social histories on every patient. Many families were never seen at the hospital because of transportation problems, father could not miss work, or because they had simply divorced themselves from further contact with the patient. The social worker then endeavored to obtain the desired information by questionnaire and through cooperation of the local public health nurse. Although the social workers led therapy groups and also saw some patients individually, their primary responsibility was to interpret family and social information to the "team," especially in view of the environmental circumstances surrounding the patient's illness. They also actively participated in furlough planning, helping to facilitate a decision as to whether the patient should return home or to a neutral environment. (11)



### III. Research Methodology

#### A. Introduction

A research design was planned in order to scientifically evaluate the effectiveness of providing vocational rehabilitation services in a state mental hospital and to attempt to determine factors which lead to success and to failure in rehabilitating patients so that effectiveness may be increased in the future.

#### B. Population Sample

##### 1. Selection of Patients

- a. The population used in this study was drawn from the type of patients usually admitted to a state mental hospital. The patients were selected from admission wards where all diagnostic types and all degrees of severity were represented.
- b. The patients finally used in this study were "rough screened" by the rehabilitation counselor as to their need for vocational rehabilitation along with a favorable prognosis as to their mental illness.

##### 2. How the Experimental and Control Groups Were Set Up

The individuals "rough screened" were submitted to the research psychologist who randomly put half the group into the Experimental group and half into the Control group. Later, when patients were evaluated, no subject was included in the Experimental group unless he had been interviewed at least several times by the rehabilitation counselor and recommendations made as to job placement. Some patients received no vocational counseling because of a lack of time on the part of the counselors, or the patients insisted that they were not interested, or the counselor perceived that a mistake had been made in evaluating them as reasonable candidates for services.

##### 3. Description of Study Groups

One hundred thirty-nine psychiatric patients were studied - 68 in the Experimental group and 71 in the Control group. Three separate pilot studies were conducted so that periodic results could be obtained and differences in counselors and psychiatric setting could be compared. The characteristics of these groups were as follows:

	<u>Experimental</u>	<u>Control</u>
	N:25	N:25
Study No. 1	24 males - 1 female Mean Age: 33.10	23 males - 2 females Mean Age: 29.54
	N:24	N:27
Study No. 2	24 males - 0 females Mean Age: 29.25	27 males - 0 females Mean Age: 29.30
	N:19	N:19
Study No. 3	3 males - 16 females Mean Age: 34.68	6 males - 13 females Mean Age: 35.00

Note: The composition of these groups was approximately equivalent.

### C. Description of the Evaluation Data

The criteria were chosen on the basis of simplicity, face validity, and direct relationship to results which are meaningful and which represent success in regard to vocational rehabilitation. Indirect methods, such as psychological tests, were avoided because reliabilities and validities are debatable and often the connection between test scores and meaningful changes in behavior are devious. The following factors were studied in evaluating the differences between the Control and Experimental groups: (1) After leaving the hospital for specified periods of time, was the patient working, in training, or was he unemployed and not in training? (2) Was the job held now better, the same, or worse than the job he held previous to hospitalization? (3) Was his mental condition better, the same, or worse than prior to hospitalization? (4) Had the patient been readmitted to the hospital since discharge; if so, how many times?

In these studies, the patients had been out of the hospital from 6 months to 2 years. In analyzing the data, the patients were rated as being "Successful" or "Unsuccessful" according to whether the ratings were favorable in regard to the variables listed above. The field counselor was asked to state the opinions of the patient, family, and employer. When the ratings from various sources were not unanimous, the majority opinion was used. (Questionnaire is attached - Appendix A).

### D. Data Collection and Analysis

#### 1. Method and Procedure of Data Gathering

The data was collected by sending out a rating sheet to rehabilitation counselors in the field. Questionnaire data was also collected from within the hospital by having the Vocational Rehabilitation Department provide information as to: (1) Number of interviews with the patient (2) Number

of tests used (3) Was a recommendation made as to job placement, etc. (See Appendix B).

## 2. Statistical Application of Data

The data appear in the form of means and percentages. Tests of statistical significance were applied to these data to determine whether meaningful differences existed unless the N was too small and differences should only be interpreted as trends.

#### IV. Procedures, Treatments, and Therapeutic Factors

##### A. Introduction

The development of the Milledgeville State Hospital Rehabilitation Program has involved changes in the physical plant, in the number of staff, and possibly of more importance, in procedures. The vocational rehabilitation staff of Supervisor, three counselors, and two secretaries, made the first physical move six months after the project commenced. The anticipated hiring of pre-vocational evaluators necessitated this move to a larger area. The second and final move was completed late in 1963, when the Center was ready for occupancy. These changes were made easily and with minimal interruption to the hospital or vocational rehabilitation routine.

As of June 30, 1964, the vocational rehabilitation staff totaled 24 and included 1 Supervisor, 6 rehabilitation counselors (of whom 4 were working in the hospital), 3 vocational evaluators, 1 work adjustment coordinator, 1 shop supervisor, 7 vocational instructors, and 6 secretaries. It was expected that the part-time psychiatric consultant would be retained, but that the purchase of personality evaluations from the 5 one-fifth time clinical psychologists would be terminated. Services of the part-time research psychologist would not be retained either. These personnel were not retained because they were no longer available to the Vocational Rehabilitation Program.

As previously mentioned, the counselors initially attempted to restrict their services to "intensive treatment" wards, e.g., those wards where there was a reasonable facsimile of a functioning psychiatric treatment team. The popularity of vocational rehabilitation was increasing however, and the other wards demanded equal attention. Sometimes going beyond the point of practicality, the counselors tried to satisfy those demands, but only to find it a near impossibility due to the enormous size of the hospital.

Prior to September 1963, project counselors were assigned to the various hospital units and much of their work was performed in the buildings, attending ward conferences and discussing cases with their respective treatment teams. With completion of the Yarbrough Rehabilitation Center, formal dedication on September 18, 1963, a unique program of psychiatric care and vocational rehabilitation under one roof began to evolve. This Center is devoted to the psychosocial and vocational rehabilitation of selected patients who possess some recognizable attributes for indoctrination into an organized rehabilitation program.

The majority of the project's experimental subjects, however, completed their preparation to leave the hospital prior to the opening of the Center. Some of the more severe cases from that group who did not leave the hospital, are now receiving the services believed to be crucial in their rehabilitation. Also now that the study, per se, has ended, the patients from the (Control) group, who were originally denied vocational rehabilitation assistance, are being served in the Center. A discussion of the Center philosophy and program will be blended with some of the earlier held



beliefs and practices in an attempt to make some comparisons and to reveal some already developing significant findings.

B. Case finding, as generally conceived, has never been a problem. In a hospital the size of Milledgeville State Hospital, there are always many more feasible, needful, prospective vocational rehabilitation clients than there are counselors to serve them. Unusual situations have developed, however, which have pressed the staff to analyze its referral procedures. Prior to the opening of the Center, for instance, one of the major riddles involved not casefinding, but case selection. The counselors, receiving more referrals than could be handled, had to make a final selection from the many who appeared to meet the requirements for both need and feasibility. Although this question was resolved somewhat by the Agency's objectives, counselor's personal resources, and other factors, it sometimes appeared that situational elements influenced the decision, i.e., (1) strong pressure from the referral source, and (2) counselor's desire to work on those wards where a "team" was more readily recognized. Stated again, the counselors clearly yielded to pressures, but were also inclined to work more with those wards where they believed they had the active interest and support of the treatment staff.

Another major problem with case finding or client selection involved the counselor's responsibility to regulate an even flow of referrals that would maintain full capacity caseloads for the vocational evaluators, work adjustment coordinators, and also keep the vocational classrooms full. It has been stated that the counselor could control his referrals and thereby avoid the acceptance of too many waitresses, or too few machinists. This has not been demonstrated thus far, however.

### C. Criteria for Feasibility

This issue is concerned with a very simply stated, but highly complex question. By what method, technique, or procedure, do you identify the patients who need and can optimally use vocational rehabilitation assistance?

#### 1. General Discussion

Some staff members feel that most persons in a state psychiatric hospital, who need to work, also need vocational rehabilitation assistance. This statement appears valid as particular viewpoints are developed. Patients of the state hospital are felt to be more severely ill as compared to those treated and dismissed from community hospitals and day clinics. Indeed, there are national trends in support of this treatment approach; the acute, possibly less severe cases, should be dealt with at the local level, i.e., by the family physician, local day (or night) hospital, or so forth, whereas the more chronic patients should be encouraged to seek help at the state hospital. One does not get into the state mental hospital because of his exceptionally good ability to relate well with his

family or to his work supervisor. The college student does not earn admission due to his knack of getting along with his professors and peers, or because he has suddenly begun to make the Dean's list. Practically viewed, a man or woman, or boy or girl, is admitted to a state hospital because they have been a nuisance to other people (12). Although the family or neighbors "saw this coming on," the sick man is now a different man. He is no longer upset, compulsive, stubborn, suspicious, or nervous; instead, he is crazy, psycho, psychotic, a lunatic. In fact, he is "ready for Milledgeville."

The need for vocational rehabilitation assistance in helping the patient stems not from the fact that here is another department or professional person who can help fill the personnel gap, although having a counselor on the ward admittedly sometimes meets this need. Of greater importance is his contribution to the hospital's awareness of the patient's pre-hospitalization behavior and the effect this has had on his interpersonal relationships with significant people in his immediate environment. How severe was his outburst at the boss? Would re-employment be considered? Must the local rehabilitation counselor intervene (now, or later) in an attempt to save the client's job? If the job is lost, is there similar or related employment that the client can be directed to? Must a new vocational choice be implemented? Must the client complete the physical separation from the family, from the town, in order to gain freedom and purpose (11)? These are but a few of the considerations and contributions, of vocational rehabilitation in determining need and feasibility of a particular individual.

Patterson (13) states that most of the emotionally disabled will not be clients of the rehabilitation counselor. Many are not ready for active consideration of vocational rehabilitation planning, while others do not need the services. Patterson clearly outlines the problems involved in client selection and in determining need and feasibility for vocational rehabilitation. In general, he felt that a mental impairment constituted a vocational handicap (and thereby the client needed vocational rehabilitation assistance), (1) when the condition interfered with, or limited, the choice of a vocational objective in the case of those clients who have never achieved vocational success, or (2) in the case where success has been achieved, when it prevented the client from continuing in, or returning to an occupation in which he has been reasonably well suited and satisfied.

The determination of feasibility also involves basic assumptions of rehabilitation. One of the basic concepts of rehabilitation (14) is that every member of a democratic society has an inherent right to the opportunity to earn a living, and make his contribution to society. Vocational rehabilitation attempts to meet society's obligation and responsibility to all handicapped individuals by equalizing their opportunities to earn a living equal to the opportunities possessed by the non-disabled members of society. This concept is supported by the principle of medical ethics requiring that all patients be seen and cared for whether they are treatable and curable or not (12).

There is a practical consideration here that presents a more difficult problem in the vocational rehabilitation of the emotionally disabled than in the case of most physical disabilities. Regulations and laws, governing vocational rehabilitation agencies, state that a counselor is required to show that all of the following conditions exist for each individual determined eligible for services (14):

1. The presence of a mental or physical disability and the resulting functional limitation or limitations in activities;
2. The existence of a substantial handicap to employment caused by the limitations resulting from such a disability; and
3. A reasonable expectation that vocational rehabilitation services may render the individual fit to engage in a remunerative occupation.

In summary of the law governing eligibility requirements, the counselor must identify the physical or mental impairment, define its (or their) functional limitations, explain how they interfere with occupational performance, evaluate the need for vocational rehabilitation services which will overcome or reduce the interference, and predict the probable outcome of the vocational rehabilitation services. This means simply, that the humanitarian base of the rehabilitation process should not obscure from view of the practical fact that the Federal-State Rehabilitation Program must prove economically sound in order to justify its existence. In essence, one of the purposes of a formally established program of rehabilitation is to save money by making the individual capable of self-support. The hospital counselor often finds that he cannot positively, comfortably make a prediction concerning the probable vocational success of a



particular patient. Wanting and having to work within the Agency framework of caution sometimes causes him to avoid doubtful cases.

Another major point for discussion concerns the provision of vocational rehabilitation services to "chronic" versus "acute" patients. Some hospitals prefer the Vocational Rehabilitation Department to work exclusively with chronic patients, thus leaving the acutely ill to plan for themselves. A National Institute of Mental Health Investigator during a recent survey (15), told the writers that each admission to the hospital should be "seen" in an attempt to appraise his need for vocational rehabilitation assistance. The time spent with an individual would depend somewhat on the apparent need for assistance as indicated by expressed needs, ward report, and social history accompanying the patient. Investigations in the community on selected patients would assist the staff in their referral decisions.

The Milledgeville State Hospital Vocational Rehabilitation Program is currently re-examining its referral philosophy and referral procedure in an effort to work at optimal efficiency and capacity. The goal, of course, would be to have all facilities operating at full capacity and to allow the counselors to carry "balanced caseloads," e.g., both chronic and acute cases. There are no immediate solutions to the question of whom to serve. However, there are limitations which will continue to restrict the number and calibre of patients referred to, and accepted by, the counselors. It is already apparent that additional qualified counselors as well as new and different approaches in psychiatric treatment, will reduce some of the pseudo barriers to working with more patients.

## 2. Applied Considerations

Actual selection of clients has been a "team" function with the counselor having final authority and responsibility for declaring an individual eligible for vocational rehabilitation services. When the project commenced, both counselors and physicians were inexperienced in the rehabilitation of the mentally ill; the physicians had insufficient orientation to the vocational rehabilitation process, and the counselors had only limited experience in working with the emotionally disturbed. The personnel turnover rate for physicians was high and the counselors had to continually orientate and re-orientate each new physician, as well as other staff members.



The original narrative outlined the client-selection criteria as follows:

- (1) A vocational handicap must exist.
- (2) The disability should be amenable to treatment.
- (3) There should be an absence of chronic condition.
- (4) There should be evidence of satisfactory functioning in the past.
- (5) There should be no other disabilities that would preclude employment.
- (6) The patient should have a fair level of personality strengths for adjustment.
- (7) The patient should have motivation for better adjustment.
- (8) The patient should be of working age.

The above listed criteria are quite general and thereby not difficult to apply. The present procedure for considering candidates for center residence attempts to combat, or balance, bias or prejudice by any single staff member. Decisions on most cases are made through group discussion at regularly scheduled referral screenings. It seems desirable to have present for discussion (1) the referral source (who is usually the patient's ward physician), and (2) a nurse from the ward who can report on the patient's general behavior. If the referral was made by another staff member, he would be present to explain the reason for referral. The counselor, working with the referring unit would also be present along with the senior psychiatrist. If it be one of the Units where there is no overlapping or continuum of treatment, i.e., where the present or referring staff is considering a near complete divorce from the patient and in which case he would now be under the care of a new (Center) staff, the following persons from the appropriate Center ward would also be present: (1) the physician, (2) the psychologist, (3) the rehabilitation counselor, and (4) the social worker.

To facilitate the referral process, no rigid (or validated) guidelines for client selection are followed. Prior to the weekly referral screening meeting, the counselor and the center physician discuss the case in terms of the patient's need and feasibility for vocational rehabilitation services in the Center. The screening meeting itself then provides an opportunity

for a closer examination of the psychodynamics involved in each case and allows the exchange of information between the patient's former treatment team and the Center staff. Although, infrequently, a majority opinion sometimes will lead to rejection of the candidate. The patient "may not be ready for vocational rehabilitation," or it might be suggested that he be placed on an open ward prior to his actual transfer to the Center. In other words, a planned program of increased responsibilities and privileges should be initiated in his present building before he takes up residence in the Center. In some instances, there will be sufficient discrepant information developed to cause rejection of the referral indefinitely.

Screening of the referrals varies markedly for those clients who need not live in the Center. The counselor meets with the referring physician and may either accept or reject the person for services, or he may postpone the decision while gathering additional information about the patient's needs as well as about the availability of suitable vocational rehabilitation services.

There appears to be no single formula that could be applied to every vocational rehabilitation referral. There are essential factors for consideration in each case, however, that seem to influence success in the Vocational Rehabilitation Program. Although all the desirable personal characteristics of a prospective client are not readily identified and some are never identified, these considerations have been useful in screening referrals:

- (1) The person should have a desire to live and to lead a purposeful life. Such motivation is sometimes uncovered and developed in therapy, in the counseling relationship, or possibly in some other gratifying activity.
- (2) The client should accept the fact that he has a problem. Patients showing massive denial of their emotional problems find it more difficult to make full use of available vocational rehabilitation services and to achieve vocational success.
- (3) The patient's pre-morbid history sometimes seems less helpful than his ward report. Ward behavior is frequently very different from his reported behavior at home, and more significant in evaluating his willingness to cooperate with vocational rehabilitation.

- (4) A Chronic condition, per se, does not seem to rule out success in a Vocational Rehabilitation Program. Other factors mentioned here, seem more significant.
- (5) Extensive out-patient therapy and/or several hospitalizations causes concern about the individual's ability to benefit from services. Nevertheless, mental health professions are eager to abandon the inflexible yardsticks of "cured-failed" as are sometimes applied to former patients. It has been suggested (8) that we should revise our idea of 52 weeks of continuous employment each year and be more realistic about expecting the patient to support himself indefinitely.
- (6) The psychiatric diagnosis seems to be of little help in identifying candidates for the Vocational Rehabilitation Program. Most patients with a basic sociopathic personality are avoided, however, as they create additional problems for the Center staff, interfere with the treatment and rehabilitation program of other patients, and have too little capacity to follow through with post-hospital plans.
- (7) The patient should want and/or request vocational rehabilitation assistance. His enthusiasm as well as his commitment to the program, may offer clues to his willingness and ability to make optimal use of services.
- (8) The availability of appropriate services is an important consideration but somewhat diminishing in significance as more effective treatment and rehabilitation approaches are introduced within the hospital and also in the community.

#### D. Yarbrough Rehabilitation Center

##### 1. Description of Facility

The Yarbrough Rehabilitation Center at Milledgeville State Hospital is a comprehensive Center, devoted to the psychosocial and vocational rehabilitation of selected patients. With completion of the Center (formal dedication on September 18, 1963), a unique program of total psychiatric care and job preparation under one roof began to evolve. The opening of the well-equipped Center greatly enhanced and augmented the existing program by facilitating comprehensive services in all four areas of rehabilitative care: medical, social, psychological, and vocational.

The facility, costing \$4 million has two wards on each of its 4 resident floors, and a total bed capacity of 360. Having a covered patio area, the entire structure is air conditioned and is adequately equipped with office space for professional and clerical personnel, conference and group therapy rooms, social and recreational areas, and vocational rehabilitation areas. The "Vocational Rehabilitation section," occupying in excess of 20,000 square feet of floor space, is equipped for counseling, psychometric testing, work sample evaluation, work remotivation, work conditioning, and vocational training in a wide variety of occupations.

The program is jointly financed by Milledgeville State Hospital and the Georgia Division of Vocational Rehabilitation. The hospital, in addition to providing the building, equipment, and utilities, also supplies critical staff members to facilitate the "team approach"; Georgia Division of Vocational Rehabilitation contributes staff as well as evaluation and training supplies. Administrative responsibilities are jointly shared. The hospital makes all final decisions regarding state hospital policy, regulations, etc., as these relate to the joint service program. The Vocational Rehabilitation Agency makes all final decisions regarding the Vocational Rehabilitation Program in accordance with the law, regulations, and state plan. The overall direction of the Vocational Rehabilitation Program in the Center and the hospital is the responsibility of the Project Director. All personnel working in this cooperative program are administratively responsible to him. The Supervisor, in turn, is responsible to the Milledgeville State Hospital Superintendent for the therapeutic quality of the services provided in the program; likewise, through proper channels of authority, he is responsible to the Assistant State Superintendent of Schools, in Charge of Rehabilitation Services, on all matters relating to the legal and administrative requirements of the Vocational Rehabilitation Agency (See Appendix C).

All patients in the Center are VR clients; not all VR clients live in the Center, however, because of technical restrictions concerning veterans and because some clients present undesirable behavior patterns. All feasible vocational rehabilitation clients will continue to transfer to the Center until the facility's capacity is reached. At that time, special needs of the individual as well as bed space, will influence the screening team's decision. There will be other considerations, i.e., patients currently residing in a building one mile away will be given preference, as some who live nearby can simply be "day clients."



## 2. Adjustment to the Facility

### a. General Discussion

Careful planning and usually much counseling time goes into preparing the patient for Center residence. Some patients need little preparation whereas others have been found to need large dosages of support before they can make the physical change from an "old ward" to the air-conditioned comfort of the Center.

In all cases, however, the patient has visited the Center for a talk with the counselor. This might be the initial interview, for a patient showing good remission. For a patient not ready to assume walk-out privileges, however, the initial interviews take place on his ward. Shortly thereafter a nurse accompanies him to the Center for further talks with the counselor. The purpose in the initial interview is to meet and get acquainted with this person whom someone feels needs and is worthy of vocational rehabilitation assistance. Factual information can be obtained later (or earlier) from the hospital record, and this thereby frees the counselor to get acquainted with the patient on more agreeable terms than would be possible if the counselor had a need to do extensive questioning and note taking.

Experience has shown that patients are interested in themselves, in their problems, in their families, in their jobs, in their home towns, in their past experiences. They are not interested in another mental evaluation or in being "psychoanalyzed". They are not interested in hearing a lecture on the history and functions of an Agency, at least, not during the initial interview; but even during these early interviews, some effort must be made to increase the client's awareness of his role and responsibilities in the rehabilitation process. The patient is not unlike other troubled people whose circumstances force them into being an agency client. Helen Harris Perlman (16), perceptive to the feelings of a (new) client, reported that "the person who comes as client to a social agency is always under stress." Regardless of the course or nature of the disturbing plight, he unavoidably feels threatened or off balance. "The client's stress is twofold: the problem itself is felt by him (not merely recognized) as a threat or an actual attack, and his inability to cope with it increases his tension." (16) Clients referred to the Yarbrough Rehabilitation Center are sometimes overwhelmed with the expectations of facing and accepting the challenge that awaits them:

J. C. was a 16 year old single girl who was the product of a broken home. Her father had left over four years ago, and she had spent the past eighteen months in the Youth Development Center (Girls' Reformatory). After release from that Center, she returned home, but continued to have spats with her mother (who had been diagnosed Schizophrenic Reaction when she was a vocational rehabilitation client). J. C. broke probation by leaving the State with her sister to visit their father. Her mother called the juvenile court judge and they had J. C. returned to Georgia and admitted to Milledgeville State Hospital. J. C. received a diagnosis of Schizophrenic Reaction and was retained on the admission ward. She was referred to vocational rehabilitation during that first week and was seen immediately by the counselor serving her building. The hospital staff, as well as the counselor, were favorably impressed with J. C. and she was given walk-out privileges (4th week). She walked over to the Yarbrough Rehabilitation Center for further interviews and testing. During that time the counselor showed her the ward where she met some of the patients and nurses. She liked the Center and asked to be transferred to it when it was revealed that she "qualified" for the training course of her choice. With hospital approval and permission by her judge, J. C. was transferred to the Center. She was received warmly by the attendants and given the customary orientation and tour. She was shown the bathroom, laundry room, activity room, coffee locker, and dormitories. There were single rooms as well as some with four beds and eight beds. J. C. elected to take her bed in a large room, which was only half occupied. She met the other girls who helped her to unpack and also advised her on what to keep out for her small chest, which clothes might be more appropriate for her locker, and which ones should be stored in the clothes room.

J. C. came downstairs that afternoon to tell her counselor she was not entirely pleased. Although not sure what was wrong, she thought the "building was too quiet." She was "not sure if she wanted to be here." The next morning J. C. visited the counselor, this time in tears. She was frightened, fearful, and said she could not go through with it. She would rather be "back on that ward where they are running around and hollering" (Admission Ward). When the counselor saw that his efforts to reassure the girl about Center life were futile, the physician was informed of the development. J. C. had threatened to run away if she couldn't return to her former ward. Dr. A. briefed the case very quickly and suggested that the girl be allowed to return. He and counselor could visit her there, giving reassurance that:

she could return to the Center when she was ready.

This case illustration is not a frequent occurrence but neither is it an isolated one. Obviously, there are many advantages for the patient who is selected for the Center program. Foremost could be his realization that the hospital has recognized him as a worthy person with possibilities for independent living. They know his past as well as his present condition, but are willing to consider his potentiality. They have chosen him to leave the drab admission (or one of the chronic) wards, and move onto a modern, pleasant Center ward, where there are custodial services, choice meats at mealtime, air conditioning, and other niceties unheard of on the "back wards". Here, he would have coed recreation on the patio, have an opportunity to be boastful when relatives visit, and be able to pursue vocational training or some other course of action which would enable him to re-enter community life, get a job, support himself and/or his dependents, and eventually regain his self-respect.

Being selected for Center residence is perceived a little differently by each person. The staff, in their eagerness to get the Center fully operating, sometimes failed to evaluate the meaning of their praise and comments about the new facility. The majority of patients coming in were able to adapt themselves, but it was the "drop outs" (or forced outs), who caused the staff to re-examine their contribution to the problem. It appeared true that the Center was all it had been said to be. The staff had eagerly awaited its opening, but the patients apparently saw its approach with dread. A very unique facility, the news media had capitalized on the ground breaking, and all - the patients, the families, the staff, and the onlookers - saw the Center as "the place where unproductive persons would be transformed into contributing members of society". To many patients, the whole idea was a threat to their present way of life. To some it meant a test of their expectations. To others, however, it was opportunity unlimited.

As a general statement, it can be safely said that most of the first Center patients were anxious. For many, the luxury was more than they were accustomed to, and they did not feel big enough or good enough to share in the plenty. Others did not overtly oppose the luxury, but reacted negatively (and perhaps rightfully) to the unexpected demands made of them. Their orientation to the Center Rehabilitation Program had been incomplete, as they seemingly had only heard what

was to be done for them, and not with them. Some patients thought they were coming to a trade school and that life in the Center would be even better (pleasant and no demands made by ward attendants) than on the previous ward. Here they would simply learn a trade, develop a skill, and leave the hospital and get a job. Some staff members shared this same erroneous belief.

At this point it may be desirable to examine some of these presumptions and their meaning (s) to the patients as well as to the staff. Their order, as reported here, is not necessarily related to the degree of seriousness or concern, but chronologically as the writers remember their materialization. They cannot actually be dichotomized, however, as they are interrelated genetically because of an apparent misunderstanding. Illustrated examples, which can be partialized here, may help to reveal how some unappealing problems developed.

b. The patients resented being reminded they were sick.

Not long after the Center opened, social workers and psychology interns made preparations to conduct group psychotherapy. Although the therapists had final authority on the selection of their members, they were eager to consider the patients referred by the counselors. As a result, patients with obvious behavioral problems were selected for the groups. At that time, every patient was not "in therapy" and only those whose problems brought them to the attention of others were recommended. The therapist was attacked in each meeting: "Who are you to say that we are sick?" "We left the Powell Building and came here for school." "We don't need therapy any longer." The group sessions were clouded by a high level of anxiety and strong feelings of hostility. Admittedly, some of the therapists were not seasoned, but each reported that they could not recall having similar problems in starting groups elsewhere in the hospital. As one stated, "It was as though I had intruded on their way of life." Another reported that "the problem would have been of normal proportions if the patients had been better prepared." The degree of anxiety in these groups was unusually high and the group leaders required considerable support to maintain their groups.

c. Many patients thought they were being transferred to the Center so they could "learn a vocation."

This may have been one of the more serious misconceptions about the Center - that it was a trade school. Beyond injuring the pride of vocational rehabilitation



personnel, the "trade school orientation" can lead to further misunderstandings and problems concerning the type of patient referred to vocational rehabilitation, as well as to the operation and goals of the Rehabilitation Program,

- (1) The quality of referrals can diminish where only those people with no training or with deteriorated skills are referred. Although these people obviously need help, not all can benefit from vocational rehabilitation assistance. Also, as a group, their many needs are greater and more difficult to differentiate; they thereby demand more staff attention when placed in the stressful situation of a classroom.

The resultant adjustment difficulties observed in the Center, with this type of patient, were only partly anticipated. Many of the "untrained" and "unskilled" patients accepted in the Center for training, were chronic patients, i.e., patients heretofore regarded as untreatable and thereby not considered as good candidates for intensive therapeutic activities. Expectations for them had been minimal on their previous wards where they may have been floor walkers, bench sitters, Friday picture show watchers, etc. In short, the response of these patients to an active rehabilitation program very loudly proclaimed that an enormous gap existed between the back ward and the Center world of education and resocialization. Even where the gap was narrowed, however, the Center Program for an individual patient had to be tailored.

J. H., 41, had been aroused from the back wards and participated in the remotivation program. Following this, she worked as a secretary (non-remunerative hospital job) for the Chief of the Remotivation Department for six months. J. H., who had been hospitalized for six years, had no obvious external barriers to leaving the hospital, for her family seemed interested in her, visited often, and frequently asked when she could be released. A depressed woman, J. H. had not demonstrated much desire to cope with the daily problems until she had been involved with the remotivators and later tried the hospital job. In other words, she had made a relatively good improvement before her referral for rehabilitation services. Vocational Rehabilitation discovered that she had completed two years of college seventeen years ago, but had then married and thereby never needed to work. Although possessing no work experience or salable skills, she was seen by the counselor as a good

prospect for services. Excited about the possibilities of living in the Center, she appeared before the screening team well groomed, appropriately dressed, and otherwise prepared to convince them of her sincerity and worthiness. She was readily accepted for services and residence in the Center, and a plan was implemented. Initial testing and interviews consistently confirmed her interests and qualifications for commercial training. Appearing well motivated and very capable, and actively participating in the planning, she was scheduled for six classes per day. At the close of the first month, the student had earned three A's and three B's. She repeated this the second month. Then changes were observed. In the classroom, the teachers noted that the client was continuing her good work, but was beginning to lose confidence. She wanted instructions repeated, and surprised her teachers even further by requesting clarification of procedures which had not posed any problem before. Outside of class, J. H. showed similar changes. On the ward, she spent more time around the nurses' station and less time with her homework. She repeatedly spoke of how difficult her classes were but could not attend to the task of preparing the next day's work. In counseling sessions, she denied having any problems in the classroom or that she was falling behind in her work. (Not a voluntary counselee, she sensed the reason for her counselor's invitation and was unable to discuss classroom activities or even admit that a problem existed.) There was a re-emergence of somatic complaints; several visits to the infirmary could not develop an organic problem. After being confronted with the medical reports, J. H. stated, nevertheless, she was in misery and "you must give me some relief before I can go on."

The staff agreed that her work load was excessive, but she scoffed at the mention of dropping some classes. She finally gave in, however, after being reassured that she had a license to react as she did to the amount of work that she had been assigned. Praised for an extraordinary effort and reassured that she was not a failure, two classes were dropped. The team then saw her enthusiasm for class return, and the tone and frequency of her somatic complaints diminish.

As a post script on J. H., her current standing is now reported on. While on a temporary visit home, she suffered severe burns after her clothing caught fire while standing too close to an open gas heater.

The accompanying psychological trauma necessitated her return to Milledgeville State Hospital for treatment, and, she remained in the infirmary for two months. Her depression gradually lifted and she was in good mental and physical condition when transferred back to the Center. It was agreed that she should have a few days on the ward to get reacquainted with the staff and the other patients, and also to re-familiarize herself with the Center atmosphere of work and school. It was apparent that she had regressed somewhat, and was thereby not ready to re-enter class. Due to her reluctance or inability to return to class, the staff delayed taking any action with her for two weeks. By then, it was apparent that her reluctance to enter class must be dealt with immediately; she was beginning to feel neglected, unworthy, and a failure. It was pretty obvious that this woman had to experience some gratifications, and very quickly. A work adjustment station was secured in the building where she had previously worked. Here, she felt comfortable, being around old friends and performing secretarial work with which she was also familiar. In less than six weeks, she had shown much improvement and returned to class where she now continues to excel. In short, she had been sick for a long while, had many problems to be dealt with, and now needs further assistance before she has the strength to leave the hospital to continue her vocational training or to enter employment. Her rehabilitation program is extensive and slow; in some areas she functions better than others. Her clerical aptitude is high, whereas her psychological aptitude is low, thereby limiting the possibilities of psychotherapy, and concurrently retarding her movement through the stages of rehabilitation to the desired goal of gainful employment.

- (2) The "trade school" orientation also serves to re-enforce such accusations as "Vocational Rehabilitation prolongs the length of hospitalization." Although it seems questionable that a large state mental hospital can function optimally and still boast of short hospitalizations, the "trade school" brand of rehabilitation certainly lends itself to a longer stay for the average client-patient. With the installation of vocational training in the hospital, many people lose sight of other and possibly more legitimate vocational rehabilitation services: counseling, psychometric and job sample testing, work conditioning, the comprehensive and thorough client assessment and counselor-client in interpretation, the feedback of information between hospital counselor and field counselor, a planned program of

rehabilitation services; the utilization of other community resources, the demonstration of interdependence between hospital and community, the team approach in furlough planning, and facilitating the continuum of services from hospital to community by personal and official acceptance of the client into the community by the field counselor.

Communication among staff members, to the patients, and within the ranks of the patient population, has far reaching implications. The objective is to see that all persons have complete and accurate information about the intentions and functions of the Vocational Rehabilitation Department; if ward personnel and patients observe referrals going to vocational rehabilitation for training only, the claim is justified that the patient will be in the rehabilitation center for a longer period than the average new patient remains on the admission ward. New patients are quickly informed that if they go to the Center, they may stay in the hospital much longer than ordinary. This, then, can be the point of departure. If the ward personnel, in the feeding or referral buildings, are properly oriented to the rehabilitation process, i.e., services available, the program operation, and which patients are desired as candidates, the program is assured of a sufficient number of referrals for all phases of operation. This means, for instance, that the short-term patient would be eager to participate in a dynamic counseling and evaluation process, planned to assist him in analyzing his past behavior in general, his employment history, his obvious as well as his not so obvious skills, abilities, and personality traits, and, finally, to assist him in the community program of rehabilitation and aftercare. This discussion gives emphasis to the claim that vocational rehabilitation has services for the short-term patient as well as for the chronic patient who is not now showing much potential for employment. It is believed that vocational rehabilitation could be involved in preventive rehabilitation work if criteria and guidelines were developed for helping to identify now those persons who will someday be labeled as "unemployable due to the nature and severity of the illness."

#### d. Co-educational activities

For some people, this is the first opportunity for mingling with the opposite sex under the peculiar circumstances that a rehabilitation center can present. As would be expected, a very pronounced gap is evident in



the area of "boy-girl relationships" for many clients. It may be presumed, that in the average, middle class community, boys and girls mix freely with friends of both sexes during puberty, and that they move rather easily into group dating, double dating, and single dating. This is part of growing up. Young people are in the process of establishing a greater independence from their parents, and receive varying degrees of supervision and maneuvering while taking each step into adult responsibility. Some parents are quite rigid in their attitudes and make most decisions themselves, maintaining that "Mother (or Father) knows best." Other parents feel unworthy or incapable to counsel their children about difficult matters, or are possibly never around to give advice. The majority of parents perhaps recognize their children's right to grow up and want to help in anyway they can, having no desire to interfere, dominate, or reject. Many times, they are baffled as to what to do, but their "healthy" concern is known by the child. When we speak of the democratic family in which each member has a voice, we refer to the vast number of so-called middle class families who have a not-too-old automobile, a nice house in a nice neighborhood where Dad earns a good living, where the children expect (and get) their school lunch money each Monday morning, where there is family love and security. In the "democratic family," both parents and children develop finesse and skill in human relationships. They learn to live together.

Although chancing a note of triteness, we emphasize that the majority of the emotionally ill have never learned the art of getting along with others, or else have been unable to adapt themselves to the environmental demands, unreasonable or not.

Although somewhat over simplified, they may eventually become a nuisance to someone, or to everyone, and seek or be directed to treatment. The hospital staff observe that some patients violently resist restraint and influence. Some fearful, passive individuals react by over asserting themselves and consequently receive disciplinary action or rejection. These people have not had the opportunity and/or ability to profit by association with adequate "important others" in the past. Because the patient has had such ill preparation for responsible adult life, hospital staff do not react with alarm when an individual evidences a problem in relating with another. Sometimes, perhaps they should.

With full knowledge that patients frequently evidence a crippled capacity to get along with others, the very idea of males and females living together was terrifying to some staff. Accounts of sexual acting out, pregnancies,

elopements, etc., have been given wide publicity whenever possible; so it is not surprising that people would resist efforts to bring both sexes together under the roof of a Center. Integration of the sexes was effected, however, above the protests and predictions of disaster. In an effort to exercise control of patient behavior, hospital attendant staff are present at dance time and during all leisure activities in the Center. "Going steady" is discouraged and sometimes a friendly staff member will remind a patient that "you're dancing too frequently with the same person," or "you've been seeing too much of Joan lately. There are other girls here. Why don't you get Mary interested in Saturday's softball game?"

Even though patient activities can be supervised fairly adequately on the hospital grounds, it is interesting to note that the number of post-hospital patient marriages has not been appreciably reduced.

- e. Recreational activities are an integral part of the total program. When the Center initially opened, a recreation therapist visited the facility and began organizing the patients and planning a recreation program. As was later revealed, however, his action although commendable, was premature. The patients-turned-clients did not, at that time, seek or desire direction, and thereby showed their rebellion to the recreation therapist through limited participation in the scheduled activities. Did they not need a recreation program? They eventually said yes, but they wanted the program to be theirs. Keenly aware of his problem, the recreation therapist immediately established lines of communication with the ward leaders. Ward leaders were elected democratically on some wards, while on others, where the patient-government had not yet been accepted, natural leaders emerged. With these patient leaders fully involved in developing recreational and other leisure hour activities, the number and frequency of both activities and participants increased. Although bingo, movies, gymnastic sessions, ball games, and visits to community activities are routine, they continue to be very popular. The stellar attraction, however, is the occasional variety show which tops all activities in drawing power. These shows which involve a tremendous amount of work and preparation, are conducted by the patients with but little help from the staff. The success of the shows reveals a startling high degree of planning and organizational ability as well as professional showmanship. A very important side light to these patient-planned performances is that an opportunity exists for the staff to "come back after hours" and see their patients or clients as they are when removed from the typical patient or client role. Stated in other words, the staff has an opportunity to see, admire, and get to know the patients as people.

### 3. Guidance and Counseling

The rehabilitation counselor in Milledgeville State Hospital can readily identify with almost any definition heretofore offered by State Agencies, Vocational Rehabilitation Administration, National Rehabilitation Counseling Association, National Rehabilitation Association, professional workers, and others. He has functioned as counselor, coordinator, administrator, and in other related posts. He has adopted "techniques" from leading psycho therapists such as Rogers, Sullivan, English, and Pierson. He has moved from non-directive to directive counseling or vice versa. He has "finally" become eclectic. He is sometimes called a vocational counselor, and sometimes referred to as a therapist; for both references, he has appreciation, but little desire for the title.

This report does not attempt to discuss schools or methods of counseling. It does, instead, present an outline of the "counseling" process as conducted at Milledgeville State Hospital. The mechanical procedure of the rendering and recording of case services is essentially like that done in most states, and identical to that done over the State of Georgia.

#### a. Getting the Referral

- (1) Discover and interview client.
- (2) Discuss him with other staff members who know him.
- (3) Review hospital ward file.
- (4) Begin case history: record referral information, give initial impressions of client.
- (5) Ascertain if the individual is now or has ever been associated with a State Rehabilitation Agency. (Ascertain client's vocational rehabilitation status in his home community while requesting information about him from the "home counselor." This is also a clue to the home counselor that an individual from his territory is in the hospital and will probably be returning home as a client.)

#### b. The Vocational Appraisal

- (1) Continue interviews with client and hospital staff.

- (2) Complete essential vocational rehabilitation forms.
- (3) Refer client for psychometric and/or work evaluation tests, if necessary. (See 4 below).
- (4) Obtain information from character references when needful.
- (5) Obtain information from previous employers when needful. (Experience has shown that many clients can be assisted in returning to former employment through timed and judicious contacts with the previous employer.)
- (6) Determine client eligibility.

c. Preparing a Case Summary

- (1) Evaluate interview information, test results, reports from other sources, and other observations - with the client. With him, select a tentative plan of action that might lead to the resolution of his vocational problems.
- (2) Write the client's family or other appropriate person about the plan. (A short letter will go a long way in relieving the family's anxieties about the patient's care while at the hospital, and also reduce the possibilities of having the patient released right in the midst of his program. In other words, the family's interests, where not contraindicated, are not neglected, and their cooperation and support is thereby gained.

d. Implementation of Plan

Client is now ready for:

- (1) Work Adjustment Services
- (2) Vocational Training
- (3) Personal Adjustment Training
- (4) Employment

- e. A client may be placed in (1), (2), or (3) above for a more intensive vocational and social evaluation. He should not remain in the same evaluation station longer than 30 days, however, without justifiable reason. If a plan cannot be developed in a reasonable length of time, the client's capacities and interests should be re-evaluated; consideration should be given to new evaluation stations.



f. **Communication with Home Counselor**

The home counselor receives a copy of the entire case history when the plan is developed. He is thus made aware of the intentions of the client and the hospital staff. This effort is extremely important in maintaining satisfactory working relationships with the field counselors. It has much significance, too, in reality testing for the hospital staff who tend to become "institutionalized" through limited contact with the community at large. The home counselors are encouraged to be candid in their examination of the written plan and their expectations of it ever being realized in specific geographical areas.

g. **Case Recording**

The purpose of this section is not to discuss the principles or the comprehensive content of case recording, but to share with the reader some wearily drawn conclusions about the approach to and use of case materials.

At the beginning of the project, the counselors utilized a structured format to develop a comprehensive, separate report which was written before the patient was furloughed. (See Appendix D). The report titled Implications for Rehabilitation oftentimes was a creative summary of the patient's background with realistic recommendations for post-hospital services. Sometimes, however, the report was a summary of other written materials and included duplications. This report was not designed to replace the conventional case history but was intended to present a "complete picture" of the patient and relate his employability to job opportunities in his former or new locale. There would be no need to duplicate this information in the case history.

Personal contacts with field counselors revealed the comprehensive report was received with various degrees of acceptance and utilization. Most counselors were intent on availing themselves to all resource materials about their new clients, while a few preferred to focus on medical reports which were also included in the transferred file. Although the client's problem areas were identified in the "Implications", the report emphasized assets, potentiality and employability. The hospital treatment teams, although acknowledging the necessity of forwarding medical reports to the field counselor,

believed that rehabilitation reports, with a positive emphasis, were more practical and useful in rendering follow-up community services. In short, the client's pathology was not denied, but the recording of such information was conservatively written so the field counselor would be aware of the presenting and historical problems but would be more impressed with the client's willingness and readiness for sustaining employment.

The most practical style of recording might be the condensed narrative (14); many counselors prefer brief, concise records which contain sufficient knowledge of the client, but yet do not reveal duplications or irrelevant material. Regardless of form or length, however, the vocational rehabilitation narrative must deal with all crucial and pertinent aspects of the diagnosing and resolving of problems:

- (1) The client should be described and his problems identified.
- (2) In determining eligibility, it must be specifically stated how the problems create a vocational handicap.
- (3) Services rendered in the hospital must be adequately described in explaining how they assisted and/or are assisting in the resolution of the individual's problems. Sufficient attention must be given to team (and client) goals and to the reasoning behind these goals.
- (4) Recommendations to the local counselor should be fairly specific, where possible, concerning training or vocational objectives, counseling approaches, follow-up treatment, and other after-care services. Where the hospital counselor is not familiar with the local counselor or the resources available to that local counselor; however, specific recommendations are unwarranted and inappropriate.

The method and approach to case recording is usually guided by state policy and by the needs of a particular client. Although much skill is required on the part of the counselor in documenting all the pertinent case data in a concise record, this approach seems most favorable to facilitating the client-study process and expediting the provision of services.

#### 4. Vocational Evaluation

##### a. Introduction

The vocational appraisal is an intimate, individualized case study which is a continuous process of gathering, organizing, and understanding knowledge about the client. Rehabilitation planning should be considered no more accurate, valid, and comprehensive than is the appraisal of the client on which it is based.

The appraisal begins, actually, in the patient's home. It is here, usually, that someone first evaluates him and determines that he is no longer socially acceptable. If he can no longer satisfactorily play his role in society; he is judged as incompetent, and admission procedures are commenced. On entering the hospital, the evaluation continues; he learns that others are interested in him. Treatment and examination are begun simultaneously. While, admittedly, the psychiatric interview is therapeutic, the physician is also evaluating the patient's need for, and ability to benefit from, particular treatment procedures. Every patient receives a complete physical and mental examination. Within a few days he might be evaluated for walk out privileges and later for town privileges, or for a temporary visit home. From the day of admission to the day of release, his needs and abilities are studied.

Referral to the Vocational Rehabilitation Department will be one of his new experiences. The experienced counselor will be evaluating him during the initial interview and from the very first contact with informants. Skill in gathering, organizing, and interpreting information comes largely with experience. The counselor learns what to look for and where to look. The types of information usually desired are traditionally categorized into groups as follows: medical (physical and mental), psychological, social, and vocational.

- b. The purpose of this section of the report is two-fold: to acknowledge that client evaluation is a multi-disciplinary, continuous process and to give a more detailed account of the contribution made by Vocational Rehabilitation.

The rehabilitation counselor is legally and morally responsible to his employer or agency for planning and coordinating an effective rehabilitation plan and program for every handicapped individual declared needful and eligible for services under the State-Federal Program. It is his responsibility to exhaust all avenues of measurement and assessment in investigating the problems and

potentiality of his clients. When preliminary interviews and counseling sessions leave many unanswered questions concerning vocational problems and vocational or training objectives, the need for a comprehensive vocational evaluation is indicated.

The vocational evaluation laboratory reviews vocational and medical information already assembled such as background data on medical-psychiatric factors, psychological factors, educational factors, and vocational factors including: (1) client's work history, (2) hobbies, and (3) avocational interests. The Evaluation Unit in the Center was established to assist the client in selecting a realistic vocational objective. This type appraisal provides objective information about the client's employability which might be obtained no other way. Primary measurement tools include psychometric tests and job sampling techniques. The extent of client involvement in this process is dependent on several factors, such as his attained education, employment history, recency of employment, apparent skills, need to change jobs.

Most clients enter, by prescription from the counselor, one or more of the three primary work evaluation areas: psychometric testing, clerical/distributive, or industrial trade skills.

- c. Psychometric tests are administered to measure the client's "present functioning level" in the areas of intelligence, educational achievement, basic aptitudes and abilities, and interests. This is important from the standpoint of evaluating his day to day living skills as well as to evaluate his potentiality for pursuing a specific type of training course or job. Some psychometric tests will also assist the staff in evaluating the client's new-learning ability which is very important when a new training or employment objective is being considered.
- d. In an intensive vocational evaluation, where the use of psychometric tests has been exhausted, work sample techniques are employed. These work samples are selected after review and interpretation of psychometric test results and other information. The samples vary from simple, routine, repetitive tasks to more complex, skilled operations. Depending on the clients achievement and satisfaction, he is moved from job sample to job sample.
  - (1) The clerical/distributive area is concerned with measuring the client's ability to work in the clerical and distributive field or for training in these areas. All tests are administered individually. The tools



used vary from standardized materials such as TOWER, to locally designed job samples. Also, a variety of office machines are available to the evaluator. Activities appraised range from office messenger to accountant.

- (2) The industrial trade area represents a comprehensive shop which provides equipment and facilities for a multi-activity program. Upon entering this area, the client is assigned first to general tasks which give a measure of his skills, dexterity, coordination, aptitude, interest, and overall potentiality for one of the work samples. The client receives individual attention, is given personal assistance and supervision and moves from simple to complex tasks, from hand tools to power tools. The client receives practice and supervision with each tool before the activity is assigned for evaluation.

Evaluators and counselors maintain contact through informal discussions as well as through the use of staff meetings and evaluation reports. A report of observations, testing results, and recommendations is given to the counselor at the conclusion of testing.

## 5. Vocational Training

Vocational Training was established in the rehabilitation program in 1963. It is essentially that kind of experience which equips a person with skills to do something for which someone will hire him. Within the confines of the hospital community are many people without such skills. Most patients referred to the Vocational Rehabilitation Department fall into this unfortunate group. Many have no or little academic training, much less vocational training. Many have never worked and thus, must be habilitated. Another group, almost equally handicapped, have not been gainfully employed for several years and, thereby, must be almost completely retrained and otherwise prepared for employment demands. Even short-term patients evidence a deterioration of salable skills and must pursue refresher training before they can enter the competitive labor market. Therefore, since an aim of the vocational rehabilitation program is to assist clients to develop useable skills, vocational training is a necessity.

Vocational training in the hospital is necessary for these reasons:

- a. In some areas of the state, training is not available.

- b. Most patient-students need to prepare themselves academically and psychologically before enrolling in community schools.
- c. Varied training areas within the hospital provide a testing or exploring environment for the patient who simply cannot be better evaluated and counseled.

A discussion of these points will further acquaint the reader with vocational training in the hospital. Before the Yarbrough Rehabilitation Center was completed, before vocational training was established, much difficulty was encountered in assisting clients to obtain training in certain areas of the state where vocational trade schools had not then been established. Where schools had been developed, especially in urban areas, our clients were placed in suitable schools and courses consistent with the rest of the rehabilitation process. It was very quickly observed, however, that the drop-out rate was too high. The clients from the hospital were not able to adapt themselves to the competitive demands of the classroom. They were not prepared for the class - and the class was not prepared for them. Much symptomology returned which was entirely unacceptable to the institution. Furthermore, the client's learning ability was too severely impaired.

Vocational training in the hospital provides a similar, demanding, competitive environment. Here, the patient can experience and deal with his frustrations with assistance from trained staff and thus develop ego strengths to cope with the anticipated pressures in the community.

The vocational classroom can also offer an evaluation service to the client. The initial days include only enough "book work" to let the client know that vocational training does involve some use of written materials. The client has sufficient freedom, however, to explore the station, observe other students, and to familiarize himself with the classroom. Many students have learned during the trial period that what did seem very glamorous, was not so at all. The use of classrooms and training stations to select training and employment objectives has given strength to the total program.

Vocational training is tailored to fit the needs of the patient, but is designed to train students on a level equal to that of training schools in the community. When a student is ready for furlough, he can continue his training at almost any public or private school in his new locale without any loss of credits earned at the hospital. These arrangements were made with the Georgia State Department of Education and with private institutions before the hospital training program was established.

**Vocational training currently offered includes:**

- (1) Electrical Appliance Repair**
- (2) Machine Shop Practice**
- (3) Welding**
- (4) Domestic Services**
- (5) Food Services**
- (6) Nurse Aide**
- (7) Barbering**
- (8) Cosmetology**
- (9) Commercial Subjects**
- (10) Drafting**
- (11) Cabinetmaking**
- (12) Automotive Repair**
- (13) Automobile Servicing**
- (14) Home and Family Management (for housewives and also for single women who must maintain an apartment)**

**6. Group Counseling**

Group counseling is carried out in the Yarbrough Rehabilitation Center by the rehabilitation counselor with clients who are involved in a comprehensive rehabilitation program. This group counseling is primarily vocational in nature; however, it does extend into the social and personal aspects of the clients life in the Center.

As mentioned previously, many of the mental patients who become vocational rehabilitation clients have a limited work history or none at all. Many other clients have not been successful in their past work experience and need reassurance in their ability to function in competitive gainful employment. These individuals, with various types of emotional disturbances, are handicapped by insecurity, feelings of inadequacy, problems in interpersonal relationships, fears about having to compete in the community, and stigma from having been mentally ill. Many of the client's dependency needs can be met and worked through in the group. Also, the group is a place where clients can release hostility and gain a better understanding of themselves.

Although individual counseling is more common and generally accepted as being more effective, group counseling has its advantages: (1) It is a more efficient use of counseling time. Several clients can be counseled at one time. (2) Problems are not so unusual that each client in the group cannot benefit from another's experience. (3) It means more to a client to be told by a peer that his plans, attitudes, etc., are unrealistic, or even untrue. (4) A well-functioning group gives clients a feeling of belonging that perhaps cannot be engendered in any other way. It gives them an identity that cannot be achieved in individual counseling. Whether individual or group counseling is used should be determined by the particular problems of the client.

In group counseling, the role of the counselor is both permissive and supportive. Feelings such as anxiety, fear, and hostility are reflected back to the group for expression. The importance of each client making his contribution is emphasized, and vocational, personal, and social problems are explored.

The primary goal of this group counseling is job orientation and job preparation. Information about various kinds of work is available to the clients to discuss and compare in an effort to orientate them to the total world of work. Selected films are obtained and shown to stimulate thought and discussion. Clients practice filling out typical job application blanks and discuss how to tell an employer about their particular skills and assets. Role playing is utilized in dealing with the job interview because it is both concrete and realistic to the client. Clients have the opportunity to play both roles, the employer and the employee, thus lowering their anxiety about this experience. The group counseling session is also a place in which the client can bring problems that he is having in his training program.

Group counseling has proven to be a valuable instrument in rehabilitating mental patients. They become more confident of their ability and more strongly motivated toward employment upon release from the hospital.

## 7. Work Adjustment

Milledgeville State Hospital does not have an Industrial Therapy Department, but does have a voluntary work program where patient labor fulfills a vital role in the day to day operation of the hospital. It is expected that a separate department will be established in the near future and all work assignments will be for the therapeutic benefit of the participants. Already, many of the hospital jobs are being assumed by vocational rehabilitation clients, and the work supervisors are being orientated to a program that is concerned with patient needs. Surprising to some, most of the hospital employees



directly in charge of working patients have shown a rapid understanding of the new concepts being introduced. The success already demonstrated with rehabilitation clients in the "Work Adjustment" program will presumably hasten the establishment of an official Industrial Therapy Department.

Work Adjustment Services are vital to the rehabilitation program and are utilized primarily for three categories of patients: (1) those in need of extended evaluation, (2) those who need to reacquaint themselves with an eight hour day, and (3) those who need vocational training.

Evaluation. The Work Adjustment Program offers realistic, extended evaluation to the evaluation laboratory. There are patients who are unable or unwilling to make maximum use of psychometric testing and job samples. There are also patients for whom these tests were simply not designed. When the evaluation laboratory and vocational training classes fail to assist the client in arriving at a wise vocational choice, the counselor usually calls on the Work Adjustment Coordinator. The Work Adjustment Coordinator has already identified and analyzed suitable work adjustment stations and opportunities in the hospital's many trades and industries. After learning the client's problem, he can very readily work with the counselor in selecting several work stations where the client can be exposed to jobs related to likely interests and aptitudes. There is a sufficient number of jobs in a hospital this size so that the client's true aspirations will eventually be stimulated and a realistic training or vocational objective will be realized.

Work Conditioning. For those patients who possess training and/or skills, but who need reacquainting to work demands, the hospital's trades and industries are available. Goals are clarified with the work supervisor who cooperates with the Work Adjustment Coordinator in building and assessing the client's physical work tolerance and psychological capacity for work. In a program of increasing responsibilities and number of work hours, the client develops adequate work habits and a proper attitude toward work production. He learns how to handle himself on the job, how to avoid interpersonal conflicts with his superiors and fellow workers. He observes work routines, yields to policy, acquires habits of punctuality, regularity, and personal neatness. Just as in the noted work programs in two British hospitals (17), regular hospital employees work alongside the patients. Patients mingling with these men and women can strengthen social skills through a variety of interpersonal relationships.

### Vocational Training.

A rehabilitation facility cannot possibly provide vocational training in but a limited number of areas, because it is something besides a vocational training center. Rehabilitation centers should never be envisaged as vocational schools, duplicating the services of existing specialized establishments. The need for vocational training at Milledgeville State Hospital is enormous, however, and the work adjustment program has facilitated the provision of additional training of an elementary nature. This training, even more so than the formal training classes, presumes completion of training in an outside school or in industry, once the client's capacity for this has been demonstrated, i.e., when furlough planning is completed and follow-up services are assured. On-the-job training in the hospital has been the major vocational rehabilitation service provided to some patients, whereas it has been complimentary to formal vocational training for many others.

Work Adjustment gives a patient simulated employment. It offers him the chance to become familiar with the conditions he will face when he leaves the hospital. In addition, the program enables the hospital staff to assess the patient's employability. As part of the total treatment and rehabilitation program, work adjustment prepares the patient for further rehabilitation and eventual employment.

### 8. Special Education

The majority of the patients at Milledgeville State Hospital have been unable to make maximum use of the public schools. In some cases, congenital and acquired physical handicaps have made public education impossible. In other cases, the problems created by social deprivations have made even the public elementary schools beyond reach.

Many patients are illiterate, and this educational handicap not only retards progress in vocational training, but most often precludes it. Vocational instructors should not be handicapped by having to teach reading, writing, and counting while at the same time trying to teach the student how to operate the lathe or style hair. In order to teach a patient a vocational skill, such as automobile repair or television maintenance, it is necessary to upgrade his basic skills in math and english so that his vocational training can be effective.

The most logical method of approach, here, is in the form of a program of education aimed at taking the individual at his present level and upgrading him to the greatest extent possible. In some cases, this may only be the teaching of basic reading and writing skills. In other cases it may be possible to

teach courses at the high school level. Many patients have satisfactorily completed the G.E.D. (General Educational Development) tests and received the Equivalency Diploma which is required by some employers.

One of the more obvious goals in planning a program of rehabilitation for the mentally ill is in the changing of behavior patterns. Teachers are with the patients on a one-to-one ratio longer than most other staff members, and this helps to make them very significant treatment team members. The need is also indicated for teachers and other staff members to work very closely together. The classroom can be (and should be) a very therapeutic activity if natural, healthy interpersonal relationships are effected. These additional contacts with persons from the outside prepare the patient for more appropriate responses to his future environment.

#### 9. Personality Evaluations

There are not enough psychologists at the state hospital to have a psychological evaluation completed on every admission. In light of this, staff members are very discriminate in requesting this service from the Psychology Department. In order to bolster the effectiveness of the Project, however, most patients in the Experimental Group were referred for personality evaluation. Many times, the counselor needed additional information for clarification of the patients cardinal personality traits. These psychological data were interpreted in its vocational implications. This knowledge of the patient's individual personal traits and personal dispositions was used by the counselor in casework as well as in vocational planning. It is extremely important to identify certain tendencies, such as sociopathy, very early in the rehabilitation process. At the time of furlough, the field counselor can be of maximum assistance to the client only if he has prior knowledge of problem areas and suggestions as to how these might be handled.

#### 10. Personal Adjustment Training

This training was designed with the purpose of giving selected clients an opportunity to acquire further knowledge and self-confidence for satisfying interpersonal relationships. They are given assistance in making optimal use of their personal resources. The course is flexible and geared to a level of learning based on individual needs.

Hospital staff too easily lose sight of the outside world even though they have a conscious understanding of this unfortunate possibility. They sometimes lose their perspective, especially where patients are involved. A marked example of this phenomenon concerned female patients going to Atlanta.



The counselor who received most patients returning there from the hospital began to complain that we were not properly preparing the patients for furlough; he stated they were coming to him poorly groomed and poorly dressed. Shortly thereafter, he was invited down to see that vocational rehabilitation patients were more advanced than other patients, as a result of their becoming vocational rehabilitation clients. He agreed that the vocational rehabilitation group of patients did look better, "but, remember," he said, "No. 1 at Milledgeville State Hospital is not necessarily No. 1 on Peachtree Street, Atlanta."

Personal grooming is most important because many employers hire by sight. This is a rather narrow reasoning, however, because it is generally accepted that when we begin showing more concern about our personal appearance, the satisfactions gained are ego building, and stimulate us to excel in other areas of life. Etiquette and good manners are also important in teaching the patient how to relate the "proper way" with a variety of people. Many patients have never learned how to dine in public or how to handle themselves in other situations; it is surprising how these aspects of daily living are taken for granted by many, but cause so much unnecessary embarrassment for our clients. Another area where the client needs help is with his basic wardrobe. All needy patients visit the apparel shop and alterations are made here before they leave. The course emphasizes economy, but correct dress. Role playing in job interviewing is also included.

These factors, and others, are extremely important when it is observed that every possible handicapping feature of the client must be minimized if he is to maintain himself in the community on a functional level.

11. Rehabilitation Specialist in Metropolitan Atlanta, working exclusively with Project Clients.

On October 1, 1961, a special counselor was assigned to Atlanta to work exclusively with Project clients returning to that metropolitan area. This assignment was made on the premise that many patients would require special consideration on their entry or re-entry into the competitive community. This special counselor would remain in this job even after a sufficient number of study clients had been served, and then work only with the more difficult cases transferred to Atlanta from Milledgeville. Services rendered to hospital clients through the special counselor and his community resources are



listed below:

- a. **Consultation and Screening Assistance Prior to Patient's Release** - Twice monthly this Specialist visits the Yarbrough Rehabilitation Staff to offer case service consultation as to community resources: i.e., medical, maintenance, employment, training, adjustment supervision, ancillary agency help. Prospective clients are interviewed to determine readiness for program follow-up. This supportive correlation of services reduces anxiety in counselor and client as to the likelihood of rehabilitation success afterwards.
- b. **Follow-Up Psychiatric Counseling** - Each client is required to come regularly to this office during early weeks of release. The purpose of these conferences is to reinforce client's identification with vocational rehabilitation as a transitional aid in his or her behalf. Counseling response is made to client's adjustment needs whether these be insight or supportive therapy, employment opportunity, information, supplementary authorizations for services not recognized earlier. Client, hereby, feels continuity of Milledgeville State Hospital treatment care that focuses on establishment of self-reliance and reality functioning.
- c. **Consultation For General Counselor** - The role of this office is several-fold, whether in direct service to client or in augmentation of regular vocational rehabilitation program staff efforts. Promotion of the rehabilitation process is primary. Case discussion sometimes is for mere support. Didactic clarifications are offered if knowledge of emotional illness factors is the counselor's hinderance. Particular concern is acted on in helping counselors acknowledge ahead of time what behavior to anticipate in clients plus structuring of conditions which must be present for case progress.
- d. **Community Liaison** - Multiple usage of boarding houses requires cultivation of relationship with supervision in each that results in nurturing of rehabilitation orientation. Herein they learn to appreciate their definite contribution to the client movement towards rehabilitation or interference with same. Sincere effort is made to match disposition of client with strengths and limitations of boarding house selected. Employment opportunities are promoted. Clients must go "get their own" jobs although extensive behind the scene negotiation is operated by this office. Encouragement of clients to utilize educational/training resources in Atlanta is a central service - to the extent of client cooperation.

- e. **Rehabilitation - treatment Experimentation -** A noticeable emphasis here is made on creating "tailor made" rehabilitation experiences for each client. Often the community is manipulated - benevolently - to accommodate the unique needs of clients so as to achieve within the community at large a therapeutic milieu. Group therapy for returning clients will be added soon, 7:00 P.M. to 8:00 P.M. on Monday nights for those persons in school or on the job who make known their wish to be followed in this manner. Later, special groups will be set up with this Specialist as co-therapist for clients who do not adjust or follow-through with assistance in the usual form.
- f. Every patient should be screened, where practical, before his furlough if he is to be followed by this office. Those who elope are acknowledged exceptions. A coordinated plan must be mutually agreed upon that in turn is reinforced by all staff on the treatment team. The patient should leave the hospital thinking all his staff contacts think of him as functioning under certain rehabilitation arrangements. This contract relationship should be identified as condition of furlough or as a "parole" contract. The firmness of this relationship enhances rehabilitation success considerably. The many clients who have come to us accordingly make progress in ratio to the quality of this contract.
- g. It is not necessary for out-patient visits back to Milledgeville State Hospital monthly if the specialist can make adequate arrangements in Atlanta. Such returns often become a burden to clients rather than opportunity.

A comparative analysis has not been made at this time of the special counselor's success rate with that of the field counselor. The eagerness of hospital counselors to send their clients to this man, however, suggests that the continuum of services from hospital to community must be fairly secure. The counselor is familiar with the hospital program, is extremely knowledgeable in the field of psychiatric rehabilitation, and is most receptive to the post-hospitalized client.

A study will be conducted later to determine the feasibility of assigning special counselors to all the major metropolitan areas of the state. If feasible, it is expected that these men will function as the present counselor in Atlanta:

- (1) Offer direct services to selected furloughed patients,
- and (2) extend guidance and support to the field counselors in his district who carry general caseloads, including psychiatric clients.

## 12. Discussion of the Team Concept

The treatment teams at the Yarbrough Rehabilitation Center meet weekly to evaluate patient progress and to discuss various problems which might have occurred on the ward, on the job, in class, within the patient's family, etc. Each team member is invited to give his own suggestions and opinions, and to ask questions or challenge decisions of another team member. This necessitates a sharing of ideas from the various disciplines which is conducive to working together for the good of the patient as well as aiding the overall morale of the total ward staff.

In the weekly meetings, usually conducted jointly by the ward psychiatrist and the rehabilitation counselor, fulfillment of plans are discussed, and, again, each team member informs the others of the patients' progress and mentions any obstacles to rehabilitation which have been encountered.

We feel it is imperative that each discipline knows what the other disciplines are doing with each patient, and what the short-range and long-range goals are with each patient. This is especially important when release planning begins; and before a patient is released from the hospital, each team member must give his consent. No important action, except in case of emergency, should be taken by a member of one profession without the consent of the group.

This team approach, where every discipline is represented and involved either directly or indirectly with each patient from the time of the patient's admission to the Center until the time of his release, and where each member shares with others, his particular knowledge of the patient is a major means of drawing the various disciplines closer together and creating an atmosphere of good morale between staff members.

## V. Results

### A. Introduction

The data presented below are based on the questionnaires returned by the field counselors. Some of the patients were not evaluated because they could not be found by the field counselor or information was too sketchy to be considered valid. Pilot Studies 1, 2, and 3 were done in that order, i.e., Pilot Study No. 1 was done first, Pilot Study No. 2 was done some months later, and Pilot Study No. 3 was done a number of months after Pilot Study No. 2. Therefore, the length of time out of the hospital, for the patients evaluated, increased from Pilot Study 1 through Pilot Study No. 3.

### B. Analysis of Pilot Studies

The characteristics of the Experimental and Control groups can be found in an earlier section of this report.

#### Results:

#### Pilot Study I

	<u>Experimentals</u>	<u>Controls</u>
	N:25	N:25
Employed or in Training	94%	24%
Readmitted, Still in Hospital, Died, or Suicide	0	24%
Now have Better Jobs than Before Hospitalization	44%	4%
Mental Condition Improved	68%	36%

#### Pilot Study II

	<u>Experimentals</u>	<u>Controls</u>
	N:24	N:27
Employed or in Training	75%	30%
Readmitted, Still in Hospital, Died, or Suicide	25%	44%
Now have Better Jobs than Before Hospitalization	50%	15%
Mental Condition Improved	92%	33%



### Pilot Study III

	<u>Experimentals</u>	<u>Controls</u>
	N:19	N:19
Employed or in Training	68%	37%
Readmitted, Still in Hospital, Died, or Suicide	47%	26%
Now have Better Jobs than Before Hospitalization	16%	16%
Mental Condition Improved	53%	53%

### Averages of Combined Pilot Studies, No. 1, 2, and 3

	<u>Experimentals</u>	<u>Controls</u>
Employed or in Training	78%	35%
Present Job Better than Before Hospitalization	41%	16%
Mental Condition Better	79%	39%
Readmitted or Still in Hospital	29%	41%

It is obvious that all these differences are significant except for the last two variables in Pilot Study III.

There is a trend for the differences to become less significant in each successive Pilot Study. This is probably due to the patients having been out of the hospital for longer periods of time which increased their chances of regressing.

#### C. Analysis of Final Study (No. 4) of all Experimental and Control Subjects

At the end of three years, an attempt was made to re-evaluate all of the Experimental subjects who had been previously evaluated in the Pilot studies. An equal number of Controls was used. All subjects were rated as "Successful" or "Failures."

Subjects were considered "Successful" if they were currently employed at the time the evaluation was made or they were in training. The "Failure" group was not currently working or in training. It was decided to not evaluate current mental status, quality of present job, and readmissions to the Hospital, because it was obvious from the ratings that often the information was very sketchy and the ratings highly subjective. It was also felt that the most direct method of evaluation was

simply to determine whether the Experimentals and Controls were working or in training or were not. If they were working, it could be inferred that they were getting along satisfactorily and that the goal of rehabilitation was achieved because this is a good test of a person's ability to adequately cope with his environment.

One hundred fourteen Evaluation reports were received; 63 from the Experimental group and 51 from the Control group. Five patients who had been in the Experimental Pilot groups were not rated by the field counselors and 20 from the Control Group Pilot Studies. The Evaluation sheets were not returned by the counselors for reasons unknown. Nine evaluations from the Experimental group and 14 from the Control group were deleted from this study because the field counselor was unable to provide sufficient information in order to make an adequate evaluation as to their current status.

Description of Groups

	<u>N</u>	<u>Males</u>	<u>Females</u>	<u>Mean Age</u>
Experimentals	54	72%	28%	33.02
Controls	37	57%	43%	32.41
		<u>Results</u>	<u>Successful</u>	<u>Failure</u>
Experimental Subjects			70%	30%
Control Subjects			46%	54%

Note: The critical ratio was 4.68, which is highly significant - well beyond .01 level of significance.

D. Summary of Findings

The Experimental group was divided into the Successful and the Unsuccessful in order to analyze some of the variables that might account for success and failure. With this information, it may be possible to increase the efficiency and effectiveness of this type of rehabilitation program in the future.

	<u>Successful</u>	<u>Unsuccessful</u>
	N:36	N:13
Age	33.22	32.08
Sex	24% Female	39% Female
Psychological Examination	27% No Examination	15% No Examination
	4% Prognosis poor	20% Prognosis poor
	61% Good Prognosis	50% Good Prognosis

	<u>Successful</u>	<u>Unsuccessful</u>
Number of Interviews by Counselor	7.54	6.50
Number of Tests Administered by Counselor	3.97	4.25
Work History	13% Poor	8% Poor
Chronicity	6%	31%
Organicity	11%	8%
Sociopathy	3%	13%
Alcoholism	9%	8%
Furlough Status	9% (1961) 11% (1963)	17% (1961) 8% (1963)

In analyzing the successes and failures of the Experimental group, according to the counselor responsible for the cases, there were no significant differences in success and failure between the two counselors who handled the male patients; there did appear to be a difference, in an unsuccessful direction, by the counselor who handled females. In the Control group (Successful), 7 were seen by the field counselor and in the failure group, 8 were seen by the field counselor. Apparently, this variable made no difference. In the Experimental group, Successful, 52% were seen by the field counselor and in the Failure group, 13% were seen by the field counselor. This variable appeared to be significant.

By inspecting the above statistics on various variables that might be meaningful in regard to whether patients were successfully rehabilitated or not, it is noted that several factors may be significant. (1) Females appear to be less successful. (2) The psychological examination appears to have some validity in pointing out cases with good and poor prognoses. (3) Chronicity, in terms of patients who had been in the hospital more than several years, appears to be a significant factor. (4) Sociopathy appears to be of some significance, but not markedly so. (5) There was a higher percentage of the Failure group who had been out of the hospital longer, which indicates that percentage of success shrinks over a period of time because the criterion becomes more stringent. (6) Support and assistance from the field counselor appears to be an important factor.

The above statistics were not treated statistically because of the small N involved in the Unsuccessful group. These findings should only be interpreted as trends.

This study should be repeated, taking into account some of the trends noted in regard to the differences between the Successful and the Unsuccessful patients in the Experimental group, to see if the total effectiveness of rehabilitation services could be significantly increased.

The final results cover a sizable number of patients who had been out of the hospital for several years. The patients were evaluated by rehabilitation counselors in local communities who had good opportunities to accurately evaluate their present status. The counselors appraised both the Experimentals and the Controls and did not know how they were grouped. Therefore, there should not have been any biases operating. For these reasons, the results above should be quite valid.



## VI. Implications of Findings

### A. Introduction

With varying degrees of success all Project goals were accomplished. New knowledge, methods, and techniques of rehabilitation were introduced into a state mental hospital and found to be effective and acceptable to both the State Vocational Rehabilitation Agency and to the State Hospital Staff. The number of mentally ill in the state achieving rehabilitation status was substantially increased from 252 in the first year of the Project to 524 in the last year of the Project. An effective cooperative working relationship has been established between the Division of Mental Health of the State Health Department and the Georgia Division of Vocational Rehabilitation and there has been a meeting of minds regarding the offering of comprehensive vocational rehabilitation services as a vital part of total psychiatric care. To some degree of success, progress has been made in increasing state and community resources including services and facilities for the rehabilitation of the mentally ill, heretofore deemed to have little or no potential for employment. Ground work, however, has been laid for further development in this latter area.

### B. Appraisal of Problems in Providing Follow-Up Services

Perhaps one of the most significant findings which has implications for further program development with cooperating agencies and other resources is the trend for the differences in Experimental and Control Groups to become less significant in each successive Pilot Study. It was suggested that this was probably due to the clients having been out of the hospital for longer periods of time which increased their chances of regression. It is also suggested that these regressions could be substantially curtailed with adequate programs of follow-up at the community level.

A problem of continuous concern in state mental hospital rehabilitation programs is the need for the provision of a thread of continuity of needed services from the hospital into the communities. Through experience in carrying out R & D Project 297 (2) the Georgia Vocational Rehabilitation Agency had become painfully aware of the difficulty involved in the solution of their problem. Consequently, during the last year of that Project the Agency sought to clarify the issues involved through the utilization of questionnaires (see Appendix E) anonymously completed by the general counselors who were being depended upon to provide the post-hospital services.

Generally, an analysis of the data obtained in the survey (see Appendix F) revealed that most of the problems involved had to do with counselor unreadiness to provide the needed services and lack of community resources and acceptable attitudes.

During the life of the current Project attempts have been made to alleviate these problems. Intensive inservice training programs for general counselors in psychiatric rehabilitation have been carried out

both at the state hospital and at the district office level. Psychiatric and psychological consultation, primarily for staff development, has been provided at the community level. Project and other Agency personnel have worked closely with state and local health agencies, state and local mental health association groups, civic organizations, and other resource groups in altering community attitudes and in developing aftercare services for the state hospital released patient.

At the end of the Project, as an evaluative measure of these efforts, the same questionnaire was utilized. Results follow:

Part I of the questionnaire asked the counselors to list the major difficulties that appeared to most adversely effect the rehabilitation of the mentally ill. Generally, the responses were again categorized in the same three major areas, yet, in reverse order as to their severity: (1) Realistic problems related to counselor's lack of time to provide all of the necessary services; (2) Lack of community based resources; and (3) Inadequate treatment before client referral to general counselor. These responses appear to reflect some degree of positive development in the areas of: (1) Counselors' feelings of competency to work with the mentally ill, (2) More realistic expectations of state hospital treatment, and (3) A very small, yet appreciable, development of better interagency and interdisciplinary working relationships at the community level.

Part II dealt with the percentage of clients served on the basis of emotional problems. The counselors reported that, during the past three years, 20.8% of their cases had psychiatric diagnosis as opposed to 10.7% in the previous survey.

Part III consisted of twelve rating scales designed to ascertain the problems of rehabilitating the emotionally disturbed and also ascertain specific feelings and perspectives of the counselors as related to past achievements, present work, and their anticipated accomplishments.

To epitomize the rating scales, there were definite indications that many counselors felt satisfied with past accomplishments in their work with psychiatric clients. Several counselors were not sure that their work had been successful; however, only one felt that his efforts had been completely unrewarding. The counselors stated that a large number of psychiatric patients could be vocationally rehabilitated. Realistic field programs were reflected in the general feeling that the counselors did not have sufficient time to effectively serve their clients. The counselors were rather divided in their opinion on professional services to the emotionally disturbed. Approximately one-half felt that their own professional skills were of foremost service, while 37% were neutral, seeing the necessity for both their own professional skills and for purchasing services.

The counselors indicated that they were sufficiently comfortable in working with psychiatric clients. Only three counselors reported that they were not completely comfortable working with emotionally disturbed clients, and 32% stated that they were as comfortable with the psychiatric

clients as with other clients. The counselors were pessimistic about the communities accepting psychiatric clients. Only one counselor reported that the community could be expected to completely assist in the psychiatric client's rehabilitation. Counselors reported that employers have about the same attitude as community toward psychiatric clients. The communities and employers seemed to be impeding factors to the successful placement and rehabilitation of the emotionally disturbed individual.

In an attempt to ascertain counselors aspirations toward working with psychiatric clients, 76% reported efforts should be increased to vocationally rehabilitate these clients. Approximately 15% felt that present efforts were adequate.

The data collected indicate counselors are not receiving sufficient support from related disciplines. Seventy-three percent reported that professional services from psychiatrists, psychologists and social workers are either unavailable or inadequate. Because the counselors are aware of the limited scope of services rendered to the client through their efforts alone, 70% have stated that they would be more enthusiastic about their work with psychiatric clients if they could be sure of good professional assistance.

Another factor pertinent to effective work in counseling the emotionally disturbed is the need for psychiatric training for the counselor. This training should be geared to a practical but comprehensive level that would allow the adequate understanding of psychopathological dynamics. Seventy-five percent of the counselors reported that they could work more effectively with psychiatric clients and obtain more satisfaction from their work if they had more training and a better understanding of the nature and dynamics of mental illness.

In the last question the counselors were asked if they felt that psychiatric clients were more worthwhile and possessed more vocational potential than physically handicapped clients. The data indicates that 44% of the counselors feel that physically handicapped clients are more worthwhile and have more potential than the psychiatrically handicapped clients; whereas, 39% feel that both clients are equally worthwhile as vocational rehabilitation candidates.

Concluding our comparison, we see the pattern of attitudes and perspectives held by the field counselors taking a more positive trend. They feel some satisfaction with the work they have done with rehabilitating psychiatric patients but express a need to increase the quality and quantity of their work. They need more time for individual counseling and recognize the need for psychiatric training in the dynamics of psychopathology. With this training, they would be more effective in rendering the needed services to this type of client. Continued public education may help resolve the apparent problems of social stigmas, employer resistance, inadequate treatment, and lack of professional assistance. With this rather positively expressed and growing general attitude toward working with the emotionally ill, it appears that more and better services will become available for the psychiatrically disabled clients who are leaving



the hospital in need of vocational guidance and other assistance to facilitate their re-entry into competitive work. Only with the needed assistance can these clients resume positions in the community and again become productive members of society.

**C. Problems of Change Required as Hospital Staff Adjust to the Idea of Vocational Rehabilitation in a Program of Integrated Services**

Project findings suggest two factors as being basic in this area:

The first of these is the mutual recognition of the needs of the participating agencies and disciplines that can be met through a joint program of integrated services. This recognized need on the part of the hospital should transcend any idea of VRA grants to replenish meager budgets and insufficient staff and which conceivably could be used to carry on the same type of traditional program. It is the responsibility of the State Rehabilitation Agency to identify and to "sell" their professional services to the hospital rather than to promote the acceptance of VRA grants. On the other hand, the Rehabilitation Agency's motivation for the joint program should go beyond the well known need to count large numbers of closures. It is the right and the responsibility of the hospital to insist that the rehabilitation service offered their patients be therapeutic and substantial to the extent that the patients can be more successfully reintegrated into the life of the community.

Prior to the development of the joint program of services in Georgia the Rehabilitation Agency and the State Hospital jointly examined their common problems. Preliminary investigations in group discussions resulted in one specific recognition of a principle that seemed fundamental in the approach to these problems. Based on this premise, it was revealed that traditional treatment of the illness and return of the patient to his former community are not enough; and, likewise, it was revealed that vocational rehabilitation is not a complete service when working alone with the mental patient. Developing from these conferences was the mutual agreement that each agency had the potential to augment and enhance the services of the other.

The second factor for consideration, which is secondary to the first, is the development of effective working relationships. A preliminary step here should be well structured agreements formulated at state-office levels and communicated to all lower working levels. The second step which becomes a continuous, never ending one, is the identification of roles and functions and the cultivation and maintenance of effective working rapport at the discipline working level. Here, it is feared, most of the burden must be upon the shoulders of the vocational rehabilitation personnel since the traditional disciplines are usually already pretty well entrenched in the hospital and are not as likely, in the initial stages, to be as well motivated to have the joint program work as would the vocational rehabilitation staff.

The approach taken by the Georgia Agency to this problem involves the selection of well-qualified, mature individuals as staff members and the



provision of intensive in-service training programs. Each staff member is continuously indoctrinated with the following eight points which are considered basic to the development and maintenance of effective working relationships:

1. Recognition of Vocational Rehabilitation needs which makes the cooperative effort desirable
2. Awareness of the nature of the needs with which we expect the cooperating agency to assist us
3. Clear idea of the contribution we expect to make to the joint effort
4. Willingness and flexibility to adjust to new situations necessary to the accomplishment of our common goals
5. Willingness to define for the cooperating agency our own needs, goals and limitations
6. Awareness of and respect for the policies, roles, functions and goals of others in the cooperative effort
7. Sensitivity to the individual needs of personnel of the cooperating agency and a willingness to help meet these needs when possible
8. A sense of individual responsibility for developing and maintaining a favorable climate in which to work.

## VII. Summary, Conclusions, and Recommendations

### A. Summary

Milledgeville State Hospital has undergone continuous change and development during the last few years. From an institution resembling what Karl Menniger once described as "a warehouse for humans," this hospital has rapidly become a progressive treatment center for the mentally disabled. From an institution with limited and inadequately staffed departments, has resulted an enterprising hospital with three operational psychiatric training programs and full accreditation for every department. New departments include vocational rehabilitation, biostatistics, public relations, chaplaincy, and volunteer services. The hospital smoothly and successfully adopted the unit system. The new building program was completed which included additional dormitories, the Children's Rehabilitation Center, and the Yarbrough Rehabilitation Center.

These changes and improvements are summarized because they reflect a new trend - action towards the implementation of concerns and philosophies for many years held on the treatment and rehabilitation of the mentally ill. This summary of advancement is mentioned, furthermore, because it is doubtful the Project would have been as successful without the progressive tempo of the total hospital environment.

The Georgia Division of Vocational Rehabilitation and the Georgia Department of Public Health entered into a cooperative working relationship aimed at offering a complete range of integrated medical, psychological, social, and vocational services with the goal of re-integrating mental patients into the life of the community. The Research and Demonstration Project was initiated at the State Hospital where services were rendered on selected wards while Experimental and Control Groups were being assigned. Knowledge, methods, and techniques partially developed in other studies were effectively applied to the treatment and rehabilitation process in this institution. It was observed rather early, however, that the staff-patient ratio was much higher in a state hospital, and the counselor must thereby assume more responsibility for client supervision than had been anticipated. The counselor, as a member of a psychiatric team, was responsible for developing, with the team, a rehabilitation plan for all experimental subjects. Not having the advantages offered by a rehabilitation facility, the counselors worked with the hospital staff in developing work stations on the campus for vocational evaluation, training, and occupational adjustment. Some clients also worked and trained temporarily downtown Milledgeville in their preparation for release from the hospital. Vocational schools in near and distant cities were sometimes utilized. When the patient was medically ready for furlough, he was usually also ready from Vocational Rehabilitation's viewpoint. At furlough time the client's vocational rehabilitation file was forwarded to the local counselor for his use with the client in providing follow-up services. In many instances, a

telephone call to the local counselor was necessary because of peculiar circumstances.

Recommendations in the file usually focused on (1) a counseling approach with the client, (2) justification for psychotherapy if needed, (3) suitable training or employment objectives, and a friendly work environment, and (4) the importance of the client's early participation in follow-up services.

#### 1. Important Findings

- a. Several reasons account for the excellent follow-up the clients received. Among these would be Project discussions at the District Office level, field counselor orientation at the state hospital, personal contacts between hospital and field counselors, and the general emphasis at the state office and central office level on rehabilitation of the mentally ill client.
- b. Isolated incidences of resistance in the community resulted for reasons mentioned in Chapter VI; there was also negative reaction to cases transferred to the community where the hospital planning appeared over presumptuous about follow-up services. This is a reality factor, of course, that must be considered anytime that one counselor initiates a plan of action for another counselor to carry through to closure. In view of the isolated setting of the hospital and the geographical distances between the hospital and most communities, however, the cooperative working procedures with the field counselors were considered satisfactory.
- c. Most clients who were refused services in the community were declined for reasons ranging from alleged irregularities in the case file to statements concerning the severity of the patient's illness. Where there was time and freedom to make personal contact, however, most conflicts were readily resolved and the client did not encounter rejection.
- d. Establishing human study groups presented some difficulty on the wards. Both groups were taken from the same wards, and oftentimes a Control patient would stop the counselor, or another staff member, and ask, "Why will vocational rehabilitation not work with me?" A patient, or any person for that matter, cannot be totally ignored without being disserved. Needless to say, there was much relief when the study groups were completed.
- e. Many times, during the project study, it appeared the Vocational Rehabilitation Department could have enhanced its acceptance and effectiveness in the hospital by increasing its staff and thereby the number of patients it could reach. Not long after the study commenced, the

counselors yielded to the demands of the other wards, and found themselves trying to serve, on the average, 4,000 patients each.

- f. For many years, rehabilitation personnel have preferred to wait until others have taken the lead in the various facets of rehabilitation work. A good example of this is our frequent reference to an emotionally disturbed referral. We are quick to say, "He is not ready for vocational rehabilitation yet." This Project Study has demonstrated that vocational rehabilitation personnel must make early contact with the patient and thereby be part of the process that "gets the patient ready."
- g. It was a surprise to most people when so many patients balked at entering the new rehabilitation facility. Questions were eventually raised about the advisability of resident clients. We prefer to believe this was simply another aspect of change which was resisted.
- h. Another jolting confrontation concerned the appearance of our clients leaving the hospital. The candid comment by the Atlanta counselor evidently stimulated the staff to consider even other needs heretofore unattended to.
- i. It was observed, during a several month period, that there was a wide latitude of reliance on different tools of measurement used in the evaluation laboratory. While one counselor would depend solely on psychometric testing and clinical observations, another would refer 80% of his clients for job sample evaluation. No analysis has been attempted in this particular phase of the program to determine effectiveness of tests and testing.
- j. What about professionalism in state mental hospitals? Is there any support to the statement that service should be the prime concern? Observations of professionals and non-professionals reveal the latter may be most effective in the day to day completion of tasks in the hospital.
- k. The physical location of Milledgeville State Hospital demands additional vocational rehabilitation services such as vocational training. Some vocational courses, however, appear more realistic and effective than others. We have had difficulty in maintaining full classes in machine shop practice and electrical appliance repair.

## 2. Significant Aspects

- a. The work adjustment services of the Project continue to serve a maximum number of clients. Many field counselors have stated they believe this is the most important vocational rehabilitation service in the hospital. They



feel this is more closely related to the demands of actual employment.

- b. Teamwork is necessary to bolster morale among staff members, and consequently among the patients. Regardless of the number of staff on the team, they must work together to provide orderly, efficient, competent services to the patient.
- c. Hospital counselors must maintain a practical perspective on community after-care, and, above all must keep in contact with the local counselors. It has helped our program to keep the mechanical aspects of rendering case services identical with that of other counselors in Georgia.
- d. The type patient served in a state mental hospital helps determine what services will be provided. In this hospital, it would be absurd to attempt a large scale vocational rehabilitation program without some provision for remedial, special, or adult education. Some skills are especially basic to other vocational rehabilitation services.
- e. The majority of our furloughed clients go to Atlanta, and at least one-third of these have never lived there before. With the population of the metropolitan area at 1.2 million, this is no place for the shy, timid, withdrawn client to be alone. Counselors on special assignments in Atlanta and in other metropolitan areas may resolve this problem for us. These counselors usually carry smaller caseloads, are better trained in the specialty area, do not follow rigid itineraries each week that frequently have them out of town. They are flexible, knowledgeable in their field, and eager to concentrate all their resources on the particular task at hand - on this client from Milledgeville now arriving at the bus station.
- f. As mentioned previously, many clients are obviously making use of boarding houses in every metropolitan area. Field counselors have worked tirelessly in identifying suitable residences in their territory for new arriving clients. Boarding houses remain the most economical type commercial residence, and are being used by more and more clients. A large number of clients going to Atlanta take temporary residence in these houses (11).
- g. The Yarbrough Rehabilitation Center is indeed a significant aspect of this Project but cannot be any greater than the program within and surrounding its walls. Various aspects of the facility program are already demanding research attention.

## B. Conclusions

1. This Project and the anticipated continuing program demonstrate the feasibility and effectiveness of two state agencies developing a vocational rehabilitation program together. Services and philosophies were satisfactorily meshed so that the needs of each were met while the Project was successfully conducted.
2. A project of this magnitude cannot be successful without the support, assistance, and cooperation of the field counselors and their supervisors, other vocational rehabilitation personnel, staff from the partner agencies, private agencies, civic organizations, and others. While Chapter V revealed sufficient follow-up to make significant inferences, additional information would have made possible a more detailed analysis of other aspects of the research effort. Nevertheless, it can be concluded that hospital vocational rehabilitation services assist the patient in moving towards occupational adjustment and stability in the community, even without counselor follow-up. The variable of counselor follow-up was significant, however, revealing a higher rate of success where such follow-up was provided. In regard to another variable, client sex, it is doubtful if this is as significant as shown in the results. Other variables such as client selection, hospital counselor, hospital treatment team, diagnosis, etc., are believed to be of more prognosticative value. Of major importance, and so, was the finding of a diminishing rate of success for clients having been out of the hospital for longer periods of time. We present a corollary to this finding: the post-hospitalized client needs follow-up attention much longer than the Vocational Rehabilitation Agency can now practically and legally provide.
3. Realistic vocational training and work experiences in the hospital provide a framework of reference for outside living which is difficult to duplicate otherwise on the hospital campus.
4. Modern evaluative tools are not optimally effective with many regressed, socially deprived patients. Less scientific, but possibly more meaningful learning experiences in basic skills, trial jobs, and personal adjustment would give the patient a realistic opportunity to respond positively to our invitations to self-fulfillment.
5. It is highly unlikely that training programs for the "mental health professions" will anytime soon abandon their use of state mental hospitals for internships, field placements, and other practicum training experiences. We feel the hospital and the student benefit mutually, the extent of profit of course being determined by the goals and contributions of each. There appears to be a real need for "sub-professionals," however, at high school or college level, persons who have not been spoiled

or delusional through formal indoctrination, persons who simply do not know any better than to work hard in helping the patient to get well and leave the hospital.

### C. Recommendations

Observations and statistical findings in this study suggest a number of directions for further research in the present continuing rehabilitation program and for research and demonstration in other areas.

#### 1. Reluctant referrals

We have arbitrarily avoided exerting pressure on the reluctant referral who denies need, is fearful of exposure, or otherwise asserts that he does not need assistance. The hospital can, of course, prescribe vocational rehabilitation services just as Occupational Therapy, Music Therapy, Mop Therapy, medications, etc. are ordered. We have attempted to avoid this approach, however, preferring to work with those patients who acknowledged their illness and more or less accepted assistance. It has appeared that our success rate with the reluctant referral is sufficiently low to warrant avoidance of further work with this type client. This should be a consideration for research, however, and not left undiscussed or to the fancies of observation alone.

#### 2. Work with the hard-to-reach patient

Several sub-groups of patients remain in state mental institutions with less hope for leaving than the schizophrenic: (1) The severely regressed patient (who might have been schizophrenic), (2) The alcoholic who is usually "dried out" and returned home many times before a CBS is evident, (3) The mentally deficient, and (4), the older, senile patient.

In an institution such as Milledgeville State Hospital, such studies could be conducted, but only with much concentration of effort. This effort seems to be extremely important for institutions, however, with the increase of psychiatric wards in general hospitals and the establishment of community psychiatric treatment centers. This type patient will probably make his way through the community clinics, and eventually reside at the large institutions, and there remain as he does today, unless concern, techniques, and approaches are improved.

#### 3. Vocational Evaluation

Vocational Evaluation conducted in the laboratory will be studied in this setting to appraise the effectiveness in selecting wise vocational training and employment choices. Do counselors make optimal use of test results, of the evaluation technique available? What variables should be considered in determining validity

of test results? What does vocational evaluation contribute to the client's over-all rehabilitation planning?

#### **4. Specialization in follow-up**

The Georgia Program has utilized the services of a special counselor in Metropolitan Atlanta for three years, with what would appear to be an excellent arrangement for hospital counselors as well for the Atlanta District counselors. As mentioned earlier, the high number of clients sent to this man would testify to the effectiveness of this service as appraised by the hospital counselors, their clients, and the treatment teams. It seems reasonable to expect a similar arrangement could be made to work with furloughed patients in the other urban areas. Some immediate considerations would include (1) a survey of the number of clients coming from and/or returning to those areas, (2) a survey of services currently rendered to those patients returning and an appraisal of the effectiveness of those services, and (3) a comparative analysis of the client re-admission rates from Atlanta and other urban areas. (4) The availability of job opportunities and (5) residential facilities should also be considered in a study of those areas.

#### **5. Long-term follow-up services**

The Project study revealed declining success rates with passage of time for patients remaining out of the hospital for longer periods. These results indicate the need for a longitudinal study providing long-term follow-up assistance. A State-Federal agency could employ such a research design with explicit goals for following and assisting the furloughed patient. This type study should offer sufficient time for intensive work in the community engaging the active participation of family, employer, and other "significant persons."



## APPENDIX

APPENDIX A	Follow-up Questionnaire I-A
APPENDIX A	Follow-up Questionnaire I-B
APPENDIX B	Follow-up Questionnaire II
APPENDIX C	Agreement Between Milledgeville State Hospital and Georgia Division of Vocational Rehabilitation for the Opera- tion of a Vocational Rehabilitation Program at the Milledgeville State Hospital
APPENDIX D	Implications for Rehabilitation
APPENDIX E	Sample of Attitude Form for Vocational Rehabilitation Counselors
APPENDIX F	Appraisal of Problems in Providing Follow-up Services

APPENDIX A

FOLLOW-UP QUESTIONNAIRE I-A

Vocational Rehabilitation Research Project 778

Date of Evaluation: \_\_\_\_\_

Name and Title of person who did the evaluating: \_\_\_\_\_

CLIENT \_\_\_\_\_ GROUP (E) \_\_\_\_\_ (C) \_\_\_\_\_

COUNSELOR \_\_\_\_\_ SEX \_\_\_\_\_ AGE \_\_\_\_\_

Has this person been seen by the Field Counselor? \_\_\_\_\_ How many times \_\_\_\_\_

1. Is this person working now? \_\_\_\_\_
  - a. How long has he held this job? \_\_\_\_\_
  - b. How many jobs has he held since leaving the hospital? \_\_\_\_\_
  - c. Is his present job the same as that recommended by the Vocational Rehabilitation Counselor at the Hospital? \_\_\_\_\_
2. Is this person adjusting satisfactorily to his job? \_\_\_\_\_
3. Does this person seem to be adjusting satisfactorily at home and in his community? \_\_\_\_\_
4. Is his present job better , the same, or worse than that held previous to hospitalization? \_\_\_\_\_
5. Is his present mental condition better, the same, or worse than prior to hospitalization? \_\_\_\_\_
6. Has this person been readmitted to the Hospital? \_\_\_\_\_
  - a. If so, how many times? \_\_\_\_\_
7. These ratings were based on :
  - a. Reports from family \_\_\_\_\_
  - b. Reports from patient \_\_\_\_\_
  - c. Reports from Employer \_\_\_\_\_
  - d. Mostly Field Counselors opinion \_\_\_\_\_
  - e. All of these \_\_\_\_\_

APPENDIX A

FOLLOW-UP QUESTIONNAIRE I-B

Vocational Rehabilitation Research Project 778

EVALUATION AS OF

CLIENT \_\_\_\_\_ GROUP \_\_\_\_\_

COUNSELOR \_\_\_\_\_

(Circle One)

1. (a) Working? Yes No  
(b) In Training? Yes No
2. Stability: Good Fair Poor
3. Employer satisfied: Yes ? No
4. Patient satisfied: Yes ? No
5. Family satisfied: Yes ? No
6. Re-admitted to hospital: Yes No Number of times \_\_\_\_\_
7. Job now compared to previous job:  
Better ? Worse
8. Present mental condition as compared to pre-hospitalization  
Patient Evaluation:  
Better Same Worse  
Family or Relative Evaluation:  
Better Same Worse

APPENDIX B  
FOLLOW-UP QUESTIONNAIRE II

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Color \_\_\_\_\_

County \_\_\_\_\_ Type of Admission \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Ward \_\_\_\_\_

Psychiatrist \_\_\_\_\_

Personality Evaluation by \_\_\_\_\_ Date \_\_\_\_\_

Counselor \_\_\_\_\_ Social Worker \_\_\_\_\_

Referred by \_\_\_\_\_ Date \_\_\_\_\_

Initial Interview \_\_\_\_\_ Furlough Date \_\_\_\_\_

Dates of Interviews \_\_\_\_\_

Total Interviews \_\_\_\_\_ Total Tests \_\_\_\_\_

Type of Industrial Therapy - Dates and Results \_\_\_\_\_

Recommendations for Post-hospital VR Services (If None, Why?)

Evaluation never initiated - Why?

Evaluation never completed - Why?

Who made placement? \_\_\_\_\_ Extent of

VR Participation? \_\_\_\_\_

If patient from Control Group evaluated, why? \_\_\_\_\_

Follow-up Data: \_\_\_\_\_



## APPENDIX C

### AGREEMENT BETWEEN MILLEDGEVILLE STATE HOSPITAL AND GEORGIA DIVISION OF VOCATIONAL REHABILITATION FOR THE OPERATION OF A VOCATIONAL REHABILITATION PROGRAM AT THE MILLEDGEVILLE STATE HOSPITAL

Currently the Milledgeville State Mental Hospital and the Georgia Division of Vocational Rehabilitation are cooperating in a program of treatment and Vocational Rehabilitation services. Since it is desirable to add other services to this cooperative effort including work motivation, vocational training and additional therapeutic support, it is necessary that an agreement be entered into that clearly establishes working relationships and lines of authority and responsibility between the Milledgeville State Hospital and the Georgia Division of Vocational Rehabilitation as regards the program of expanded services to be offered in the Milledgeville State Hospital.

The proposed program will provide comprehensive services in all four areas of rehabilitative care; medical, social, psychological and vocational. (Attached narrative outlines the program in detail.)

The program will be jointly financed by the Milledgeville State Hospital, which will provide the state funds in the amount of \$60,000 which will be matched by the Georgia Division of Vocational Rehabilitation with \$140,000 making a total operational budget of \$200,000 to finance the joint program.

The administrative responsibility will be shared jointly by the Milledgeville State Hospital and the Georgia Division of Vocational Rehabilitation. The Director of the Division of Mental Health will make all final decisions regarding state hospital policy, regulations, etc., as these relate to the joint service program. The Director of the Georgia Division of Vocational Rehabilitation will make all final decisions regarding the Vocational Rehabilitation program in accordance with the law, regulations, and state plan.

The program will have an advisory committee composed of representatives from each cooperating agency. The Milledgeville State Hospital representative will include the Director of Unit I, who will act as chairman of the Committee, and the Medical Director of the Yarbrough Center. The Assistant State Director and the Program Manager, Georgia Division of Vocational Rehabilitation will represent the state Vocational Rehabilitation Agency. The Supervisor of Vocational Rehabilitation services will serve as secretary to the Committee.

This Committee, with the consent and approval of the Director of the Division of Mental Health, the Superintendent of Milledgeville State Hospital and the Director of Georgia Division of Vocational Rehabilitation, will coordinate program policies and procedures. The Advisory Committee will meet at regularly scheduled times and will review and evaluate the needs and the progress of the facility.

The over-all direction of the Vocational Rehabilitation Program will be the responsibility of the Supervisor of Vocational Rehabilitation Services. All personnel working in this cooperative program will be administratively responsible to him. The Supervisor will, in turn, through proper channels of authority, be responsible to the Superintendent of Milledgeville State Hospital for the therapeutic quality of the services provided in the program; likewise, through proper channels of authority, he will be responsible to the Director of the Georgia Division of Vocational Rehabilitation in all matters relating to the legal and administrative requirements of the Vocational Rehabilitation Agency.

Milledgeville State Hospital agrees:

1. To provide adequate office space, evaluation areas, vocational training areas, training equipment, maintenance services, necessary utilities, custodial help, etc., so that a high quality program of vocational

rehabilitation services can be carried out.

2. To provide all necessary diagnostic information and treatment services to patients eligible for vocational rehabilitation services.

3. To provide continuing treatment and follow-up care as needed and required to those patients who have been accepted by the Division of Vocational Rehabilitation as its clients even though these individuals may have been discharged from the center as patients and may be receiving vocational training, adjustment training, or some other vocational rehabilitation service, or may be actively engaged in employment in the community.

4. To assure that sufficient time can be set aside in the patient's treatment program so that appropriate vocational evaluation and training procedures may be carried out while the patient is receiving services in the center.

The Georgia Division of Vocational Rehabilitation agrees:

1. To provide sufficient professional and clerical staff to carry out a vocational rehabilitation program in the center of the highest professional quality which will consist of:

- a. Vocational evaluation
- b. Vocational diagnosis
- c. Work remotivation
- d. Work adjustment training
- e. Vocational counseling and guidance
- f. Vocational training

2. To assume responsibility for the development of the vocational rehabilitation program in the center and to advise the Milledgeville State Hospital on the purchase of necessary equipment to outfit the vocational areas.

3. To accept referral of those patients who need and are eligible for vocational rehabilitation services such as those listed above as well as the provision of necessary vocational rehabilitation services when the Client leaves the hospital and returns to the community (e.g. pre-vocational

training, adjustment training, vocational training, prosthetic devices, et cetera) to these patients in accordance with the provisions of the approved State Plan for Vocational Rehabilitation.

4. To assist the other professional disciplines in the coordination of program between the center and the community for those patients who are eligible for vocational rehabilitation services, to make available to these patients the full resources of the Georgia Division of Vocational Rehabilitation, and to keep the center staff appraised of subsequent developments in these cases after they return to the community.

5. To provide administrative, technical and consultative services as may be needed through the Division's State and District Vocational Rehabilitation Staff.

Milledgeville State Hospital will provide the following staff for the amount of time indicated to carry out the medical, social and psychological aspects of the program:

- 1 psychiatrist (full time)
- 1 psychologist (full time)
- 1 psychiatric nurse (full time)
- 4 work orientation therapists (full time)
- 1 chief social worker (2/5 time)
- 1 social worker (3/4 time)
- 1 social worker (1/2 time)
- 1 social worker aide (3/4 time)
- 1 social worker aide (1/2 time)
- 1 work remotivation director (1/2 time)

The Georgia Division of Vocational Rehabilitation will provide the following personnel to carry out the vocational aspects of the program:\*

- 1 Vocational rehabilitation supervisor
- 1 Vocational training coordinator
- 15 Vocational training instructors
- 4 Work adjustment instructors
- 2 Clerical workers

\*In addition to the above listing the Georgia Division of Vocational Rehabilitation currently employs the following staff members in Milledgeville State Hospital Vocational Rehabilitation Program:



- 1 Vocational rehabilitation supervisor
- 5 Vocational rehabilitation counselors
- 3 Pre-vocational evaluators
- 5 Clerical workers
- 1 Consulting Psychiatrist (1/8 time)
- 1 Research Psychologist (1/4 time)
- 5 Consulting Psychologist (1/5 time each)

**TERMS OF AGREEMENT**

- (1) This agreement becomes effective on the date of signature and shall continue in effect unless modified as follows:
- (2) This agreement may be amended by the agreement of the Director of Mental Health, Department of Public Health and the Division of Vocational Rehabilitation at any time.
- (3) This agreement may be terminated by either party following lapse of one year from the date of written notification by either agency.
- (4) This agreement provides for the transfer of the current Vocational Rehabilitation Staff, now working at the Milledgeville State Hospital under a Federal Research and Demonstration Grant, to this Cooperative Program at the end of the Grant period.

Division of Mental Health  
Department of Public Health

\_\_\_\_\_  
Director

\_\_\_\_\_  
Date

Division of Vocational Rehabilitation

\_\_\_\_\_  
Director

\_\_\_\_\_  
Date

## APPENDIX D

### IMPLICATIONS FOR REHABILITATION

\*BLUE, Mary  
England County

Date of Report: 5-10-64  
Counselor: Joseph Lee  
Initial Interview: 12-2-63  
Total Interviews: 15+  
Total Tests: 6 + Tower

#### MEDICAL ASPECTS AND HISTORY

This 52-year-old, Caucasian, twice divorced female was admitted to Milledgeville State Hospital from Logan County, by 1960 Law, on 11-11-63. She was referred to Vocational Rehabilitation on 12-1-63, actively participated in a total rehabilitation program, and is scheduled for hospital furlough and subsequent Vocational Rehabilitation follow-up services on 5-22-64.

Mrs. Blue was born February 15, 1912, in Baltimore, where she grew up with her parents, three brothers, and one sister. Mary was very close to her father whom she describes as a sober, hard-working man, who was easy for her to talk with. She describes her mother, however, as a very domineering individual who has used her many and frequent psychophysiological illnesses to control the family. Mary, the youngest sibling, has always thought that she was unwanted by her mother; the mother is now living in Lowerville, Georgia, with the client's sister.

Mary quit school after the eighth grade in order to help support the family, whom she describes as being very poor. At the age of 16, she met the man who was to be her first husband. They married four years later and lived together eleven years before "his infidelity" caused the divorce. Their only child was 9 years of age at that time. Mrs. Blue assumed support and full responsibility of the son and "sent him through college." He is now married, a prominent citizen of the community and is Registrar of Cherokee College.

Mary and her son moved to Lowerville when she was 31. She entered immediately into employment and also did voluntary work with the church which took up much of her spare time and also helped to lessen the emotional strain of her divorce as well as the problems experienced in relocation. Years later, she began dating a policeman in Lowerville, against her family's wishes, and married him in February of 1961. The policeman himself was a divorcee, and, like our client, was closely attached to a son. The father and son tie was extremely close and precluded the possibility of a third party entering the relationship. There were problems and conflicts from the very beginning of the marriage. This, another failure in life, was followed by other difficulties, unmet needs, and family pressures which prompted Mary to leave Lowerville and

\*To protect the identity of the patient, fictitious names of persons and places are being used.

move to Metropolis. In June of 1963, she went to Metropolis where she became depressed, lonely and confused. Not a young woman any longer, she neither had the personal appearance, apparent stability, or perseverance to secure employment. For several weeks, she evidenced insomnia, nervousness, belligerence to her associates, excessive spending sprees. Finally, her relatives had heard enough and thereby initiated proceedings to have Mary admitted to the State Hospital for the mentally ill.

#### **MEDICAL DIAGNOSIS**

**Personality Trait Disturbance: Passive Aggressive Personality**

#### **PROGNOSIS**

Prognosis appears very guarded unless this woman is given substantial support and rehabilitation followup upon leaving the hospital.

#### **PLAN OF TREATMENT AND RESULTS**

Upon entering the hospital, Mary was given a mental examination which found her to be reasonably alert, demonstrating a fair degree of judgment, and was seemingly well-organized. She was administered Trilafon initially, but has not been on medication for the past two months. Early referral and acceptance by screening team indicated that she was a good candidate for services in the Yarbrough Rehabilitation Center. Throughout counseling, testing, and other rehabilitation experiences, she has continued to impress the staff. Patients and staff, on referral ward as well as on rehabilitation ward, have been fond of Mary as she actively participates in all activities. Teen-age patients see her as a mother-figure and she has very subtly taken advantage of this situation. Filling this role, with maturity, she has actually assisted the treatment program while simultaneously gaining stature herself.

Vocational testing revealed there was some absence of job skills. However, work seemed important to her as a defense against failure. She responded energetically to discussions of work and was subsequently placed on a non-remunerative job within the hospital as receptionist and general office clerk. While her level of skills increased (typing from 26 to 48 wpm) counseling services encouraged motivation and helped to establish realistic goals.

There was a temporary setback during the hospitalization at which time her son telephoned the hospital, stating the he did not wish Mary to be released. Case discussion in ward conference resulted in the Social Service Department calling the family in in an effort to work through this barrier. Casework was successful in giving the family a better understanding of the patient's problem as well as their own contribution to her illness. She has since been able to leave the hospital on a temporary visit for a pleasant weekend vacation in Lowerville. Letters and visits from her mother and siblings reassure Mary that she is not neglected and unwanted. She is now gaining strength for her venture outside the hospital.

## **CAPACITIES**

### **Description of Client**

Mary's tranquil hospitalization resulted in her gaining from 129 pounds on admission to 148 pounds now. This much weight for her 5' 6" frame makes her a little plump; however, she is a rather attractive woman who always dresses neatly, appropriately, and attractively. She is well-groomed and wears her dyed blond hair in current style. Her posture is good, she appears well-cultured, and she is also quite spontaneous, articulate, as well as humorous in her conversation. She wears glasses, is righthanded and has one arm that is mildly curved; the curvature does not impose a physical handicap, and she shows normal motor activity.

Results of the physical examination were within normal limits, and she appears to be in good physical condition.

### **Education**

In addition to her eighth grade education, she has received PBX training via employer but began her business career as a result of completing a four month evening course in general office work at a local trade school.

Academic testing revealed deficiencies in the basic areas with resultant scores of 8.3 grade level in Reading, 6.4 grade level in Spelling, and 4.9 grade level in Arithmetic.

### **Intelligence and Personality**

Intelligence testing revealed a Verbal IQ of 95 and a Performance IQ of 109. Intellectual functioning seems retarded due to her limited education. In light of past vocational accomplishments, we would expect her to have the native ability of Bright Normal intelligence.

Although no special psychological evaluation was requested in this case, consultation with the team psychologist revealed that Mary has made considerable progress in group psychotherapy. Her behavior has changed from hostility and resentment towards her family to insight and understanding of her own behavior and how it brought her to the hospital. She has been motivated for treatment and rehabilitation. Having seemingly been rejected by her mother, Mary had developed very little ability for positive, meaningful, relationships with family members or other persons. Prior to her hospitalization, she had felt that she had received very little real help from her family and tended to blame her impulsivity and other irrational behavior on them. For many years, Mrs. Blue had worked hard, supporting herself and child, as well as proving that she could be independent. But more recently she has found herself very dependent on others, even for subsistence. Craving more recognition and acceptance, she only irritated her family and worsened their relationships.

Through her therapeutic experiences in the rehabilitation program, she has now begun to see herself as an attractive person with much capacity for social intercourse and occupational achievement. Initially, wanting



to return to a community neighboring Lowerville, she now has become more "future oriented" and has been able to make the decision to return, instead, to Metropolis. Gains made in the counseling relationship have enabled her to make the decision on returning to a city, which although at one time presented many frustrations for her, now presents itself as a land of opportunity. Job opportunities in her field are most plentiful there, as are a wide range of vocational rehabilitation services.

### Work History

Mrs. Blue's first employment was with a telephone company in Maryland. She was a PBX Operator for three years and says that she "loved it!" She left this job when she got married.

Her second employment was with the J. B. Stone Construction Company as a PBX Operator at the shipyard. She worked here three years until the shipyard closed.

Next employment was working with a city hospital as PBX Operator. She stayed on this job for twelve months and then "left for advancement."

Next employment was with Brown's Department Store where she worked as a Cashier for two years. She earned \$40 weekly and her supervisor was Mr. Joe Brown.

Mrs. Blue next worked for the Lowerville Auto Parts for one year. She worked as a Bookkeeper, keeping the cash journal, petty cash and payroll entries. "She left for advancement."

Next employment was with the Alice Dress Shop where she worked as Bookkeeper for 8½ years. She kept a full set of books and was actually in charge of the Bookkeeping Department. Beginning at \$45 per week she advanced to \$80 before she "left for advancement."

Next employment was with the H. L. Finkelman CPA Firm. She worked here as Bookkeeper for two years at \$90 a week. She left this job in March of 1963 to visit in Boston, Massachusetts. She was having marital problems and wanted to leave the Lowerville area.

In Boston, she worked for the Massachusetts Insurance Convention for one month at \$75 per week; she said that she was homesick for her family and quit to return to Georgia.

In review of these employments it appears that Mrs. Blue worked for a total of seven years as PBX Operator and approximately 12½ years in bookkeeping-type positions. She looks with favor upon her past employment record and has much desire to continue in the bookkeeping phase of business if this will be possible. Social Service information confirms her past experience as Bookkeeper, and informants also reflect favorably upon her overall proficiency. We believe that her work here at MSH has been a valid example of her usual vocational performance, work attitudes, and interpersonal-office relationships.

### Interests

There is a positive correlation between this woman's past work history, expressed desires, and inventoried interests. Her Inventory profile accented Business at 95%ile, Personal-Social 70%ile, Scientific 70%ile. In types of interests, her Computational score was 95%ile. Her level of interest was at 10%ile, again calling our attention to her tendency to avoid challenging work. Her low aspiration level is effected by her fear of failure.

### Aptitudes

Psychometric profile is attached. Also, see vocational evaluation final report of February 11, 1964. Significant discrepancies between psychometric results and pre-vocational evaluation serve to confirm the need for extensive vocational testing in order to further appraise true vocational potential.

### Motivation

No longer possessing a defeatist attitude, Mrs. Blue has mobilized her personal resources and now feels confident that she can participate in follow-up rehabilitation services and reach a satisfactory level of independent living.

### REALITIES

Mrs. Blue has accepted her illness and made a positive response to treatment, making good use of the hospital staff and services. Vocational rehabilitation services were implemented by her active, rational, mature participation. Her assets include a work history of substantial, continuous employment and other evidence of satisfactory work adjustment. Her employability is further enhanced by her attractive dress and youthful grooming.

Intelligence testing agreed in showing Mrs. Blue to be a woman of above average intelligence, quite capable of performing successfully in professional work. Aptitude testing with the TOWER series indicated that she is now functioning on a level that would facilitate her re-entry into bookkeeping, general office, or accounting work. Her manifested, expressed, and inventoried interests were consistent in reflecting her preference for return to bookkeeping.

Liabilities include her continued dependency on her mother and the need for further reassurance that she had the love, acceptance, and support of her family. These relationships are being strengthened currently through our Social Service Department.

The treatment program will carry over into the community where Mary is expected to need considerable support in developing acceptable friendships and in feeling comfortable with herself in Metropolis. The rehabilitation counselor, Mr. Asa Barnard, will review this report along with other pertinent data prior to Mary's furlough in order that he can acquaint

himself with her work potential as well as needs to be met during the adjustment period. Division of Vocational Rehabilitation is the sponsoring Agency, and living accommodations will be arranged before she is actually furloughed. It is felt that she could function better if placed in a situation that would render her group-participating and group-support. A supervised half-way house would be ideal. Her ward therapist has recommended continued group psychotherapy and it is felt that Mr. Barnard will be able to get her into one of the medical college therapy groups. It is also being recommended that Mrs. Blue join the Metropolis fellowship club where she can enjoy and benefit from the well-rounded program of social living. Other community resources will be utilized as the need is indicated.

The availability of post-hospital services during the crucial transitional period will significantly affect her ability to adapt herself to the demands of her environment in an acceptable manner.

APPENDIX E

SAMPLE OF ATTITUDE FORM FOR VR COUNSELORS

QUESTIONNAIRE ON REHABILITATION OF THE MENTALLY ILL

This questionnaire is a part of an attempt to realistically evaluate the problems involved in the vocational rehabilitation of the mentally ill in Georgia. Since all completed forms will be considered as anonymous, you are invited to be as candid as possible.

I. List in the order of their difficulty of solution three problems which to you appear to most adversely effect the rehabilitation of the mentally ill.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

II. During the past three years approximately \_\_\_% of my clients have had a psychiatric diagnosis.

III. On the following rating scales, by circling the appropriate number please indicate the degree to which you feel the accompanying statements are either true or false. By checking the mid-number "3" you would be indicating the statement to be equally true or false. Numbers to the left of "3" represent an increasing amount of truth as the scale moves toward "1". Numbers to the right of "3" represent an increasing amount of falseness as the scale moves toward "5".

1. My efforts to rehabilitate psychiatric clients have been unrewarding.

Completely True    1    2    3    4    5    Completely False

2. Very few psychiatric patients can be vocationally rehabilitated.

Completely True    1    2    3    5    5    Completely False

3. The field counselor does not have time to offer effective services to the psychiatric client.

Completely True    1    2    3    4    5    Completely False

4. Generally speaking, the field counselor can be of greater service to the psychiatric client by purchasing services rather than by offering his own professional skills.

Completely True    1    2    3    4    5    Completely False



5. When working with the psychiatric client, I feel just as comfortable and secure as I do when I work with the physically handicapped.

Completely True 1 2 3 4 5 Completely False

6. Generally speaking, communities are accepting of psychiatric clients and can be counted on to assist in their rehabilitation.

Completely True 1 2 3 4 5 Completely False

7. Generally speaking, employers are willing to hire the psychiatric client.

Completely True 1 2 3 4 5 Completely False

8. I feel we should make a greater effort to vocationally rehabilitate more psychiatric clients.

Completely True 1 2 3 4 5 Completely False

9. It has been my experience that professional services from psychiatrists, psychologists, and social workers, necessary for working effectively with psychiatric clients, are either unavailable or inadequate in quality.

Circle one: Unavailable Inadequate Both

Completely True 1 2 3 4 5 Completely False

10. I would be much more enthusiastic about working with psychiatric clients if I could be sure of good professional services to assist me.

Completely True 1 2 3 4 5 Completely False

11. I could work with psychiatric clients more effectively and it would be more enjoyable, if I had more training in this area.

Completely True 1 2 3 4 5 Completely False

12. I feel that psychiatric clients really are more worthwhile and have more potential than physically handicapped clients.

Completely True 1 2 3 4 5 Completely False

## APPENDIX F

### C. Appraisal of Problems in Providing Follow-up Services [Excerpt from R & D Project 297 Report]

During the last year of the project, since we were still encountering some difficulty in securing a thread of continuity of needed services from the hospitals into the communities, we made, through questionnaires (see Appendix H), a survey of the problems involved including the feelings and attitudes of the general counselors relative to effective field services to psychiatric clients. These questionnaires were anonymously completed by the general counselors. A tabulation and analysis of the results follows:

Part I of the questionnaire asked the counselors to list the major difficulties that appeared to most adversely affect the rehabilitation of the mentally ill. The responses were categorized in three major areas: (1) Inadequate treatment before client-referral to general counselor for vocational or training placement. (2) Lack of out-patient follow-up, psychiatric consultation, and other professional assistance. (3) Other realistic problems faced by the counselor.

(1) Most frequently listed were statements reflecting feelings that clients had had inadequate treatment and hurried referrals. The clients are seen as being unpredictable, unstable and unable to persevere on a single job, lacking in motivation, too negative in self-concept and too dependent on the counselor, leaving the hospital too soon and still possessing much bizarre behavior accompanied by unrealistic goals. Where clients have not yet been hospitalized, psychiatric evaluations are difficult to secure because of the limited number of psychiatrists available. Also, many psychiatrists are reluctant to work per Vocational Rehabilitation's fee schedule.

(2) All of our counselors feel the brunt of inadequate out-patient facilities and other professional assistance. There was an expressed plea for out-patient clinics staffed with a complete psychiatric team, including a vocational rehabilitation counselor to focus the team's interest on the vocational implications of the individual's progress or remission. The counselors see the need for halfway houses and local psychiatric consultation. There is sometimes accelerated family rejection after the client's discharge from the hospital, and the counselor is aware of the need for social workers to help alleviate these and other pathological family situations. This would allow the counselor to devote more time to his own specialty.

(3) The traditional social stigma attached to mental illness still exists and is probably felt most remarkably by the counselor - that is, exclusive of the former patient himself who is most keenly sensitive to society's rejection. Counselors, facing this problem every day, feel that the communities are not "really" ready to accept the patient into their way of living again - not on the basis of a pre-illness level. This is true within the family circle, other living situations, and

particularly at work. Basic doubts and fears do not change overnight, and there is much employer resistance to the counselors' placement efforts. However, some of this resistance may be a direct result of poor placements previously made. The counselors are now becoming more seasoned and more scientific in their placements of psychiatric clients and this, alone, should continue to lower the bars that are gradually lessening. In many cases, an individual has worn out his welcome in the community and manipulation of the "total" environment is indicated. This is more difficult with those cases where there is a parallel need for a halfway house, which is not available.

Very much aware that a disproportionate amount of time is required in working with psychiatric clients, as compared to the physically disabled, the counselors stated that they did not have even the minimum time required to effectively serve their clients. They are already pressed because of the "excessive demands of the other individuals on their caseloads." A few counselors felt they were being "pushed to accept cases not feasible," but the majority felt that they could more effectively fulfill their roles if they were provided psychiatric training. Over one-half felt the "lack of professional training and skills."

In review of these counselor-seen adversities, which sometime overlap and could otherwise be categorized, we see that the general counselor has rather definite attitudes about mental illness and current rehabilitation trends. He sees many former patients coming to him with excessive dependency needs and also evidencing more serious emotional restrictions that may have been more adequately dealt with in intensive treatment, if such treatment had been available. Many counselors feel that they have neither the time nor training for extensive "depth counseling". Adequate living arrangements are always difficult to locate as are family-counseling services. The counselor's efforts should be complemented by a social worker's skillful casework handling of family dynamics that enter significantly into the client's psychopathology. Out-patient clinics and local psychiatric consultation would support the counselor in his job. And when the stigmas attached to mental illness are removed, the client will be less defensive, with a more positive self-image, and have more residual strengths remaining to cope with other rehabilitation problems.

Part II of the questionnaire dealt with the ratio of clients served on the basis of emotional disorder. The counselors replied that, during the past three years, 10.7% of their cases had psychiatric diagnoses. 5.2% of Georgia's 1962 rehabilitants were psychiatrically disabled.

Part III consisted of rating scales designed to further appraise the problems of rehabilitating the emotionally disturbed and also to appraise specific feelings and perspectives of the counselors as related to past achievements, present work, and their anticipated accomplishments.

To summarize the rating scales, there were definite indications that many counselors feel satisfied with past accomplishments in their work with psychiatric clients. However, several counselors were not sure that



their work had been successful, and many others felt that their efforts had been unrewarding. The counselors stated that, for the most part, a good number of psychiatric patients could be vocationally rehabilitated. Realistic field problems were reflected in the general feeling that the counselors did not have sufficient time to effectively serve their clients. The ratio here was about 3 to 2. The counselors were rather divided in their opinions on professional services to the emotionally disturbed. About one-third felt that their own professional skills were a foremost service while a slightly larger number found more satisfaction in purchasing services. An equally sized group were neutral, apparently seeing the necessity for both.

The counselors indicated that they were sufficiently comfortable in working with psychiatric clients. As compared to their confidence held in serving the physically disabled, they stated, 2 to 1, that they were just as comfortable with the mentally disabled. The counselors project somewhat different feelings for the community as they overwhelmingly, 5 to 1, stated that the communities were not accepting of the former mental patients and generally could not be counted on to assist in their rehabilitation. The odds were even greater in regard to employer resistance where the counselors replied, 9 to 1, that employers were not willing to hire the emotionally disturbed client.

In an attempt to appraise personal aspirations in work with these men and women, the counselors, very optimistically, stated almost unanimous intentions to increase their efforts to vocationally rehabilitate more psychiatric clients. However, there were a few that felt that present efforts were adequate.

The counselor, in many cases, is the only actively involved "helper" in the transition of client from hospital to community, family, and work. To serve the individual, he must become involved with the day to day problems arising in any and all situations. Sometimes, the counselor may be unaware of other community resources, and in other situations, there is no other assistance available. Because the counselors are aware of the limited scope of services rendered to the client through their efforts alone, they have stated that they would be much more enthusiastic about their work with psychiatric clients if they could be sure of good professional assistance.

Another realistic factor recognized as relevant to effective work in counseling the emotionally disturbed is the need for psychiatric training geared to a practical, but comprehensive, level that would allow an adequate understanding of psychopathology. The counselors replied, 10 to 1, that they could work with psychiatric clients more effectively and thereby feel more satisfied with their efforts and their personal contribution in the team approach if they had more training and a better understanding of the nature and dynamics of mental illness.

In a question that appeared somewhat ambiguous, as well as offensive, the counselors were asked if they felt that psychiatric clients were more worthwhile and possessed more vocational potential than physically handicapped clients. The replies were almost 8 to 1 to the negative,



with nearly one-half of them feeling that psychiatric clients were considered on an equal basis with the physically handicapped.

Concluding, we see that a pattern has evolved in the attitudes and perspectives held by the field counselors. They feel some satisfaction with the work they have done, but express need to increase the quality of their work as well as the number of persons served. They need more time for individual counseling and also recognize the need for psychiatric training to more effectively render this as well as to coordinate other services. Public education may help resolve the apparent problems of social stigmas, employer resistance, and inadequate treatment and professional assistance. It appears that with this rather positively expressed general attitude toward working with the mentally ill, more and better services will become available for our mentally disabled who are leaving the hospitals in need of vocational guidance and other assistance to facilitate their re-entry into the competitive work-world.

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