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The member-employee program at a Veterans Administration Neuro-Psychiatric Hospital

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THE MEMBER-EMPLOYEE PROGRAM AT A VETERANS ADMINISTRATION NEURO-PsYCHIATRIC HOSPITAL

A THESIS
SUBMITTED TO THE FACULTY OF ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
EDDIE GLEN TATE JR.

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
JUNE 1955
In this study, the writer has explored the Member-Employee Program as an intermediate step in the rehabilitation of mentally ill patients in Veterans Administration Neuro-Psychiatric Hospitals. The Member-Employee Program has been used effectively at these hospitals to indicate to the staff the readiness, initiative and the responsibility of the individual patients.

The purposes of this study were to determine the roles of the Member-Employee Program in the rehabilitation of the patient, to show the obstacles in the path of the program and how they have been removed, to show the social worker's role in the program and to show the effectiveness of the program to help patients in the hospital in which the study was made.

The material used in this study was obtained from social service records, clinical records and progress reports of patients on member-employee status. These data were supplemented by conferences with doctors, social workers and others who were familiar with the cases. Published materials as well as unpublished materials and attendance at some meetings of the Medical Rehabilitation Board provided background information and framework for interpretation.

This study included twenty-five patients which was the total number placed on member-employee status at the hospital where the study was made, during the first year of the program's inception. The program was one year old on November 1, 1954.

As a result of this study, the following conclusions were derived:

The insistence on total rehabilitation so that an individual is restored "to a station of independent earning power" (Webster's definition) is an indication of an inflexibility which can be detrimental in the
treatment of the mentally ill. Moreover, it is a denial of differences among individuals and of the societal dicta to which we conform. An ability to compromise, to lower goals and to decrease pressures so that a sick person can move out of an institutional setting and live in a community and participate in its functions within the limits of his shortcomings is rehabilitation in the psychiatric sense, if not in accord with the dictionary definition.

An examination of the Member-Employee Program as it developed at this hospital offers a valuable lesson in administration and in human understanding for similar institutions interested in organizing such a program. A treatment program must have a philosophy and a purpose and must approach attainable goals periodically as a program and for each patient served by it. From its inception, the Member-Employee Program was faced by many obstacles in its path and as each was hurdled, philosophy and purpose began to materialize.

A year from its inception, the Member-Employee Program, and its functioning arm, the Medical Rehabilitation Board, have become a definite and entrenched part of the hospital's treatment and rehabilitative facilities. Statistics for so young a program are meager but the fact that only four of the twenty-five patients placed on member-employee status during the first year of the program were removed and returned to patient status, leads the writer to feel that the Member-Employee Program manifests more positive factors than negative factors in the adjustment of psychotic patients. The fact that some patients were able to move out of the hospital and others were able to remain on member-employee status after resolving their problems and fears through participation in the program and other
patients were unable to accomplish such movement, indicates further that some patients are not able to benefit through this program and that perhaps further study should be made regarding the values of the program as a therapeutic tool in order to screen more closely the patients chosen to be member-employees. There is a possibility that we may realize 100% satisfactory adjustment of the patients placed on member-employee status if a definite criteria for selection of patients for the program is formulated.

The final conclusion in this study is that, in spite of the few negative aspects of the Member-Employee Program as a therapeutic tool, it is a most promising program designed to help mentally ill patients to live normally in their respective communities, and as the program grows and further statistics are compiled regarding the successes and failures encountered, greater results will be realized by patients placed on member-employee status in the future.
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CHAPTER I

INTRODUCTION

Significance of the Study

Complete rehabilitation, which is the ultimate long-range goal in the Veterans Administration Hospital, should not blind us to the intermediate milestones which can be achieved in the hospital. To afford the patient a setting in the hospital similar to that in the community is a near impossibility because we cannot remove the impact of institutionalization and its negative as well as its positive meanings for the patient concerned. Therefore, the Member-Employee Program must be viewed as another step in the rehabilitation of the patient and not as an unique installation in a hospital to compare with conditions in private industry. Hospital industry is geared to the tempo of the limitations brought to work details by the individual patients.

Member-employment is not an intermediate step but a goal in itself. It only becomes one of the intermediate steps when the patient is ready for his next step toward total rehabilitation (realism prevents an arbitrary time limit). The Member-Employee Program has been used effectively at Veterans Administration Neuro-Psychiatric Hospitals to indicate to the staff the readiness, initiative and the responsibility of the individual patients.

Purposes of the Study

The purposes of this study were to determine the roles of the Member-Employee Program in the rehabilitation of the patient, to show the obstacles in the path of the program and how they have been removed, to show
the social worker's role in the program and to show the effectiveness of
the program to help patients in the hospital in which the study was made.

The data for determining the role of the Member-Employee Program in
the rehabilitation of the mental patient were found in pamphlets published
by the Veterans Administration and from the active hospital records of
patients who hold or have held member-employee status.

Information regarding the obstacles faced and the handling of these
obstacles was obtained through verbal contacts with the doctors and social
workers who worked with patients on member-employee status and through the
notes taken from meetings of the Medical Rehabilitation Board.

Data showing social service participation in the program were obtained
by further reading of records and notes from meetings and from reports sub­
mitted by Social Service to the Medical Rehabilitation Board. Discussion
of the program with the participating social workers, doctors and other
members of the Medical Rehabilitation Board added to the writer's knowledge
of the program.

Method of Prodecure

The material used in this study was obtained from social service re­
cords, clinical records and progress reports of patients on member-employee
status. These data were supplemented by conferences with doctors, social
workers and others who were familiar with the cases. Published materials
as well as unpublished materials and attendance at some meetings of the
Medical Rehabilitation Board provided background information and framework
for interpretation.
Scope and Limitations

The Member-Employee Program at this hospital was one year old on November 1, 1954 and twenty-five patients were placed on member-employee status within the year. The writer felt that a study of the entire universe would provide more enlightenment on the Member-Employee Program and its effectiveness as a step in the rehabilitation of the patients than would a sample of the universe. The greatest limitation in this study was the fact that the writer was not present to observe at first hand the formation of the Member-Employee Program at its inception.

Description of the Setting

This study was made in a Veterans Administration Neuro-Psychiatric Hospital for the care and treatment of mentally ill male veterans. The hospital has a bed capacity of approximately 2500 and the larger portion of the patient population is treated for mental disorders of a functional nature (as distinguished from organic), with a predominance of schizophrenics. The patient population consists mainly of veterans who are admitted from the metropolitan New York area and from the Long Island counties of Nassau and Suffolk.

Treatment at this hospital consists of the various forms of therapy currently used in mental illnesses: individual and group therapy, electro and insulin shock therapy, occupational and corrective physical therapy, sedative therapies (drugs and hydrotherapy) and psycho-surgery.

Since the long-range goal of treatment in the hospital is to help the patients move out into the community, the patients may appear before the medical staff at any point in treatment for consideration of release from the hospital. This appearance may be instituted by the psychiatrist in
charge of the case when he considers the patient sufficiently improved and ready to adjust in the community. The medical staff may also consider the patient for release from the hospital at the request of the social worker, the patient or a responsible relative. In the event of a staff decision that the patient has improved sufficiently to leave the hospital, (a) he may be discharged AMA (against medical advice), (b) he may be discharged MHB (as having received maximum hospital benefits) or (c) placed on trial visit status whereby his adjustment is followed for a period of ninety days to a year before he is discharged. The trial visit program, when a patient does not go to his own home, is divided into three categories known as, (1) Foster Home Placement, (2) Protective Job Placement and (3) the Member-Employee Program. The Member-Employee Program is the most recent program instituted in the Veterans Administration Hospitals, and it is this program around which the focus of this study is centered.
CHAPTER II

HISTORY OF THE MEMBER-EMPLOYEE PROGRAM

The recent development in the Veterans Administration of the Member-
Employee Program represents a pioneer undertaking which promises to be a
milestone in the treatment of the mentally ill. A pilot experiment suc-
cessfully conducted in the Veterans Administration Hospital at Perry Point,
Maryland led to the optional establishment of a member-employment program
in Veterans Administration Neuro-Psychiatric Hospitals. As modern psychi-
atriy is well aware that present rehabilitation programs for mental patients
do not quite complete the bridge between hospital and community and that
complete treatment cannot be given in a hospital setting, the Member-
Employee Program is steadily gaining a foothold in Veterans Administration
Neuro-Psychiatric Hospitals. In the past, prior to the Member-Employee
Program, many attempts were made to find ways and means of motivating psy-
chotic patients to release part or the whole of their psychosis in favor
of more "normal" activity. After extensive study in this area it was de-
cided that financial reward may help resolve many problems since money is
one incentive that is as effective within the hospital as it is outside.
Its greatest advantage lies in its exchange power which enables each pa-
tient to choose his own final reward through his acquisition of the means

1Peter A. Peffer, "Money: A Rehabilitation Incentive for Mental
pp. 84-92.

2Veterans Administration Technical Bulletin 10 A-333, Member-Employ-
ment Programs in Psychiatric Hospitals, (Washington, December 15, 1953),
p. 1.
to purchase what he wants and to express his independent interests. With this concept the Member-Employee Program became a reality and was introduced to the Veterans Administration through the Veterans Administration Hospital at Perry Point, Maryland, with the idea in mind that "the mission of modern medicine must extend beyond definitive medical treatment to a program of dynamic therapeutics designed to bring the chronically ill patient to the highest functional level of physical, psychological and socio-economic adjustment compatible with his disability." There are several factors which must be considered before a member-employee program is established in a hospital. The following factors must be considered and carefully studied:

a. The hospital must have facilities available other than hospital beds to quarter member-employees (i.e., attendants' quarters; administrative space which could be converted to living quarters). As members they are entitled to medical and dental care when required. However, since their income is in excess of $20.00 monthly, those who might previously have been entitled to Government-issue clothing and incidentals due to indigence may no longer be eligible for indigent issues. Also, services and issues to which they may have been entitled previously by virtue of their status as psychiatric patients would no longer be applicable.

b. The patients must be eligible for domiciliary care and qualified for member-employment.

c. The hospital must have need for such employees.

d. Establishment of a Member-Employee Program in a psychiatric hospital does not entitle the station to additional personnel ceiling.

e. For the purpose of this program, a member-employee is considered as 0.3 of a regular full-time employee.

f. If the program is discontinued or decreased, reconversion to regular ceiling is accomplished at the same rate as the original conversion.

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Establishment of the Program at the Hospital Where the Study Was Made

The first step in the institution of the Member-Employee Program in this hospital was the establishment of the Medical Rehabilitation Board on July 2, 1953 in accordance with the Central Office Bulletin. The prime objective of the Medical Rehabilitation Board was to establish a basis for coordinated essential services to the disabled person for whom usual staff services have been unproductive. The Board aimed at a common overall understanding of the patient on the part of all the specialists involved with him, undertook unified planning of activities with regard to all the aspects of the patient's total health problem and to supplement and encourage the efforts of the staff members (and the consultative conferences among individual specialists) aimed at good interrelationships in working out various features of the patient's problems. The function of the Medical Rehabilitation Board involved joint planning for a consistent, interrelated, integrated service to the patient on the part of the individual board members. Without the Medical Rehabilitation Board the Member-Employee Program could not function as the Board selected the patients for consideration for member-employee status and was the governing body of the Member-Employee Program. Teamwork is essential in this program and in an effort to form a team including all staff members directly concerned with the patient, the Medical Rehabilitation Board has a permanent membership comprised of the Chief or Acting Chief of the Physical Medical and Rehabilitation.


5 Ibid., p. 1.
Service, as chairman; the Executive Assistant of the Physical Medical and Rehabilitation Service, as secretary; and a representative of Social Service and one of Vocational Counseling Service as members. Meetings of the Medical Rehabilitation Board may include other personnel who are not regular members of the Board. Other members are the Chief of Service and/or the physician concerned, social worker assigned to the patients, ward nurse concerned and any additional staff members directly concerned with the rehabilitation of the patient under consideration as designated by the Chairman of the Board.

The Member-Employee Program became a part of the rehabilitative process at this hospital on November 1, 1953 to provide additional means of meeting the rehabilitative needs of the patients. This program was planned to provide carefully selected patients with the opportunity to function as paid employees to work and live within the controlled environment of the hospital until their adjustment and performances warranted their return to the outside community and complete independence from the hospital.

Difficulties Encountered in Establishing the Program

The Member-Employee Program, the same as any new idea, was faced with many obstacles at the time of its inception. Prior to installing the program in the hospital as one of the rehabilitative tools, the Medical Rehabilitation Board discussed extensively the feelings and attitudes of hospital personnel regarding the place of the Member-Employee Program in the hospital. After many meetings of the Medical Rehabilitation Board, it

6Ibid.
was realized that the following difficulties would have to be faced and removed on an administrative level before the program would be able to function properly:

a. Availability of jobs.

b. Distortion of the purposes, goals and aims of the program.

c. Unwillingness of personnel to recognize and appreciate the therapeutic aspects of the program.

d. Lack of interpretation of the program to the general personnel.

e. The fears and ignorance of personnel regarding the program.

The question of available jobs for member-employees was a pressing problem demanding immediate attention since the paucity of jobs would limit the program as a therapeutic and rehabilitative tool. After extensive research and planning by the Medical Rehabilitation Board, positions were made available as elevator operator, janitor, kitchen helper, carpenter, painter, and laundry worker. Member-employees' duties are the same as those of regular employees with the same job description. They accrue 13 days annual leave but no sick leave. The salaries range from $657.00 to $821.00 per year. Those receiving $657.00 get approximately $25.00 every two weeks and those who receive $821.00 get approximately $30.00 every two weeks, and all member-employees receive room, board and laundry service plus their salary.

The problems presented by the distortion of the purposes, goals and aims of the program and the unwillingness of personnel to accept and recognize the therapeutic aspects of the program were alleviated when the program and its functions were interpreted to the general personnel and everyone associated with the Member-Employee Program had a clear and
intelligent understanding regarding the niche in the hospital structure which the program would occupy. The Medical Rehabilitation Board, after many meetings held for the purpose of discussing the problems confronting the Member-Employee Program in its actual functioning, formulated the following educational plan with the idea in mind that a definite plan of interpretation and subsequent understanding of the function of the Member-Employee Program by both the professional and non-professional staff members would remove many doubts and fears regarding the program.

The goals of the Member-Employee Program and the roles of the Medical Rehabilitation Board and the professional staff were clarified as the major steps in the educational program.

a. The needs of the patient and the needs of the hospital were coordinated with the knowledge that the goals of the Member-Employee Program are (1) primarily, to consider what is best for the patient and (2) secondarily, what is best for the hospital.

b. The Medical Rehabilitation Board must be flexible, able to enforce its decisions, be active, be energetic and be interested in the welfare of the patients. Prior to this understanding the Medical Rehabilitation Board did not have a standard method of procedure and was unable to function as it should.

c. Non-professional staff was reassured that member-employment would not result in loss of jobs for regular personnel. Opposition of certain divisions in the hospital was largely due to the fear of the lay personnel that member-employees would cause them to lose their jobs.

d. The professional staff (Medical, Social Service and Psychology) must implement the program, prevent sabotage and refer cases for consideration.

Records were kept of each meeting of the Medical Rehabilitation Board in which the various difficulties encountered were discussed, and these records show that, through this program of interpretation by the Medical Rehabilitation Board, the difficulties encountered in the establishment of the Member-Employee Program were gradually overcome and the program began
to function properly and with purpose.
CHAPTER III

CRITERIA FOR SELECTION AND PLACEMENT OF PATIENTS FOR MEMBER-EMPLOYEE STATUS

The importance of education and communication is clearly seen when we examine the methods by which patients are referred for consideration for member-employee status. Any individual in the hospital who recognizes a potentiality in a patient may bring this fact to the attention of the psychiatric team either directly or through the member-employee supervisor. The psychiatric team evaluates the case and if favorably inclined refers the patient to the Medical Rehabilitation Board. The case is thoroughly discussed by the Board, both pro and con; after the patient appears before the Board he is approved or disapproved and recommendations are made for furthering his rehabilitation.

Discussion around the establishment of the Member-Employee Program raised the question of the types of patients to be considered for member-employee status. It should be clearly understood that this program is not suitable for all cases of mental illness and it should also be noted that member-employee status represents a terminal step in hospital rehabilitation aimed at easing the transition to the community. Unless this fact is clearly understood a great deal of misunderstanding and friction may arise concerning the relative merits of particular patients. When it is believed that a patient is able to develop a satisfactory work pattern, to

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7 Reuben Margolin (ed.), "Member-Employee Program...New Hope for the Mentally Ill," Veterans Administration Hospital, Brockton, Massachusetts, First Veterans Administration Workshop, December 8 through December 10, 1954.
take care of himself with minimal supervision, to handle his earned funds and to conduct himself in a generally acceptable manner, he is to be referred through the ward physician, to the Medical Rehabilitation Board for consideration of conversion to member-employee status. When the Medical Rehabilitation Board approves such conversion for a patient, the patient is placed on trial visit status and reported as an absent bed occupant and then entered on the rolls as a member-employee. Following this, he is processed for placement as a member-employee. This action is required in order to avoid need for recommittment if rehospitalization becomes necessary. In the event that a member-employee fails to make a satisfactory adjustment, he will be immediately readmitted to the hospital as a patient.

Prior to placement on member-employee status, the patient is carefully prepared by his ward physician, social worker and the vocational counselor. He is followed at regular intervals by the supervisor of member-employees and the ward physician, utilizing the assistance of all the services (Physical Medical and Rehabilitation, Social Service, Vocational Counseling Service and Psychology Service) concerned, including the member-employees' work supervisor.

Reasons for First Selection of Patients for Member-Employee Status

With the knowledge in mind that each patient has his own individual problems and needs, the Medical Rehabilitation Board evaluated each patient referred for member-employee status in order to select the patients who would be most likely to derive benefits by becoming a part of a balancing movement which weighed assets and liabilities, strengths and weaknesses, constructive and destructive courses of action manifested by each of the
patients. Even though the Medical Rehabilitation Board attempted to select the patients whom it was felt would derive the most benefits from the program, the writer does not wish to give the impression that this program was restricted only to those patients whose futures appear bright. For example, the chronic and long hospitalized patients, some of whom were alcoholics and men well past the prime of life, were screened and it was from this group that some of the first twenty-five patients were selected for member-employee status. It is often felt that the chronic and long hospitalized patients should be considered for member-employee status in preference to those patients whose futures appear bright because the latter group will be most likely to leave the hospital and had not exhausted the other rehabilitative programs as had the majority of the chronic and long hospitalized patients. The ages of these first patients placed on member-employee status ranged from 19 to 67 and their diagnoses were varied. The primary reasons for selecting the first twenty-five patients, as shown in their individual records and progress reports, were as follows:

1. Some patients were selected because it was felt that they needed the approval and support provided by the Member-Employee Program in order to strengthen their egos and overcome feelings of rejection so that they may function outside the hospital.

2. Some of the older patients had failed to adjust previously within the framework of other rehabilitative programs designed to help them move out of the hospital (protective job placements, foster home placements and trial visit in the home) and it was decided that the Member-Employee Program was a last resort if they were to ever move out of the hospital into their respective communities.

3. Some patients had negative relationships with their families and consequently were unable to return to their homes. It was felt that member-employee status was necessary as an interim step in their eventual

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rehabilitation as they needed help in preparing themselves for moving out of the hospital into a home other than their own.

4. Some patients were ready to leave the hospital except for an inability to function in work situations. These patients were selected for member-employee status because it was decided that they would learn to take orders and accept instructions and supervision in preparation for accepting positions in regular work situations following departure from the hospital.

5. Some patients were selected in order for the Medical Rehabilitation Board to determine if they were able both mentally and physically to perform favorably as a member-employee on the basis of an eight hour workday. The majority of the patients in this group were aged patients.

6. It was decided that some patients would be able to overcome their intense dependency needs through participation in the Member-Employee Program to the extent that they would be able to function outside the hospital in a work setting.

The Social Worker's Role in the Member-Employee Program

In this program the social worker and the patient are confronted with a situation wherein the latter discards his patient's status, yet does not leave the hospital. The continuing close relationship with the hospital provides the member-employee (our patient) with an opportunity to obtain help for his problems through the continuing casework relationship. He finds a new freedom of choice and responsibilities; these are often stimulating and intriguing, but sometimes confusing to him. The realization that he is free to leave the hospital after working hours is often accompanied with fears and anxieties as to how he will be able to manage without supervision. The relative nearness of the hospital gives both security and some apprehension regarding the ease with which he may be returned to

patient status if he fails to make a good adjustment.

In preparing a patient for member-employee status, the social worker encounters the usual attitudes which are met in helping patients to leave the hospital. These run the gamut from an over-eager acceptance of the idea, which is often a mask for a great deal of anxiety and considerable feelings, to tremendous reluctance to consider leaving the hospital at all. The social worker must help the patient realize and understand that member-employee status is a step on the road toward community living and adjustment, the ultimate goal.

Some patients have very strong feelings about the salary received by member-employees and have little if any desire to participate in the program as they feel that they should receive the same salary as regular employees. These patients who do not recognize the therapeutic aspects of the program consider themselves as regular employees and consequently feel that they are being exploited when their salaries are not equal to those of regular employees. The social worker must help them, through a strong casework relationship, to understand that they are not regular employees and may not receive pay in the same amount as regular employees. Patients must be helped to understand that being placed on member-employee status does not mean that they are being hired by the hospital as regular staff members, but that they are placed on member-employee status so that the medical team may observe them in order to learn if they are able to function normally during an eight hour work day and if they are ready to take their places in the communities in which they wish to live following departure from the hospital. Some of the difficulties encountered by the social worker in interpreting the program to prospective member-employees
were alleviated when the Medical Rehabilitation Board formulated a definite policy of not hiring member-employees as regular hospital personnel. It was felt that a deviation from this policy would seriously hamper the administration and achievement of the entire program. The needs of a particular patient may be met in this manner but the resultant harm to the entire program would militate against such action. The social worker is able to state definitely to patients that it is an administrative policy not to hire them as regular employees and as a result of this policy they will not be able to receive salaries equal to those of regular employees.

Since Social Service and Vocational Counseling Service are deeply concerned with the patient's move to member-employee status, a sound, cooperative relationship between these two departments is essential for maximum help to patients. The team approach seems to be the one best suited to counteracting the dangers of segmentation of the person and the confusions that stem from overlapping areas of service. The essence of teamwork is fluid interaction and it can involve many or few people. Although a rigid delineation of duties has not been necessary because of the team approach, it has been found that the social worker can be of most assistance to the patient when the major emphasis is on an explanation of the patient's social adjustment to the hospital. The general skills and techniques used in helping patients accept other changes in their hospital status and treatment are effective in working with patients prior to referral to the Medical Rehabilitation Board for member-employee consideration.


11 Harris K. Goldstein, op. cit., p. 23.
CHAPTER IV

ADJUSTMENT OF PATIENTS PLACED ON MEMBER-EMPLOYEE STATUS

Twenty-five patients were placed on member-employee status during the first year of the Member-Employee Program and this chapter is dedicated to providing evidences of their adjustment on a satisfactory or unsatisfactory basis. The adjustment of these patients was evaluated by the Medical Rehabilitation Board as they were observed regularly following their placement as member-employees. The adjustments were evaluated on the basis of ability to function in work situations and in social situations in an acceptable manner.

Satisfactory Adjustment

Of the twenty-five patients placed on member-employee status, twenty-one were considered as having made satisfactory adjustments. Sixteen of these patients remained on member-employee status at the end of the first year and five left the hospital for further schooling and/or private employment. Although only five patients succeeded in leaving the hospital, the remaining sixteen were considered as having made satisfactory adjustments and were not returned to patient status. The remaining patients were continued on member-employee status for a second year due to the evaluations of the Medical Rehabilitation Board which resulted in decisions that they needed additional supervision before release from the hospital would be advisable. These patients had shown enough positive factors to warrant their remaining as member-employees, but had not sufficiently solved their problems to warrant discharge or active trial visit from the hospital.
The following summaries of adjustment reports will illustrate the adjustment made by the five patients who attained the ultimate goal desired by the hospital.

1. Patient A was a twenty-six year old, single, white veteran with a diagnosis of Passive Aggressive Personality with a past history of being an alcoholic. He had been hospitalized for seven months prior to placement on member-employee status and the fact that he was an alcoholic was the basis for many doubts as to his ability to make a satisfactory adjustment as a member-employee. The patient was placed on member-employee status on April 5, 1954 and remained in the program until December 4, 1954. During this time he made a very good adjustment and worked in the wood working shop where he repaired hospital furniture. Patient A was able to reinforce his ego to the extent that he could move out of the hospital on active trial visit to accept employment at a lumber company.

2. Patient B was a nineteen year old, single, Negro veteran with a diagnosis of Schizophrenic Reaction, Undifferentiated Type. He had been hospitalized for eight months prior to placement on member-employee status and it was felt that he may be able to move out of the hospital if his self-confidence was reinforced before he could fall into the pattern of the chronic patient. The patient was approved for member-employee status on April 12, 1954 and worked in the Dietetic Service where he made an excellent adjustment. Through participation in the Member-Employee Program, patient B developed sufficient confidence in himself to move out of the hospital one month after becoming a member-employee.

3. Patient C was a thirty-two year old, single, white veteran with a diagnosis of Dementia Praecox, Paranoid Type and had been hospitalized for six years prior to placement as a gardener in the Member-Employee Program. The patient was approved for member-employee status on April 12, 1954 and during the time he remained in the program he learned to adjust to an eight hour workday, which was the goal set by the Medical Rehabilitation Board when he was selected for member-employee status. On June 17, 1954 two months after placement in the program, patient C was discharged from the hospital to accept employment with a plastic firm.

4. Patient D was a twenty-four year old, single, white veteran with a diagnosis of Schizophrenic Reaction, Paranoid Type and had been hospitalized for nine months prior to placement as a member-employee. He was approved for member-employee status on July 6, 1954 and worked as a psychiatric-aide runner. This patient wanted to return to school and pursue his studies in Retail Food Merchandising, and he was placed on member-employee status so he could gain sufficient confidence in his own abilities to function adequately in competitive situations. This goal was realized when the patient was
released from the hospital on September 2, 1954, two months after placement, and enrolled in the school of his choice.

5. Patient E was a fifty-six year old, single, white veteran with a diagnosis of Paranoid State, Chronic Moderate and he had been hospitalized for one year prior to placement as a member-employee. He was approved for member-employee status on January 25, 1954 and was able through participation in the Member-Employee Program as a janitor to resolve his fears and anxieties about leaving the hospital to the extent that he was discharged on April 8, 1954, three months after placement as a member-employee.

Unsatisfactory Adjustment

The four member-employees who were returned to patient status were considered as having made unsatisfactory adjustments because they were unable to adjust to the program and function within its structure. The following summaries of adjustment reports will illustrate the failure of these four patients to adjust favorably.

1. Patient F was a fifty-five year old, single, white veteran with a diagnosis of Inadequate Personality and a history of excessive alcoholism. He was considered as a poor risk because of his alcoholic history but it was decided that the Member-Employee Program was the only rehabilitative facility remaining which may help him to move out of the hospital. The patient had been placed in protective job placements in the past and was unable to adjust in these settings. He had been hospitalized for fifteen years (with periods away from the hospital) prior to his placement on member-employee status. Mr. F worked as a janitor and performed his duties well. However, after two altercations with a fellow employee and after returning to the hospital in an inebriated condition on several occasions, he was returned to patient status on December 29, 1954, six months after becoming a member-employee.

2. Patient G was a thirty-five year old, single, white veteran with a diagnosis of Schizophrenic Reaction, Simple Type and had been hospitalized for four months prior to becoming a member-employee on March 9, 1954. He was placed as a kitchen helper and worked diligently, but due to excessive drinking after work hours and failure to return to the hospital in time to report to his job, Mr. G was returned to patient status as a poor risk only seventeen days after becoming a member-employee.

3. Patient H was a thirty-one year old, single, Negro veteran with a diagnosis of Chronic Brain Syndrome, associated with Central
Nervous System Syphilis. He had been hospitalized for ten months prior to placement as a member-employee and it was hoped that participation in the Member-Employee Program would give him the opportunity to determine his ability to accept and be employed on a regular full-time forty hour week basis. The patient was approved for member-employee status as a psychiatric-aide runner on July 6, 1954 but his inability to perform satisfactorily in this capacity led to rehospitalization seventeen days after becoming a member-employee as it was the opinion of the Medical Rehabilitation Board that he was not ready to remain in the program at this time.

4. Patient I was a forty-one year old, single, white veteran with a diagnosis of Schizophrenic Reaction, Undifferentiated Type and had been hospitalized for ten months prior to placement as a member-employee. Patient I was selected for member-employee status because it was the opinion of the Medical Rehabilitation Board that this advanced phase of rehabilitation was necessary in his case as it appeared that he could not leave the hospital and immediately pursue the occupation for which he was trained without first developing his ego strengths and his ability to relate to people. He was placed as a psychiatric-aide on August 12, 1954 and returned to patient status on October 8, 1954 because he became very confused while at work and was unable to function well enough to perform his duties, except on a superficial level.

The primary importance of the adjustment of the patients, as shown in this chapter, is the bearing it has upon the evaluation of the Member-Employee Program as it helps and/or fails to help hospitalized patients. As shown in the summaries of the member-employees' adjustment reports, patients of many ages and with varied diagnoses were able to benefit from this program even though individual differences of patients prevented some member-employees from making satisfactory adjustments. The fact that individual differences of patients placed on member-employee status had an effect on their adjustment, further shows that the Member-Employee Program is not suitable for all cases of mental illness even though the majority of the twenty-five patients shown in this study made satisfactory adjustments.
CHAPTER V

SUMMARY AND CONCLUSIONS

In this study, the writer has explored the Member-Employee Program as an intermediate step in the rehabilitation of mentally ill patients in Veterans Administration neuro-psychiatric hospitals. In order to evaluate the Member-Employee Program as a therapeutic tool at this hospital, the satisfactory and unsatisfactory adjustments of the first twenty-five patients placed on member-employee status during the first year of the program's existence were studied. In addition, the history of the program was studied and emphasis was placed on the difficulties encountered in establishing the program (availability and limitations of jobs, distortion or the purposes, goals and aims of the program, unwillingness of personnel to recognize and appreciate the therapeutic aspects of the program, lack of interpretation of the program to the general personnel, the fears and ignorance of personnel regarding the program) and how these difficulties were overcome, the function of the Medical Rehabilitation Board whose prime objective is to establish a basis for coordinated essential services to the disabled person for whom usual staff services have been unproductive, the role of the social worker who must help the patient overcome his anxieties and fears about becoming a member-employee and must interpret the program to the patient so he will understand that it is a step toward leaving the hospital, the criteria for selecting patients for member-employee status and the goals of the Member-Employee Program.

As a result of this study, the following conclusions were derived:
The insistence on total rehabilitation so that an individual is restored "to a station of independent earning power" (Webster's definition) is an
indication of an inflexibility which can be detrimental in the treatment of the mentally ill. Moreover, it is a denial of differences among individuals and of the societal dicta to which we conform. An ability to compromise, to lower goals and to decrease pressures so that a sick person can move out of an institutional setting and live in a community and participate in its functions within the limits of his shortcomings is rehabilitation in the psychiatric sense, if not in accord with the dictionary definition.

An examination of the Member-Employee Program as it developed at this hospital offers a valuable lesson in administration and in human understanding for similar institutions interested in organizing such a program. A treatment program must have a philosophy and a purpose and must approach attainable goals periodically as a program and for each patient served by it. From its inception, the Member-Employee Program was faced by many obstacles in its path and as each was hurdled, philosophy and purpose began to materialize.

A year from its inception, the Member-Employee Program, and its functioning arm, the Medical Rehabilitation Board, have become a definite and entrenched part of the hospital's treatment and rehabilitative facilities. Statistics for so young a program are meager but the fact that only four of the twenty-five patients placed on member-employee status during the first year of the program were returned to patient status leads the writer to feel that the Member-Employee Program manifests more positive than negative factors in the adjustment of psychotic patients. The fact that some patients were able to move out of the hospital and others were able to remain on member-employee status after resolving their problems and fears
through participation in the program, while other patients were unable to accomplish such movement, indicates further that some patients are not able to benefit through this program. Further study should, perhaps, be made regarding the values of the program as a therapeutic tool in order to screen more closely the patients chosen to be member-employees. There is a possibility that 100% satisfactory adjustment of the patients placed on member-employee status might be achieved if definite criteria for selection of patients for the program were formulated.

The final conclusion in this study is that, in spite of the few negative aspects of the Member-Employee Program as a therapeutic tool, it is a most promising program designed to help mentally ill patients to live normally in their respective communities. As the program grows and further statistics are compiled regarding the successes and failures encountered, greater results may be realized by patients placed on member-employee status in the future.
APPENDIX
SCHEDULE

1. History of the Member-Employee Program:
   A. Establishment of the Member-Employee Program

2. Difficulties encountered in establishing the program:
   A. Availability of jobs
   B. Educating the personnel to recognize and appreciate the therapeutic aspects of the program
   C. Administration's feelings about the new program
   D. Patient's negative feelings about the program
   E. Distortion of the goals and aims of the program

3. Salary range of member-employees

4. Hospital care available to member-employees

5. Selecting and preparing patients for member-employee status:
   A. Physical requirements
   B. Mental requirements
   C. Social requirements
   D. The role of Medical Staff in the preparation
   E. The role of Social Service in the preparation

6. Adjustment of patients placed on member-employee status:
   A. Satisfactory adjustment
   B. Unsatisfactory adjustment
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