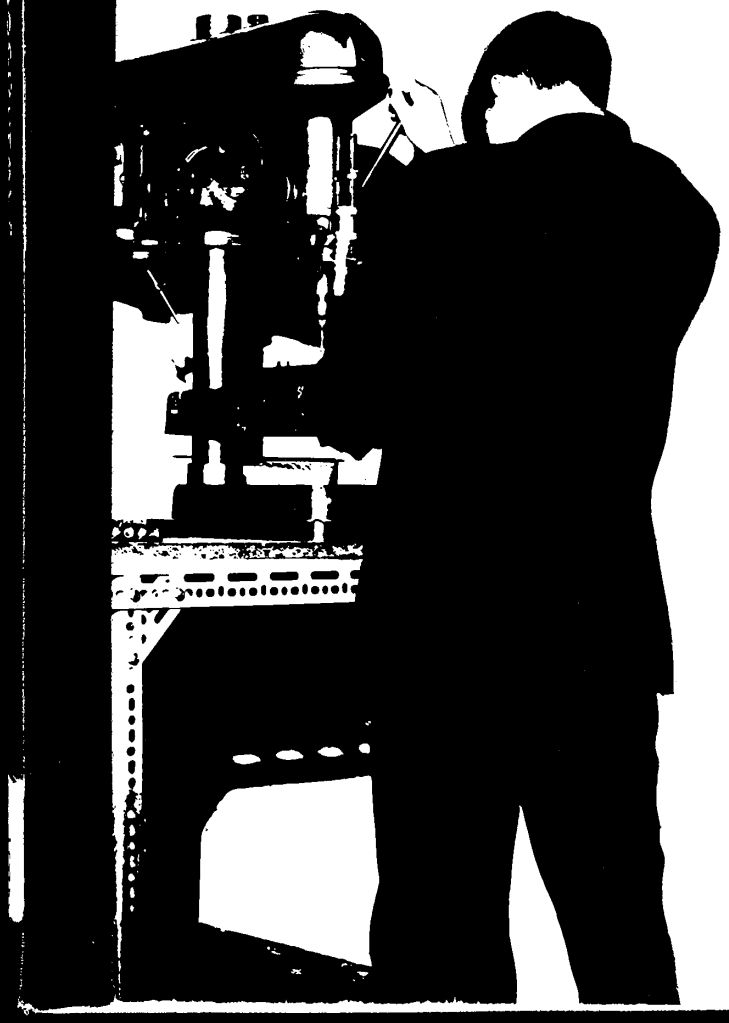
Industrial Therapy in Psychiatric Hospitals

A King's Fund Report



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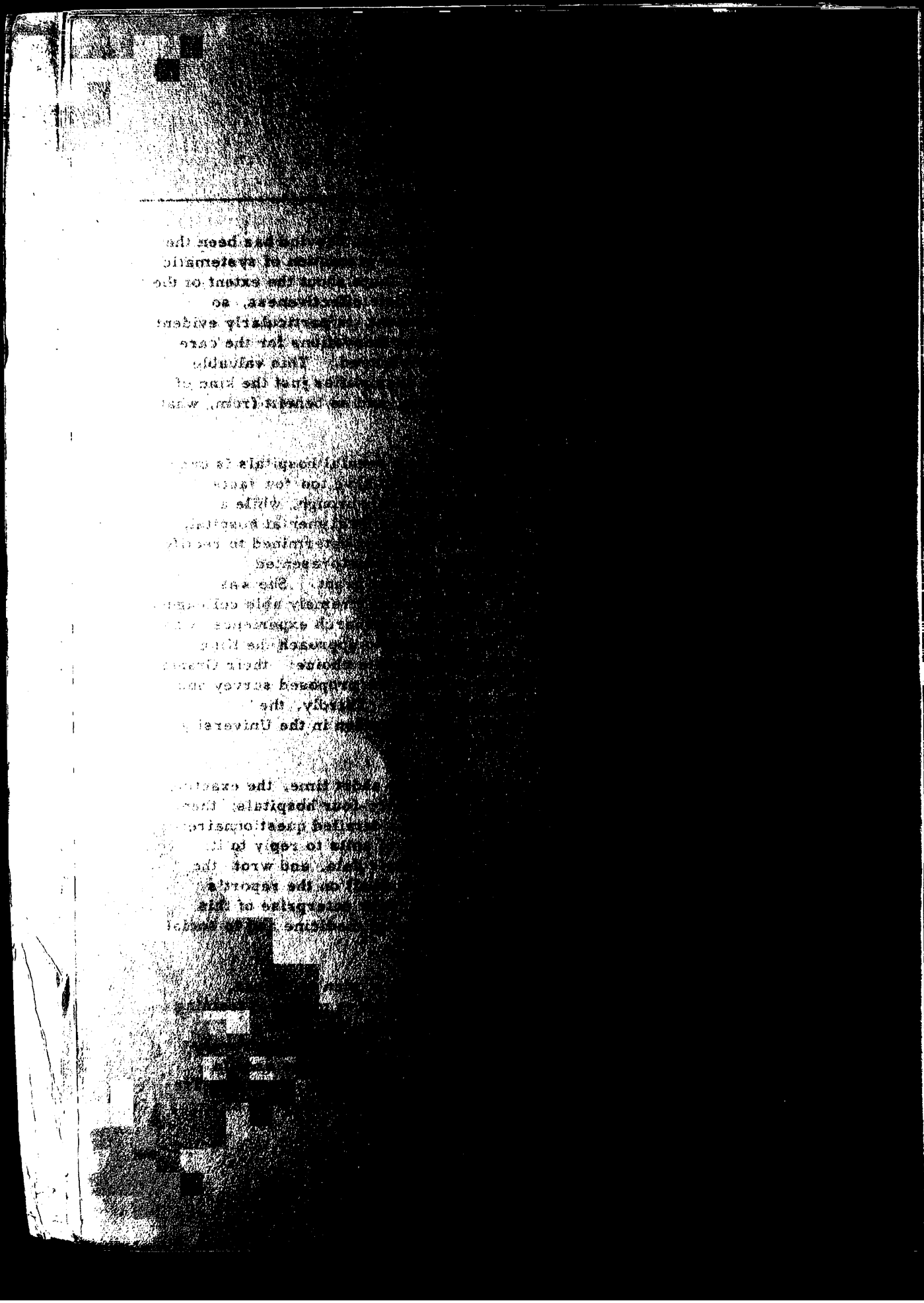
FOREWORD

A surprising shortcoming of our National Health Service has been the failure to build an organisation into it for the promotion of systematic operational research. The need for more facts about the extent of the facilities available, their functioning and their effectiveness, so necessary for planning and future development, is particularly evident in the mental health service where so many innovations for the care and rehabilitation of patients are being introduced. This valuable report by Mrs Wansbrough and Dr Miles exemplifies just the kind of study that is required if we are to evaluate, and so benefit from, what we are doing.

The rapid increase in industrial units in our mental hospitals is one important recent development about which we have too few facts. The fact should also be recorded that Mrs Wansbrough, while a member of the management committee of her local mental hospital, recognised this omission. Moreover, she then determined to rectify the matter and to tackle the substantial problems presented formulating a research project and obtaining a grant. She was helped by three circumstances. Firstly, an extremely able colleague, Dr Agnes Miles, who had also had relevant research experience, was keen to collaborate; secondly, her decision to approach the King Edward's Hospital Fund was a most appropriate choice: their Grants Committee quickly appreciated the value of the proposed survey and the determination and zeal of the applicants. Thirdly, the Department of Sociology and Social Administration in the University of Southampton provided a working base.

The authors completed, within a remarkably short time, the exacting tasks of visiting industrial units in some thirty-four hospitals; then, on the basis of their observations, devised a detailed questionnaire; prevailed on a surprisingly high proportion of units to reply to it; organised the computing and tabulation of their data, and wrote the report. I hope they do not mind my having dwelt on the report's origins and progress; but it does illustrate how enterprise of this sort can make a valuable contribution to social medicine and to social administration.

The report is only the first part of the authors' plan to assess industrial units both as therapy and as an effective means of training and rehabilitating patients for work in the community after discharge. They have very appropriately begun by doing a survey to assess the extent to which industrial therapy units are used in our hospitals; what the aims of the different units are; how they are organised; for whom they cater; and to see what proportion of patients are discharged into regular employment.

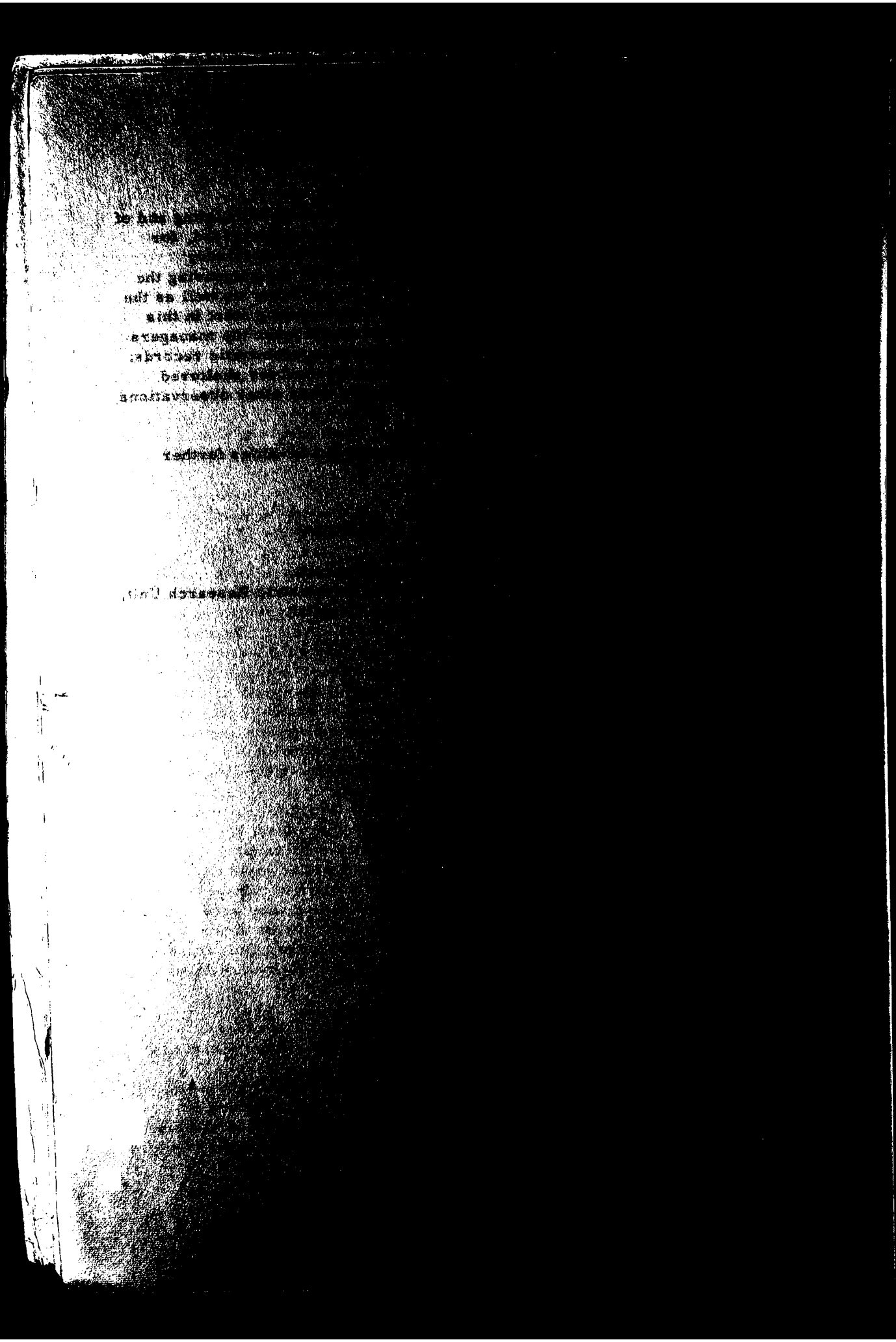


Their findings, comments and recommendations are stimulating and of considerable practical value. I was interested and surprised, for instance, by the number and variety of industrial units already introduced. So there are important opportunities for comparing the effectiveness of the different methods used in the units, as well as the different types of work therapy: indeed, an interesting start in this direction is made in the report. The report will make the managers of units more aware of the importance of keeping systematic records; and direct the local authorities' attention to the need for sheltered employment and hostels. But these and very many other observations are much better made in the report.

I look forward to, and wish Mrs Wansbrough and Dr Miles further success with, their next projects.

PETER SAINSBURY

Director of Research,
MRC Clinical Psychiatric Research Unit,
Graylingwell Hospital.



INTRODUCTION by Professor J H Smith

This interim report is the first fruit of a modest but important study made possible by a grant from King Edward's Hospital Fund. Its concern with the organisation and effectiveness of industrial therapy in psychiatric hospitals reflects the significant changes in the traditional views first, of the mental patient and his relation to the community and, second, of the hospital itself as a social system. Industrial therapy provides an explicit link between the world of the hospital and the world of work. It is not, as the authors point out, a mere diversion for patients otherwise unoccupied: it is a conscious attempt to create, within the once totally segregated hospital environment, a work situation as close as possible to that obtaining in the world outside - a world to which more and more patients seek to and do return.

In the great majority of psychiatric hospitals in this country some form of industrial therapy has been established. It is a measure of our ignorance - but also of the value of this enquiry - that this simple fact is not widely appreciated, even among the hospitals themselves. To a certain extent, this ignorance is an inevitable consequence of traditional attitudes to mental illness and the social taboos attached to discussion of what goes on in 'asylums'. At the same time, the authors found little evidence of an exchange of ideas and experiences between the hospitals themselves; on certain matters e.g. sources of contracts, there was a positive reluctance to exchange information at all. Outside the hospital, the overlapping responsibilities of government departments in respect of rehabilitation and employment further multiply sources of information and criteria of assessment.

This fact-finding report, then, aims to provide the first step towards a comprehensive analysis of a major development in the field of mental health and rehabilitation. All of us concerned with the study hope that it will serve to stimulate discussion and further investigation of the many problems involved. It is pleasant to record at this point that the King Edward's Hospital Fund have made it possible for Mrs Wansbrough and Dr Miles to continue their work; Dr Miles, by means of comparative studies in different hospital work places, proposes to assess the effects of industrial therapy on psychiatric patients, while Mrs Wansbrough will be carrying out a more detailed examination of certain technical features of the operation of the units.

This Department was happy to provide a base for the study in the University of Southampton, and to welcome Mrs Wansbrough and Dr Miles as Honorary Research Fellows. The nature of the enquiry called for a great deal of co-operation and goodwill from many people. Particular mention is due to all the hospitals who returned the questionnaire and who received the authors as visitors to their

INTRODUCTION by Professor [illegible]

This interim report is the [illegible] made possible [illegible] concerned with [illegible] a psychiatric hospital [illegible] traditional [illegible] of the [illegible] continued [illegible] industrial [illegible] hospital [illegible] a means [illegible] attempt [illegible] end [illegible] in the [illegible] to a [illegible]

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industrial units. The Ministries of Health and of Labour provided useful information and assistance: Dr A R May MRCP DPM (now with the WHO) was particularly helpful, as were Mr J A Marshall and Mr E S C Sams of the Ministry of Labour. The success of the project owes a great deal to the interest and enthusiasm of the members of the Steering Committee appointed for the project by King Edward's Hospital Fund. We would also like to acknowledge our debt to the Fund's Officers, Mr M C Hardie and Mr I Roberts. Professor J P Martin saw the project through a crucial stage in the spring and summer of 1967, while I was in the United States. Dr Peter Sainsbury's interest and support is made clear by his Foreword but we would like formally to record our thanks to him.

J H SMITH

Department of Sociology & Social Administration,
University of Southampton.

SUMMARY

1 In the 1950s advances in pharmacology and in methods of treatment generally resulted in the possibility of discharge for a greatly increased proportion of long-stay psychiatric patients. It was then realised that the existing types of occupation in the hospitals were inadequate in preparing patients for work outside. A new approach was sought for and many of those engaged in the rehabilitation of long term patients turned to industrial therapy.

Many claims have been made for industrial therapy since its beginning, but so far little systematic data exists and its value in the treatment and rehabilitation of psychiatric patients has not yet been established. There seemed urgent need for investigation and the present survey represents the first phase of a three-year research project commissioned by the King's Fund.

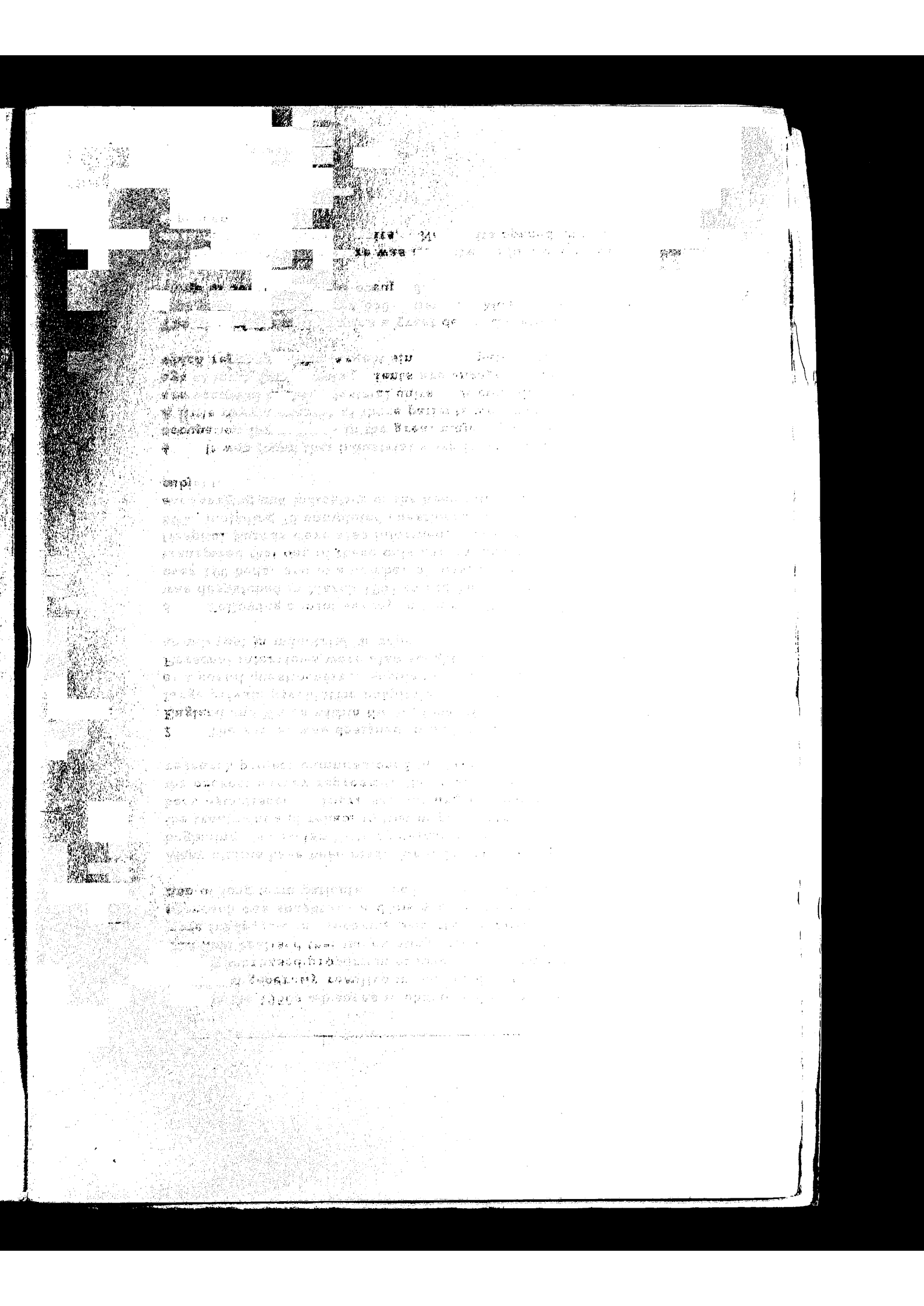
2 The survey was designed to include all psychiatric hospitals of England and Wales within the National Health Service and also the large private psychiatric hospitals. The main method was the use of a postal questionnaire, supplemented by many visits to hospitals. Personal interviews were also sought with a number of people having an interest in industrial therapy.

3 Following a pilot survey in ten hospitals the final questionnaire was despatched in March 1967 to 122 Mental Illness hospitals having over 100 beds, and to a number of private hospitals, although it transpired that one of these only has an industrial unit. The Regional Hospital Boards were also informed. The response rate of just on 80%, including 75 completed questionnaires was considered to be encouraging and indicative of the keen interest prevailing on the subject.

4 It was found that industrial work is an established form of occupation for patients in the great majority of Psychiatric Hospitals. A little over a quarter of those patients who work in these hospitals are occupied in the industrial units. A considerably higher percentage of male than female patients are engaged on industrial work which represents the largest single occupation for male patients.

The size of the units varies a great deal: the smallest unit occupies four patients, the largest 650 patients. Most units fell within the range of 50-300 patients occupied.

During 1965 and 1966 there was an increase in the number of patients working in the industrial units. New units opened and existing ones expanded.



Nearly three-quarters of the male patients discharged directly from the industrial units entered open employment after leaving the hospital. The proportion of corresponding female patients is a great deal lower, between one-third and a half.

5 Hospital staffs were invited to express their views regarding the aims and value of industrial therapy. It was found that there is a general agreement among the hospitals that the units have three distinct functions in connection with three types of patients:

a. for long-stay but not severely handicapped patients the function of industrial therapy is conceived as gradual work-training with a view to discharge;

b. for medium-stay patients it is conceived as preventing the loss of work-habits; and

c. for long-stay, severely handicapped patients its function is conceived as a humanitarian one.

There are certain advantages, connected with industrial work, which were emphasised by most hospitals, as follows:

a. industrial work is more rewarding financially as hospitals are able to pay extra to patients from the income;

b. industrial work, by approximating the concept of 'work' in outside society, carries more prestige for the patients;

c. patients leave their wards to work and thus their lives in the hospital resemble more the outside pattern of a division between living quarters and work-places;

d. industrial work can provide more work and in greater variety than do other forms of occupation in the hospitals;

e. no other work in the hospital prepares patients for outside working conditions to the same extent.

Hospitals differ in the emphasis placed upon particular functions of their units. In most cases it does not seem that these functions were purposefully specified, more often they seem to have been developed, in a given direction, according to the intentions of the initiator of the unit, and the particular needs of the time.

6 The maximum amount of money a patient can receive in the hospital is 39/11d, because of National Insurance regulations.

It was found that over a third of the patients working in the industrial units are paid in the form of an allowance rather than a wage; another third are paid by time rates weighted for punctuality, attendance, application to work, neatness, etc. A considerably smaller percentage of patients (18-20%) are paid by piece-rates which are connected only with their work in the units.

7 It was found that the large majority of the patients are referred to the industrial units by the Medical Officer in charge, who, in some cases, consults the nursing staff.

In 92% of the units assessment of the patients is carried out by the Manager of the unit.

Patients who have difficulties in working in the industrial units are transferred to other types of work in some hospitals; but in others they are kept in the units to try to solve their difficulties.

8 Premises, working conditions and the degree of mechanisation of the units were examined.

9 It was found that 50% of the industrial units staff can be regarded as qualified in nursing, occupational therapy or an industrial skill. The majority of the units staff are on the nursing establishment: less than a tenth are trained occupational therapists.

10 The hospital staff were invited to comment on their staffing problems. The comments received related to four areas of problem:

a. shortage of staff

b. inadequacy of pay, particularly of industrial staff

c. difficulties of relationship

d. need for training.

11 The qualifications and salaries of the unit managers were analysed.

It was found that over half of the 'managers' were members of the hospitals' senior nursing staff.

12 Work undertaken by industrial units is described. It falls into three main categories:

a. sub-contract work;

b. manufacture of products which the unit markets on its own account;

[redacted]

c. internal work for the hospital.

13 Hospital staff were invited to comment on the problems connected with work supply. Many comments referred to the difficulty of maintaining a continuous supply of varied work. It was found that in the years 1965 and 1966 nearly half the units suffered interruptions in their work supply. However, the squeeze did not affect the supply of work adversely since the shortage was no worse in 1966 than in 1965.

Great variety in the average annual value per contract was noted ranging from £33 per contract to £800.

Distance from the sources of work and problems of transport and storage are discussed. Over half the hospitals consider their storage space inadequate and many are handicapped by transport difficulties.

14 Responsibility for policy decisions, and the need for liaison with local authorities, are discussed, particularly in relation to sheltered work. This responsibility is divided among different government departments and authorities.

1 BACKGROUND TO THE STUDY

1. It has long been the practice of Psychiatric Hospitals to keep their patients occupied. Psychiatrists were traditionally of the opinion that work is beneficial for mental patients and that it would be clearly against their interests to live in the hospitals without an occupation. The custom grew up that patients, especially those remaining in the hospital for several years, were occupied in the hospital 'service' departments or, as they are also called, 'utility' departments (e.g. laundry, sewing room, repair workshops etc.), in the hospital gardens and in cleaning the hospital buildings. These types of work were readily available and were of importance for the running of the hospitals.

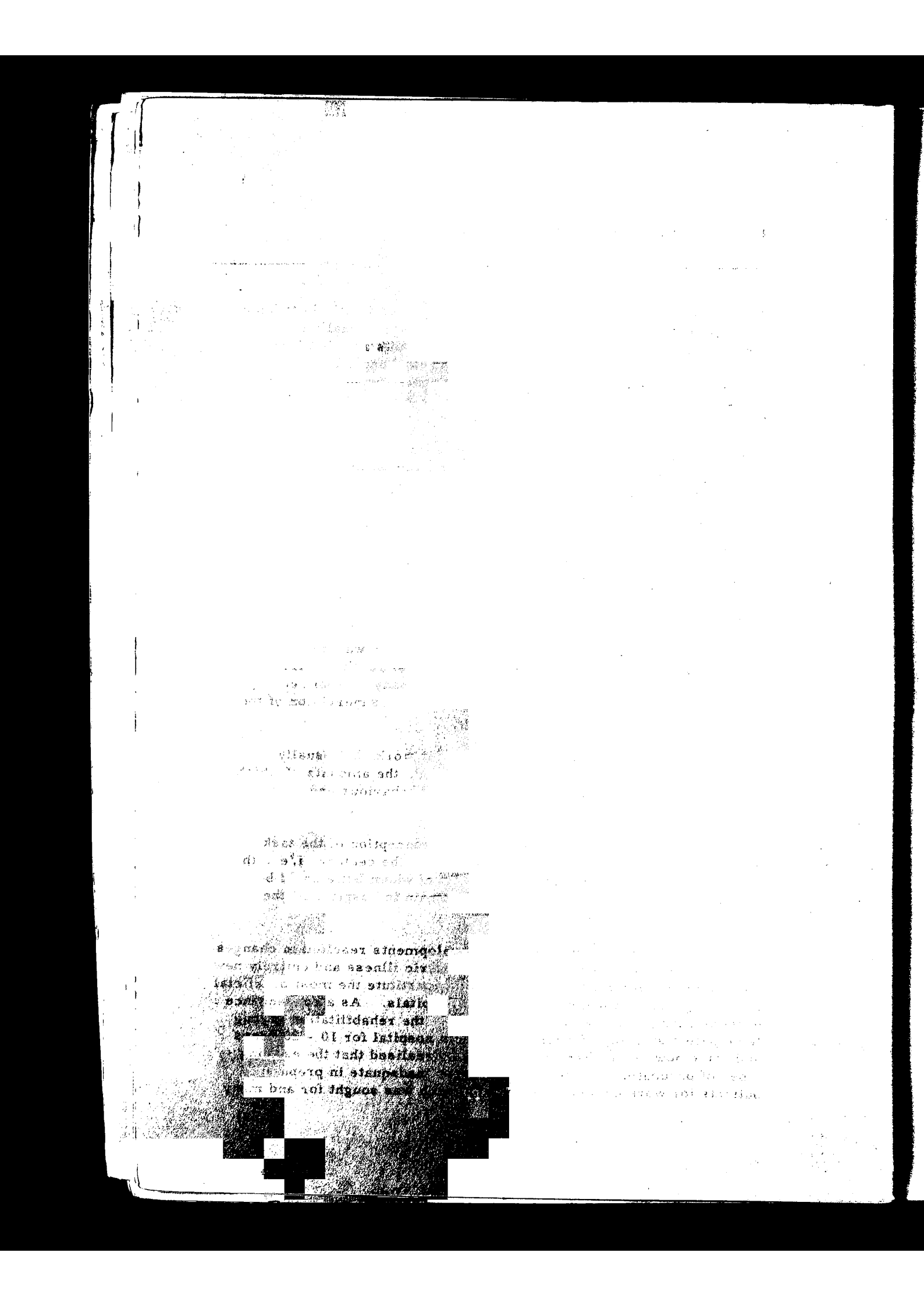
Patients, in smaller numbers, were also placed in the Occupational Therapy Departments and were there engaged in 'arts and crafts' activities, painting pictures, weaving rugs, making baskets etc. Some of the products of these activities were sold whilst others were not marketable; in any case, many of the activities were diversionary.

2. But whatever a patient's occupation, his life was spent within the hospital walls and was regulated by hospital routine. He was constantly in the company of other patients, many of whom could do no work at all and all were completely under the supervision of the hospital staff.

Patients were not paid 'wages' in return for work, but usually received some pocket money, or 'allowance', the amounts of which were decided by the staff, based on general behaviour and other factors.

This work pattern was consistent with the conception of the task of Psychiatric Hospitals during the first part of the century, i.e., the safe custody of patients, for the majority of whom little could be done and who, in all likelihood, would remain in hospital all their lives.

3. In the 1950's pharmacological developments resulted in changes in the patterns of several types of psychiatric illness and entirely new ideas were put forward as to what would constitute the most beneficial social organisation within Psychiatric Hospitals. As a consequence of these changes a new problem emerged: the rehabilitation of long term patients, many of whom had been in hospital for 10 - 20 years and could now be discharged. It became realised that the existing types of occupations in the hospitals were inadequate in preparing patients for work outside. A new approach was sought for and many



of those engaged in the rehabilitation of long term psychiatric patients turned to industrial therapy. In subsequent years many industrial therapy units were established and, increasingly, short stay patients, as well as long stay ones, were included.

4. Perhaps the clearest definition of industrial therapy was given by one of the most experienced psychiatrists in the field, Dr W V Wadsworth in 1962. He said that the aim of industrial therapy was:

> 'to preserve outside interests, standards and attitudes during a patient's stay in a mental hospital, both for short and long-stay patients, and re-establishing such standards and attitudes in the case of the latter who may have lost them over the years, by work of an "industrial" nature.'

5. Industrial therapy differs from other types of hospital work in many respects. It is never purely diversionary, but is either sub-contract work or production to be marketed. The hospital industrial units are, ideally, housed in a separate building, but in any case have a place of their own away from the wards; they are frequently staffed by non-hospital industrial staff. The patients' weekly pay is based on the work carried out by them.

6. Many claims have been made for industrial therapy since its beginnings. It is argued that patients are prepared for outside employment by learning timekeeping, workshop behaviour, inter-action with work-mates and supervisors and, perhaps most of all, by learning that the standard of the product is of great importance. Their life in hospital more resembles the life outside, with periods of working time spent away from the living quarters. It is held that industrial work carries more prestige than utility work and bears more relation to what society generally understands by work: that as patients earn a wage, no matter how small, they can contribute to their own upkeep and thus are more independent and have more personal freedom. It is also argued that in some cases the course of the psychiatric illness itself is influenced. Claims made for industrial therapy have not gone unchallenged: arguments have also been put forward to show that the results achieved by industrial work can be achieved by other types of occupation and that the results are only moderate, applying but to a small section of the psychiatric patients.

7. So far, there is little systematic data on this subject and the value of industrial work in the treatment and rehabilitation of psychiatric patients is not yet established. However, more and more industrial units have been set up and industrial therapy is now an established feature of most psychiatric hospitals. There seemed an urgent need therefore to investigate the present state of these units in the country and their value in treatment and rehabilitation.

2 SURVEY METHOD

9. The main method was the use of a questionnaire (see Appendix D). The questionnaire consisted of six sections:

1.	Patients:	the number and types of patients involved in industrial and also non-industrial work and the numbers joining and leaving the industrial unit;
2.	Payments:	methods of payments to patients and calculations of rates;
3.	Staff:	numbers, grades and experience;
4.	Work:	contracts and other work, price fixing methods, work supply and income;
5.	Conditions:	housing, working arrangements and conditions, machinery and equipment;
6.	Policy and Comments:	patients' referral, assessment and transfer, outside contacts, personnel in charge of the unit: their comments regarding its aims and values.

In addition to the questionnaire proper, two types of patients 'census' were designed: one to give details of each individual patient who worked in the industrial unit during a particular week, and another to give similar information about patients who left the unit during the previous year.

10. Personal interviews were sought with a considerable number of people interested in industrial therapy, and their experiences, views and plans were recorded. This information was used as a background to the survey itself.

Also, visits were made to a number of psychiatric hospitals with industrial units, the purpose in the first instance being to prepare the questionnaire and afterwards to gain more information and knowledge about these units. It was envisaged that these visits would also serve as a preparation for the second phase of the investigation, the evaluation of the effects of industrial therapy. For this purpose, in addition to factual data, the views of the personnel running the hospital units regarding the aims and value of industrial work for psychiatric patients were elicited. In all, thirty-eight industrial units were visited.

8. The present survey was planned as a first phase of a more extensive investigation of industrial therapy. The research workers felt it essential to establish the present practice in this field before any, more detailed, studies could be carried out. The aim of the survey was primarily fact-finding: to establish the volume of industrial therapy and the variety of practices.

The survey was designed to include all psychiatric hospitals of England and Wales within the National Health Service and also the large private psychiatric hospitals. It was hoped that information obtained from these hospitals would enable the building up of a comprehensive picture of the industrial units in this country.

3 PROCEDURE AND RESPONSE

11. During the first stage of this enquiry a draft questionnaire was prepared on the basis of which a pilot survey was conducted. The draft questionnaires were sent to 10 hospitals with industrial units, the medical superintendents of which had previously indicated their willingness to co-operate. They were also sent to a number of other people connected with industrial work for psychiatric patients and the answers, together with many helpful comments and suggestions, were of great value to the preparation of the final questionnaire.

12. The final questionnaires were dispatched at the end of March, 1967. They were sent to every Mental Illness Hospital (Ministry of Health Code 12) of over 100 beds in England and Wales, a total of 122 hospitals. The names of these hospitals were obtained from the Hospital Year Book and the Ministry of Health's list.

13. In addition, the questionnaires were sent to a number of private hospitals although it transpired that only one of these, the Cheadle Royal Hospital has an industrial unit. It was, however, decided to treat this unit separately, in the present survey, not because it is a private hospital unit, but because of the administrative complexities which its development has engendered. These are: firstly, 75% of its patients are now National Health Service patients and Local Authority trainees under contractual arrangement; secondly, it is a limited company, marketing its own product; and thirdly, it contains a Ministry of Labour Sheltered Workshop under Disabled Persons Employment legislation.

Lastly, for information only, Regional Hospital Boards were given copies of the questionnaire.

14. The hospitals were asked to return the questionnaires by May 15th, or to indicate, on an enclosed form, if they had no industrial unit. As many hospitals required more time to answer the questionnaire, the closing date had to be postponed to the end of July. This postponement also enabled the research workers to visit some hospitals and assist them with the more difficult questions.

The final response was as follows:-

Table I

	Hospitals
Questionnaires answered	74
No industrial unit	22
Have industrial unit but cannot answer questionnaire	25
Irreplaceably lost in post	1
Total	122

Of the total number of hospitals 100 had an industrial unit; of these 74 returned the questionnaire and the Interim Report on the Survey of Industrial Therapy is based on their answers.

15. Hospitals with no industrial unit were asked to indicate if they planned to set up one, or if they had a particular reason for not introducing industrial therapy. Of the 22 hospitals without industrial units seven, mostly geriatric hospitals and neurosis centres, replied that their patients were not suitable for industrial work; five said that they were considering the possibility of industrial units but had made no decision as yet; one hospital had decided against industrial work, and in another the medical superintendent disapproved of it on principle; one hospital had too few patients, and one had had to discontinue industrial work owing to lack of orders consequent upon the "squeeze". Six hospitals gave no reason.

4 THE PATIENTS

16. The first task of the survey was to establish the extent to which industrial therapy is used today in Psychiatric Hospitals. It was found that of the 122 such hospitals in England and Wales 100 have Industrial Units, and on this basis it can be said that industrial work is now an established form of occupation for psychiatric patients and is used in the majority of hospitals.

17. As already stated, of the hospitals which have industrial units 74 participated in the present survey. These hospitals had altogether 82,611 patients.

Table II

Patient population of 74 participating hospitals

	Male	Female	Total
In patients	34,777	45,345	80,122
Day patients	1,130	1,359	2,489
Total	35,907	46,704	82,611

Patients over 65

18. Of course, the patient population of the hospitals is drawn from various age groups and it was deemed important to elicit how many of the patients were over 65 years of age. It was found that 27.0% of all male patients and 47.8% of all female patients were in this category. Thus it should be borne in mind when considering the numbers of patients working in the hospital that a substantial proportion of them are above normal retirement age.

Patients Working

19. Of the whole patient-population included in this survey, 46.4% of the male, and 56.8% of the female patients worked in the hospitals. The selection of patients for work usually depends on length of stay in the hospital, on the severity of the illness and on age; patients staying only for a few weeks in hospital, and those who are very disturbed or very old, normally do not work. However, many patients of over 65 years of age work, if considered fit and active enough to do so.

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Patients over 65

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the hospital on the severity of ...
only for a few weeks in hospital ...
very old, normally do not work ...
years of age work, if considered ...

Types of Work

20. Details of the hospitals' work-arrangements were elicited in order to measure the relative importance of Industrial Units against other occupations. For this purpose the various work activities were divided into five categories: (1) Industrial Unit; (2) domestic duties (cleaning the wards and other hospital buildings, helping in the kitchen, etc.); (3) Occupational Therapy; (4) hospital service departments e.g. laundry, sewing room, furniture and shoe repair work-shops; (5) all other duties.

Table III

Patients' work in 74 participating hospitals

Type of work	Male patients No.	%	Female patients No.	%	All working patients No.	%
(1) Industrial Therapy	7644	33.0	5529	20.9	13173	26.5
(2) Domestic Duties	5101	22.1	6677	25.2	11778	23.7
(3) Occupational Therapy	4660	20.2	10846	40.8	15506	31.2
(4) Hospital Service	4146	17.9	2691	10.1	6837	13.8
(5) Other duties	1575	6.8	800	3.0	2375	4.8
Total	23126	100.0	26543	100.0	49669	100.0

This table clearly shows the relative importance of industrial therapy. In the case of male patients, industrial work is the largest single occupation in these hospitals; although in the case of female patients occupational therapy comes first and industrial work takes only third place. Domestic duties come second for both sexes. For all patients together, occupational therapy is the largest single occupation with industrial work taking second place.

21. The above pattern of patient-employment is fairly consistent throughout the country. The few differences occur in the following regions: in the East Anglia and Manchester Regions 'domestic duties' are the largest single work-category for both male and female patients; in Leeds Region industrial and occupational therapy rank equally at the head of the list and in the Newcastle Region industrial and not occupational therapy has the highest percentage of female patients.

22. The explanation for the much higher percentage of males than females engaged in industrial therapy probably lies in two directions. Firstly, there is a considerably larger number of female geriatric

Types of Work

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[

patients then male ones, and these patients are unsuitable for industrial work; indeed they are hardly able to leave their wards. However, many of these patients can be engaged in occupational therapy sessions. Secondly, in many hospitals industrial work is regarded as a preparation for outside employment and thought to be more important for male patients, all of whom must find employment if discharged, than for female patients, some of whom may return to their families without necessarily taking up employment. This point will be referred to again when the aims of industrial therapy will be discussed.

In summary, it can be said that over a quarter of the patients, who work in the hospitals are engaged in industrial work.

23. Having established the relative position of industrial units in comparison to other work-places in the hospitals, the next question to consider is the actual size of these units.

Table IV

The sizes of Industrial Units

Size of Unit	Number of Units
under 50	8
50 - 100	14
101 - 200	24
201 - 300	20
301 - 400	4
401 - 500	-
501 - 600	3
601 - 700	1
Total	74

The smallest Industrial Unit employs 4 patients and the largest employs 650 patients.

The differences in size are very large; the majority of the Units (79. 3%) however, fall in the middle categories, employing between 50 and 300 patients. The Cheadle Royal unit employs 139 patients and trainees.

patients than male ones, and the [illegible] industrial work; indeed they are [illegible] However, many of these patients [illegible] therapy sessions. Secondly, [illegible] regarded as a preparation for [illegible] more important for male patients [illegible] if discharged, than are female [illegible] their families when [illegible] will be referred to [illegible] discussed.

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[illegible] special units [illegible]

Size of unit	[illegible]
under 50	[illegible]
50 - 100	[illegible]
101 - 200	[illegible]
201 - 300	[illegible]
301 - [illegible]	[illegible]
401 - 500	[illegible]
501 - 600	[illegible]
601 - 700	[illegible]
Total	[illegible]

The smallest industrial unit [illegible] the largest employs 680 patients.

The differences in size are very [illegible] majority of the units (70.3%) however, fall in the middle [illegible] employing 50 and 100 patients. The Chronic Day [illegible] and trainees.

Increase of Patients Working in Industrial Units

24. The figures given so far relate to the Industrial Units as they are at the present time. It is, however, most important to consider the developments of the units over the past few years in order to see whether industrial therapy is increasing or decreasing in the hospitals. Therefore, in addition to eliciting information about the number of patients who worked in the Industrial Units at the time of the enquiry, hospitals were asked about the numbers of patients entering and leaving the units. This information was requested for the two years prior to the enquiry, 1965 and 1966, as the pilot study showed that hospital records relating to the years before 1965 would not be available.

Unfortunately, many hospitals were not able to give the required information owing to inadequate records. Each hospital patient's place of work and any changes therein are recorded in his file; but in many hospitals no central records are kept of patients working in a particular work-place or of patients entering and leaving this work-place. Thus information was received from between 44 and 58 hospitals (particular sections of the relevant data were given by differing numbers of hospitals) and therefore in the following analysis the mean numbers are used.

Table V

Mean number of patients entering and leaving the Industrial Units

	New patients entering the Industrial Units			Patients leaving the Industrial Units			Increase of patients
	Male	Female	Total	Male	Female	Total	
1965	61	49	110	46	32	78	32
1966	72	52	124	48	39	87	37

25. There was an increase in the number of patients working in the Industrial Units during both years. The mean rate of increase was fairly stable being only slightly higher in 1966 than in 1965. Industrial Therapy increased during these years in two directions: in the number of new Industrial Units opened and in the expansion of existing ones.

There has been a difference of opinion among psychiatrists regarding the function of the units in present day Psychiatric Hospitals: arguments have been put forward to show that these Units are 'old-fashioned' and have outlived their usefulness in that the character of the patient population of these hospitals has changed since Industrial Units were first set up. The results of the survey show that these

	Male	
1903	61	45
1904	72	52

arguments are not generally accepted as the Units were increasing as late as 1965 and 1966 and, if anything, the rate of increase was higher in 1966 than previously.

Patients Entering and Leaving the Industrial Unit

26. Regarding new entrants to the Units information was sought as to the numbers of long-stay and short-stay patients.

Table VI

New patients entering the Industrial Unit

Mean Numbers

	Long-stay patients (over 2 years in hospital)	Short-stay patients (under 2 years in hospital)	Total
1965	53	57	110
1966	59	65	124

The figures above show that the present nation-wide practice is to include short-stay patients in industrial therapy: indeed, more than half the new entrants in 1965 and 1966 were short-stay patients.

27. The numbers of patients leaving the Industrial Units during 1965 and 1966 include those patients who were discharged and those who, after a period in the unit, were considered to be unsuitable for industrial therapy. In the hospitals where information was available on this point 64.1% of the patients leaving the Industrial Units in 1965 and 69% of those leaving in 1966 were discharged.

It is, of course, impossible to say how far this result shows the success of industrial therapy in the discharge of patients. It may be that it is the policy of some hospitals that patients considered to be 'hopeful' cases are sent to Industrial Units. Also there are no comparative figures available on the discharge rates of patients from other hospital work-places. The fact remains, however, that a majority of patients in the Industrial Units were eventually discharged.

28. To what types of employment did these 'successful' patients go after leaving the hospital ? Hospitals were asked to answer this question concerning patients discharged direct from the Industrial Units during 1965 and 1966.

[illegible] are not generally accepted [illegible]
[illegible] as 1965 and 1966 and it [illegible]
in 1966 than previously.

Patients Entering and Leaving the [illegible]

24. Regarding new entrants [illegible]
to the numbers of long-stay [illegible]

New patients [illegible]

	long-stay patients (over 2 years in hospital)
1965	25
1966	39

The figures above show [illegible]
include short-stay patients [illegible]
half the new entrants in [illegible]

27. The numbers of [illegible]
and 1966 include those [illegible]
after a period in the work [illegible]
industrial therapy. [illegible]
on this point, 14% of the [illegible]
and 69% of those leaving in [illegible]

It is, of course, important [illegible]
success of industrial therapy [illegible]
that it is the policy of some [illegible]
'hopeful' cases are sent to [illegible]
comparative figures available [illegible]
other hospital work-places. [illegible]
majority of patients in the [illegible]

28. To what type of employment [illegible]
after leaving the hospital? [illegible]
question concerning patients discharged [illegible]
during during 1965 and 1966.

Table VII

Patients' First Employment after Discharge

Type of work after discharge	1965 Male %	1965 Female %	1966 Male %	1966 Female %
Open employment	74.2	47.3	73.8	38.4
I.R.U. or G.T.C.	6.5	nil	5.9	3.8
I.T.O.	3.2	5.4	2.7	3.8
No gainful employment	16.1	47.3	17.6	54.0
Total	100.0	100.0	100.0	100.0

The majority of discharged male patients entered open employment after leaving the hospital. This is an expected result as hospitals, in the majority of cases, discharge patients only when employment is available for them. The fact that work-training organisations like I.T.O's and I.R.U's take such small percentages of all discharged patients indicates the lack of such facilities, rather than unwillingness to make use of them.

An interesting feature of the table shows that an increasing proportion of female patients do not take up employment after discharge. It was expected of course that more female than male patients would leave the hospital without taking up employment; the increase in this statistic between 1965 and 1966 was not expected.

This may reflect the economic restrictions of the country: discharged psychiatric patients seeking mainly unskilled labour would find it more difficult to obtain work than in times of full employment. While male patients can be discharged only in exceptional circumstances without employment (when their families can afford to support them), female patients can return to their families without necessarily having a job to go to.

The Influence of Availability of Work and of Outside Sheltered Employment on Patients Entering and Leaving the Units

29. When considering the numbers of patients who enter and leave the Industrial Units, it should be remembered that several factors not connected with Industrial Therapy may have a great deal of influence on the figures. Two such possible influences were considered: firstly the availability of work in the units on the number of new entrants and secondly the availability of sheltered conditions outside the hospitals on the number of discharges.

Table VII

Type of work after discharge	
Open employment	
I.H.O. or O.T.C.	
I.T.O.	
No gainful employment	
Total	

To test the question of how far lack of work in the Industrial Units influenced the placing of new patients in them, hospitals were asked to estimate the number of patients whom they would consider suitable for industrial work if enough work were available. It was found that each hospital would consider, on average, a further 46 patients (24 males and 22 females) for working in the Industrial Units if work was available for them. This seems a high figure, considering that the total number of new entrants per unit during the whole of 1966 was 124. It means, that far from not having enough patients for the units, there are waiting lists, and that at least one reason for not expanding the units further is insufficiency of work for all the suitable patients.

To test the second point, the extent to which the lack of sheltered conditions outside influenced the number of discharges from the Industrial Units, hospitals were asked to estimate how many patients still in the unit could be discharged if enough sheltered employment and hostel accommodation were available. It was found that an average of 35 patients per unit were considered suitable for discharge at the time of the inquiry but had to stay in hospital because of the lack of hostel accommodation and sheltered employment. By 'sheltered employment' respondents appear to mean suitable work provided in the community as well as 'sheltered work' under the Disabled Persons' Employment Act.

This is a very important result. It means that the numbers of 'successful' patients i.e. those ready to be discharged, in the Industrial Units were, in fact, underestimated in the analysis mentioned in (24) above, as many more could have left the hospital but for the foregoing factors. It also means that another factor behind the estimated number of patients waiting to be placed in the units is the fact that patients do not leave when they are ready to do so but are obliged to stay on, occupying places for which others are waiting. Most of all, this result underlines the need for more sheltered employment and hostel accommodation for discharged patients. This point will be returned to later.

The estimated numbers of patients who could be placed in Industrial Units if enough work were available is consistent throughout 11 of the 15 Hospital Regions and also consistent with the national mean figures mentioned above. The exceptions are Oxford and Manchester Regions where the corresponding numbers are much higher (about three times greater than the national mean) and the South Western Region and Wales where they are very low (less than a quarter). The estimates concerning the numbers of patients who could be discharged if sheltered conditions were available are fairly consistent with the mean throughout the Regions.

30. It has not proved possible to include the patients and trainees of Cheadle Royal Hospital in the foregoing analyses of patient figures since they are not comparable. For instance, since part of the unit

already is a Sheltered Workshop under the Disabled Persons Employment Act, it would be meaningless to include Cheadle Royal patients in the First Employment after Discharge Table. (Table VII).

But the figures are of interest. Numbering 139, the work-force consists of private and National Health Service patients, and local authority 'trainees'. 102 are in-patients, 37 day patients and trainees. 93% are (or were) long-stay patients who have been (or had been) in hospital over two years. The remaining 7% includes only one woman. Overall the sexes are almost equally balanced, men slightly preponderating. 20% are over 60 years of age. The number of new entrants appear to be falling: 68 in 1965, 55 in 1966. Indeed, it is considered at the hospital that Cheadle Royal's own long-stay population having been worked through, the places made available to the Regional Board are also ceasing to be taken up to the full extent.

5 HOSPITAL STAFF'S CONCEPTION OF THE AIMS AND VALUES OF INDUSTRIAL THERAPY

Aims of Industrial Units

31. How are the tasks of Industrial Units conceived by the hospital personnel connected with them ? Hospitals were asked to express their views on this point and in the following section their comments will be discussed. Although it is important to examine these views as being the only information on the collective opinion of hospital personnel connected with 70 odd units, they have to be regarded with caution since some comments were expressed clearly and at length, whilst others were lacking in clarity or were too brief. Thus, it could not be ensured that all opinions were given equal weight. There is a general agreement among the hospitals that Industrial Units have three distinctly different functions in connection with three types of psychiatric patients.

a. Long-stay patients who have been in hospital for a number of years, but who may be discharged in the future, are regarded, in most units, as being the category of patients for whom industrial therapy is the most important.

   In the past, these patients were employed in the hospitals, if at all, at light maintenance work. They lost the 'habit' of work and in this condition could not be regarded as fit for employment outside the hospital. So, the work-habit and work-skills need to be restored in them, before their discharge from the hospital can be contemplated. The function of the Industrial Unit with regard to these patients is conceived as gradual work-training: teaching them time-keeping, simple work-skills, co-operation with fellow-workers, the importance of the finished product, etc. with the view of rehabilitation.

b. Medium-stay patients form the second category. These patients stay in hospital for a few months, perhaps a year, and then return to the community. The task of the Industrial Units, with regard to these patients is seen to be that they keep the work-habit by regular employment and do not become dependent on the hospital providing everything for them.

c. The third category is the long-stay, severely handicapped patients who, in all probability, will never leave the hospital. These patients are employed in the Industrial Units mainly on humanitarian grounds: it is inhuman to require patients to live for long periods without an

occupation. If they do so, the probability is that they will further deteriorate, thus requiring more care and becoming more of a burden to themselves and to society.

Values of Industrial Units

32. Industrial work, of course, is not the only possible type of employment for hospital patients; they can be, and are, employed on hospital maintenance and occupational therapy. There are, however, certain advantages, connected with industrial work, which most hospitals emphasised in their comments. Firstly, industrial work is more rewarding financially, as hospitals are able to pay extra to patients from the income. This may, at first sight, seem a very small advantage, as the maximum a patient can receive is 39/11d a week. Under hospital conditions, however, even small differences can matter a great deal: patients can buy cigarettes, beverages and even clothing with the money they receive. Moreover, the weekly money may represent more than its purchasing power: it can give a degree of independence to a patient if he is not obliged to ask the nursing staff for every necessity of life.

Secondly, in many hospitals it is felt that industrial work carries more prestige for the patients than does hospital maintenance work. It is argued that industrial work approximates more to the concept of 'work' valued by society than does, for example, cleaning the ward and thus gives the patients more self-respect and prestige.

Thirdly, by working in an Industrial Unit, the patients in many hospitals leave their wards during working-hours. Thus their lives resemble more the outside pattern of a division between living quarters and work-place. Also, the unit represents, in many hospitals, the only regular contact patients have with the outside world as the work-supervisors are not the usual hospital personnel.

Fourthly, industrial work provides more work and in greater variety than does hospital maintenance work and occupational therapy. Several hospitals found that only by setting up an Industrial Unit would they ensure regular employment for all those patients suitable for work, and that a large number of patients who were unable to work in the hospital maintenance departments because of particular handicaps, could be occupied on simple industrial work.

The fifth, and perhaps most usual argument is that from an educational point of view the Industrial Unit's value is outstanding: there is no other work within the hospital which prepares the patient for outside working conditions to the same extent. The fact that a standard is set by the manufacturer teaches the patients that the quality of their work is important. Also, workshop behaviour, interaction with workmates and supervisors, and work-routine can be taught, realistically, only in Industrial Units.

33. Not all these arguments were put forward by all hospitals; but each hospital which set up an Industrial Unit argued more or less along these lines. The main differences among hospitals lie in the emphasis placed upon particular functions of industrial work and in the general hospital regime, into which industrial work is fitted. The majority of hospitals which participated in the survey regard rehabilitation of the long-term but 'hopeful' patients as the most important function of the industrial unit. These hospitals gear the work of their unit to the needs of this type of patient, even if the unit is not exclusively manned by them. Among these units are the most 'industrialised' ones, those in which machines are installed and more difficult work is carried out under little supervision.

Other hospitals gear the unit to the needs of long-stay severely handicapped patients, who are likely to stay in hospital for the rest of their lives. These units undertake fairly simple work and carry out their tasks under more supervision than does the group mentioned above.

34. The units also differ a great deal according to the particular type of hospital regime in which they operate. In a hospital, for example, which is run as a therapeutic community, the industrial unit is regarded as part of this. The patients of the unit are regarded as a 'group' and discussions would be organised regularly about their problems in connection with work and with relationships amongst workmates and between patients and staff etc. These types of hospital, however, are few at present.

Hospitals differ greatly according to whether their regimes are more, or less, authoritarian and disciplinary, and the management and organisation of the industrial units reflect these differences. In a disciplinarian hospital the unit's function can be to teach patients 'how to behave' when together and it may also be used just to occupy them because it is easier to keep order this way; whilst in a permissive hospital the patients' satisfaction in working is emphasised and the patients are allowed a great deal of freedom in work-habits.

35. It does not seem, from the history of the units, that the particular function of each was purposefully decided. Rather do they seem to have been developed in one direction or another, according to the intention of the initiator of the unit, and the particular needs of the moment. For instance, in one hospital, a charge nurse, with interest and experience in industry, may have started a highly industrialised unit to prepare patients for outside employment, whilst in another, a nurse or occupational therapist may have designed the unit to meet the need to occupy very handicapped patients on suitable work. The two hospital units then might have kept largely their original characters, a typical pattern in the history of industrial units. Less usual are those units which were initiated as a deliberate policy of the hospital's senior staff (usually

the Medical Superintendent) and which were developed according to pre-determined and carefully thought out plans. Of course, any unit can later develop on lines different from the original ones, or expand to cover other needs; but typically, units are influenced a great deal by the initiator's ideas and their original character.

Importance attached to Industrial Units

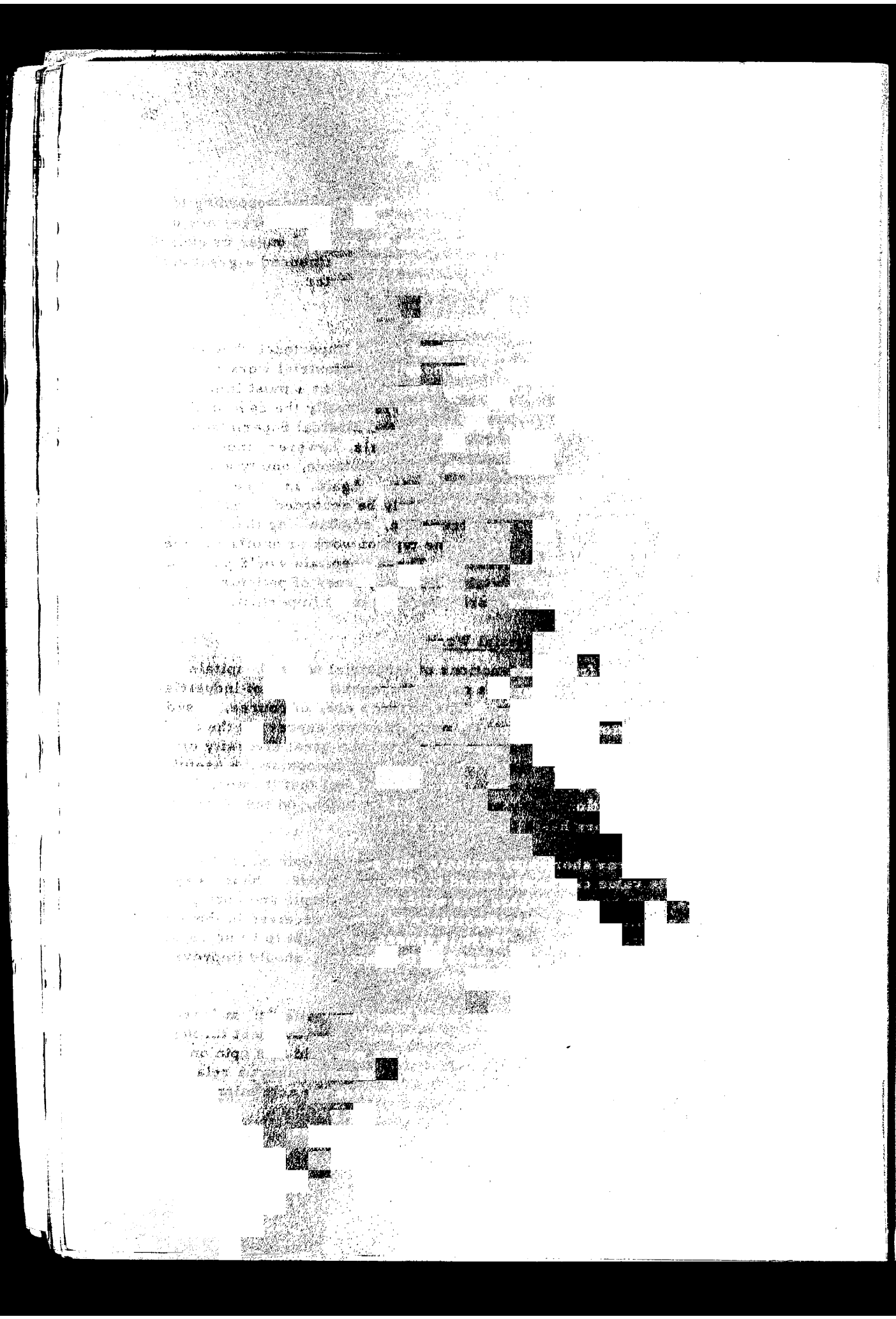
36. Hospitals also differ a great deal in the importance they attach to their industrial units. In some hospitals industrial work is regarded as the main rehabilitating channel and as a most important part of the hospital's programme. This is usually the case in those hospitals where the unit was initiated by the Medical Superintendent on a planned basis. In a number of hospitals, however, industrial units are regarded as of very moderate importance, one type of occupation amongst many for the patients. Again, in some hospitals industrial work may deliberately be accorded no greater importance than other types of occupation, emphasising that the particular aptitude of patients for one type of work or another is the decisive factor in work-allocation. These hospitals would point out that industrial work is not suitable for many types of patients and the existence of a variety of work-places is most important.

Therapeutic Value of Industrial Work

37. As distinct from the functions of industrial units, hospitals were asked to express opinions on the therapeutic value of industrial work for psychiatric patients. The answers are, of course, based on the impressions of therapists, many of whom expressed the need for systematic study. The answers revealed a great diversity of opinion. Some psychiatrists, while they may recognise the usefulness of industrial work in other ways, do not feel that it improves the clinical condition of any patient. Others think, on the contrary, that industrial work has a therapeutic effect.

38. As regards short-stay patients, the general opinion is that no therapeutic value can be attributed to industrial work. Short-stay patients, it is argued, regard this work as too simple and boring, they do not attach the same importance to money received in the unit as do long-stay patients. There is generally thought to be no reason why this type of work, or any work in the hospital, should improve the condition of short-stay patients.

39. Opinions are different regarding long-stay patients: at least some of the psychiatrists feel that therapeutic improvement through industrial work is possible. Psychiatrists who hold this opinion argue that, firstly, the work supervisors, by maintaining a relatively high output, with a minimum of errors, provide the activation needed by severely handicapped chronic schizophrenic patients. The immobility, which tends to be a feature of the illness, is thus reduced.

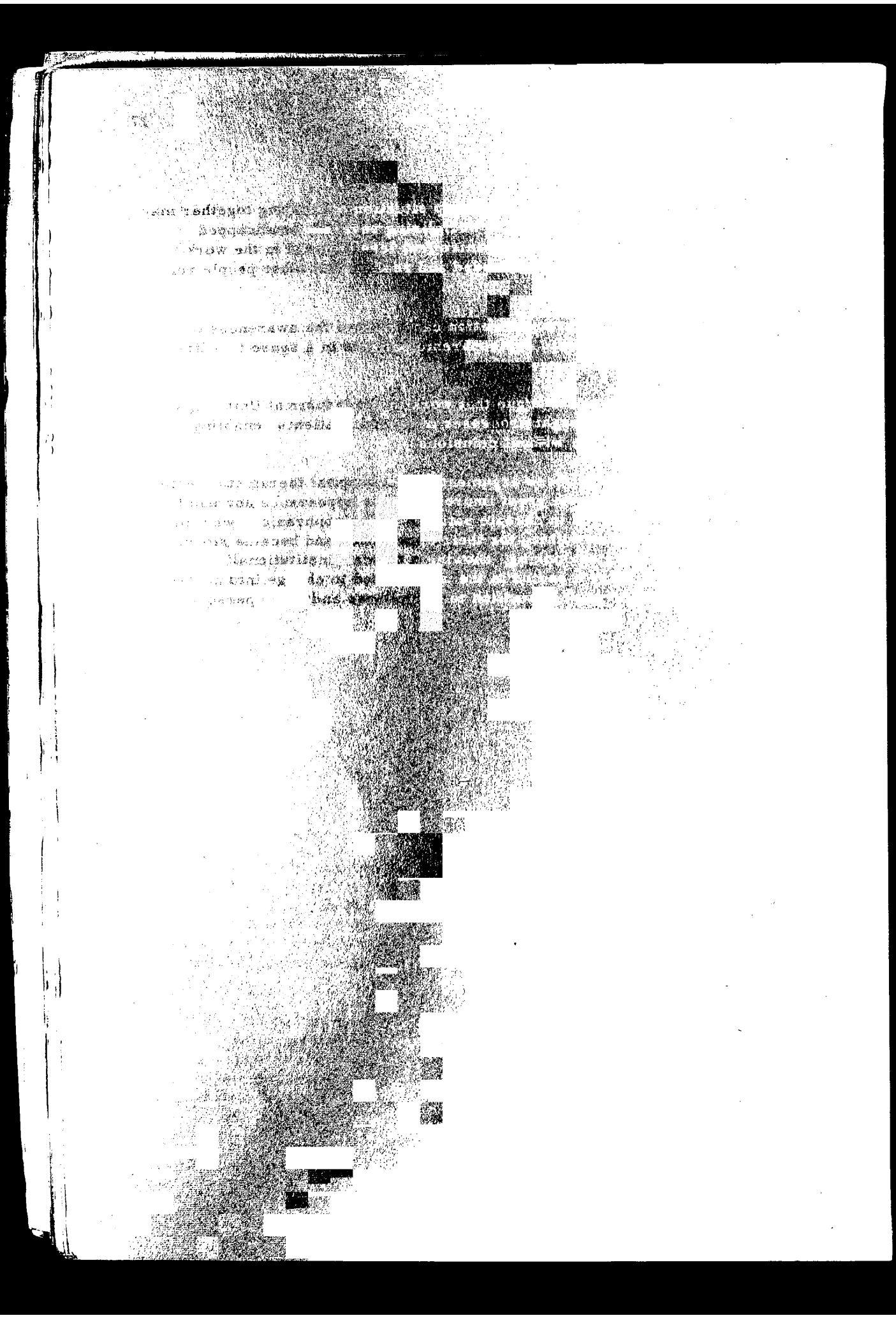


Secondly, they argue that the group situation of working together may play a most important part in socialising severely handicapped patients. Solitary schizophrenics feel less isolated in the work situation, where they feel needed and realise that other people rely on them.

Thirdly, the same group situation can improve the awareness of environment in chronic schizophrenic patients in a sense that life in the ward cannot.

Fourthly, some would argue that work in the Industrial Unit helps to discipline the thought processes of chronic patients, enabling them to concentrate without delusions.

40. In addition to these arguments most hospital therapists mention in their comments the great improvement in appearance and habit which was observed in chronic patients. Schizophrenics, who for many years cared nothing for their appearance and became slovenly, dirty and neglected-looking, showing a typical 'institutional' appearance, after a period in the unit started to change into neater, tidier persons, paying attention to cleanliness and other personal habits.



6 METHODS OF PAYMENT

41. The methods by which patients are paid in the Industrial Units are of very great importance. Several of the main advantages associated with industrial work over other types of work in the hospitals, are connected with the money patients receive for working in the Units. Hospitals were asked to give information about the amounts of money patients receive in the Unit, the way these amounts are fixed, the form payments take, about the hospital personnel who fix the amount and those who hand over the payments to the patients.

42. The maximum amount a patient can receive in the hospital is 39/11d per week. This level is fixed by the fact that if a patient earned more, a National Insurance contribution would become payable and this would much complicate the payment system and would involve hospitals in a great deal of additional expense. The exact amounts paid to patients in the Units are not yet available, as information about this was asked for on the 'Lists of Patients' who worked in the Industrial Units at the time of the enquiry. These 'lists', as explained previously, could not be analysed by the Computer Centre in time to be included in this report and will follow later. But the amounts vary between 5/-d a week and the maximum 39/11d a week.

43. Hospitals were asked to give information about the methods by which the actual amounts paid to patients are fixed. Answers were to fall into one or more of six categories, one of which 'time rate fixed within the Unit' was to prove superfluous as it was not in use and it is thus excluded from the following analysis.

It is possible that various sections of the Industrial Unit of a hospital use different methods of fixing the patients' pay; even within the same section more than one method may be in use. Therefore information was collected about the number of patients whose pay is fixed by a particular method, rather than about the number of Units which use these methods.

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44. Table VIII

Patients paid by various methods in the Industrial Units

	Male Patients	Female Patients
Allowance rather than a wage	37.2%	34.7%
Time rate weighted for punctuality, attendance, etc.	35.3%	33.3%
Piece rate fixed by price offered by manufacturer	9.9%	10.7%
Piece rate fixed by work measurement	6.9%	9.3%
Other methods	10.7%	12.0%
Total	100.0%	100.0%

At Cheadle Royal Hospital, 65% of the workers are paid by piece-rate, some also earning bonus, and 35% by time-rate or allowance.

The largest single category in the case of both sexes is the allowance, closely followed by weighted time-rate. These two categories together represent the payment methods of approximately 70% of the patients who are engaged on industrial work. In fact, the difference between these two methods is not very great. When a patient is paid by an 'allowance' this means that members of the staff decide how much money he should receive each week. The staff members would usually base their decision on the patient's behaviour in the hospital: on his co-operation with the staff and with other patients, on his willingness to work, on the extent to which he takes care of his appearance etc. In other words, the staff base their decisions concerning the patients' allowances on very similar factors to those which are taken into consideration when the amounts are fixed by time rates, weighted for punctuality, attendance, application to work, neatness etc. There can be slight differences: in some hospitals for instance, there are individual scoring cards in use for the purposes of the weighted time-rate method, on which a patient is given a score for each factor and the amount of money is based on his total score. But more often weighted time-rates are fixed by the staff without the use of such pre-defined systems. The most important difference between the two methods is that the weighted time-rate is, in principle, connected with the patient's behaviour in the workshop

only, while the allowance is also influenced by behaviour outside it. In practice, however, this difference is blurred: a patient's neatness, punctuality and co-operation are part of his total behaviour in hospital and cannot be separated, in and out of the workshop.

Contrary to allowances and weighted time-rates, the methods of payment based on piece-rates are directly connected with only one factor: work carried out by the patient. In this sense the piece-rate method, however the amount paid by piece is fixed, is the one with most resemblance to wages paid for industrial work in the outside society. However, as the table shows, a considerably smaller percentage of the patients engaged on industrial work paid by this method.

45. This pattern of payments to patients is fairly widespread throughout the country. The differences in paying methods exist between individual hospitals rather than between different parts of the country. The main exception is the Sheffield Region, in which all the hospitals participating in this survey strongly favoured piece-rates. In this Region 85% of the patients engaged on industrial work were paid by the piece-rate method. The other regional preferences (i.e. where all the hospitals in a Region inclined to using the same methods) were in the South East Metropolitan Region, in the Oxford Region and in the Manchester Region where hospitals paid practically all their patients by allowance and weighted time-rates and did not use piece-rates.

Methods of Payment as Incentives

46. This result of the survey should be considered in its relevance to three aspects of industrial therapy: (a) the incentives for patients to work, (b) the dependence of patients on the staff and (c) the differences between Industrial Units and other work-places of the hospitals.

Firstly, the patients' incentives to work will be considered. Why do patients wish to work in the hospital ? The answer to this question is a fairly simple one. Patients who stay in hospital for several months, even years, want to work, generally, because it is much preferable to complete idleness. The economics of every day life in outside society do not have the same force: patients are provided with board and lodging, clothes and some entertainments, whether they work or not. In a rather simplified way, it could be said, that patients are willing to work because it would be too boring not to do so; but how well they are willing to work is a different matter and the level of work is connected with the incentives they are offered. The main incentive that can be offered to the patients is the amount of weekly money, which, even at this low level, does, in hospital conditions, make a difference. Packets of cigarettes, cups of tea, a bright scarf or lipstick may mean a great deal to the patients. The results of the survey show, however, that in the

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punctuality and co-operation ...
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Contrary to allowances and ...
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Methods of Payment as Incentives

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majority of the hospitals the amount of the patients' money is not directly connected with their work or, at least, not only connected with work but with many other factors. Allowances and weighted time-rates are based not only on the patients' work, not even on their behaviour in the Industrial Unit, but also on their general behaviour in the hospital. Therefore in those Industrial Units where these methods of payment are in use the extent to which money-reward is offered as an incentive to work better is limited.

This is an important finding of the survey and, at first sight, it seems a surprising one. Especially so, as the importance of observing one of the main principles of industrial work, pay according to work, has been often emphasised in the literature. The explanation probably is that these methods of paying are an inheritance from the past of the mental hospital organisation, when the 'good' behaviour of the patients was more important to the staff than the standard of work they attained.

47. The importance of the amount of money received by the patients in the Industrial Units as incentive to work well is, in fact, further reduced by the system of indigent pocket money allowances. Indigent pockey money is given to patients who have no other income in the hospital. The reason for this is that there are a number of psychiatric patients who cannot work because of too severe mental or physical handicaps. Hospital authorities traditionally have taken the view that these patients should receive a small amount of pocket money every week. This means that the difference between the financial position of a patient who works and that of a patient who does not work can be negligible. In fact it is the practice of some hospitals not only to give pocket money to those patients who are unable to work, but also to supplement the small earnings of patients who are only capable of limited work. The principle behind this practice is a humanitarian one: it is not the fault of the handicapped patient that he is unable to work well, and he should not thus be penalised. This is understandable; but the effect of this practice is to reduce the value of the patients' earnings as incentives to good work.

With the exception of two hospitals, indigent pocket money is paid in every hospital. The usual practice is to keep this separate from payments made to patients for working in the Industrial Units.

Methods of Payment and Dependence upon Staff

48. The result that the large majority of patients are paid by an allowance or by weighted time-rates, is also worth considering in its relevance to the patients' dependence on the staff. One of the advantages, associated with working in the Industrial Units, is that patients 'earn' their money, that they receive it for work done and therefore feel a measure of self-reliance and less dependence on the hospital staff. Patients generally depend on the staff throughout

their entire lives in the hospital. The staff arrange their routine and supervise their activities. It was thought, therefore, an advantage that in the Industrial Units patients can earn money which is theirs by right and can gradually learn that it is up to them if they wish to earn more. But in those Units where the money has no direct bearing on the work carried out, this argument does not apply: patients there receive a sum allotted to them by the staff on whom their dependence is not lessened.

Industrial Work and Other Hospital Work in the Light of Payment Methods

49. It may now be of interest to consider the whole subject of the differences between industrial work and other hospital work in the light of payment methods. Apart from the nature of the work, the most important distinguishing feature of industrial therapy, as emphasised repeatedly in the literature on the subject, is its principle of payment for work done. This is not the case in other hospital work-places, where the nature of the work (for instance cleaning or diversionary activities) prevents this principle operating and, in any case, the accepted system is the allocation of pocket-money, according to, among other things, the ability of the patients to manage it. However, from the result of the survey, it seems that a large number of those patients who work in Industrial Units also receive pocket money and not wages for work done, and in this sense it makes little difference whether they are engaged on industrial or other work. The conclusion must be that with regard to payment many Industrial Units differ hardly at all from other work-places of the hospitals.

Bonuses and Other Incentive Methods

50. Those hospitals where patients were paid by methods other than piece-rates, weighted time-rates or allowances, were asked to specify what these consisted of. Two methods thus revealed seem worth mentioning as rather interesting variations although the percentage of patients paid by these methods is too small to affect the analysis of payment methods above.

In a few hospitals group-work is much emphasised, the view being that patients need the team-situation, the joint effort and co-operation for therapeutical and rehabilitational benefits. The payment-system therefore has been designed with this purpose in mind: a group of patients is engaged on a particular task and is paid as a group for it. The money earned is divided amongst the group members either in equal proportions or according to their respective merits. But if the group increases its earnings then the amount of money received by each member is correspondingly increased and vice versa.

The other method was a system of grading patients according to the degree of supervision needed. This method of payment was based

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[illegible] many activities. It was thought [illegible] in the Industrial Units patients can earn [illegible] and can gradually learn that it is up [illegible] money. But in those Units where the [illegible] the work carried out, this argument [illegible] receive a sum allotted to them [illegible] is not lessened.

Industrial Work and Other Hospital Work Methods

49. It may now be of interest to [illegible] differences between industrial [illegible] light of payment methods. [illegible] most important distinguishing [illegible] emphasised repeatedly in the [illegible] principle of payment for work [illegible] hospital work-places, where [illegible] cleaning or diversionary [illegible] and, in any case, the accept[illegible] money, according to [illegible] to manage it. However [illegible] a large number of those patients [illegible] receive pocket money and [illegible] it makes little difference wh[illegible] other work. The [illegible] many Industrial Units [illegible] the hospitals.

Bonuses and Other Incentive [illegible]

50. Those hospitals where patients [illegible] than piece-rates, weighted [illegible] specify what these consisted of. [illegible] worth mentioning as rather [illegible] percentage of patients paid by the [illegible] the analysis of payment methods above.

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[illegible] was a system of grading patients [illegible] supervision needed. This method of payment [illegible]

on work-units, the value of one unit being 4/-d at the time of the enquiry. There were three grades consisting of patients needing constant supervision, those needing a fair degree of supervision and those needing only a minimum of supervision. Each patient would progress from one grade to the next when becoming more self-reliant.

It should also be mentioned that within the usual broad types of piece-rate methods some interesting and well thought-out ways of establishing the rates exist. There is no space available to describe all the methods in detail, especially as these are mostly worked out to suit existing circumstances and patients, but it should be noted that in a number of hospitals much thought was given to the working out of piece-rate methods.

51. In addition to basic weekly payments, patients in some Industrial Units also receive incentive increases and bonus payments. The number of Units where these types of additional payments are paid is not high, and the amount of such payments is not substantial. Bonus payment is the more usual of the two. Two main types of bonus are in use: the Christmas bonus for all patients working in a Unit and the bonus paid for extra time worked. Thus in some Units patients may be asked to work over-time when a rush-contract is not finished on time; or to work during a holiday-period or on visiting day in order to complete particular contracts. In a very few Units 'incentive increases' for improved work are also paid.

In addition to these payments there are, in some Units, other benefits attached to working there; outings for the patients of the Unit at Christmas and in the summer are arranged, or parties given and small presents distributed, all financed from the Unit's income.

Who Pays the Patient and in What Form

52. Apart from the method of fixing the amount of pay, the way the payments are made may also matter to the patients, but probably to a lesser extent. Who hands the money to them on pay-day and in what form ? Hospitals were asked to indicate whether the Industrial Unit staff, the ward staff or the finance office staff pay the patients. Most hospitals named one of the three, but some of those with units divided into sections, named more than one. In approximately 60% of the Units the Industrial Unit staff pays the patients, in 23% it is the Finance Office staff and in the remaining 17% the ward staff undertakes the duty. Thus, in the majority of the Units patients are paid either by their work supervisors or by independent finance staff, and this system emphasises the connection between work in the Unit and pay.

53. It was also asked whether patients receive their pay in wage packets or as loose change. It is difficult to estimate how far this may matter to the patients. But it can be argued that wage packets are associated with outside standards and are therefore valued more and also that handing over wage packets represents more respect towards patient-workers on the part of the staff than does the handing over of loose change and is therefore, again, valued more by patients.

It was found that in 66% of the Industrial Units patients receive their pay as loose change and in the remaining 34%, in wage packets. Cheadle Royal Hospital workers are paid by wage packet in the factory.

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It was found that in 66% of the industrial ...
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Cheadle Royal Hospital workers ...
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7 METHODS OF REFERRING, ASSESSING AND TRANSFERRING PATIENTS

54. What are the systems of referring patients to the Industrial Units, of assessing them while working there and of transferring them from the Unit ? Hospitals gave information on these points by describing the arrangements of their Industrial Units.

First, the ways by which patients are referred for work in the Industrial Units will be considered. Basically, every patient throughout the country, who works in an Industrial Unit, has been referred there by the Medical Officer in whose charge he is in the hospital. The differences between hospitals are in the degree of informality of the procedure and in the extent to which the Medical Officer consults other members of the hospital staff.

Some hospitals described very formalised systems of referring patients to particular work-places. These systems usually consist of conferences (the names given differ a great deal: case conferences, assessment meetings, etc.) at specified intervals, weekly, fortnightly or monthly, when the cases of patients are discussed and decisions are made. In some hospitals referral cards are in use on which details of a case and reasons for the referral are recorded. In other hospitals the practice of referring patients for work in the Industrial Unit is entirely informal: the Medical Officer in charge considers individual cases and suggests industrial work, often after consulting the nursing staff. The nursing staff may also be consulted in some of those hospitals where referrals are dealt with at conferences. The degree to which the doctor in charge consults the nurses and other staff members varies a great deal: industrial therapy for patients is regarded as an entirely medical matter by some doctors and as a matter for joint decision by others.

55. Patients' progress in the Industrial Units have to be assessed in order to see whether they show any improvement and whether they should leave the Unit. Assessments are formalised processes in some Units and informal ones in others. In the former cases periodical (usually monthly) reviews of patients' progress are held and, in some hospitals, work-reports or progress charts are produced. In the latter cases, it is usually a Medical Officer's asking about his patient's progress or an individual problem-case which prompts the assessment.

In 92% of the Units, assessments are carried out by the Industrial Unit Manager. In the remainder there is a Medical Officer, permanently concerned with the Unit, who assesses the patients, usually in consultation with the Industrial Manager.

56. In several Units the assessment of patients is linked with the review of their pay, and some of these Units have established elaborate scoring systems. The items which are considered for assessment, and scored, are similar in all Units: patients' time-keeping, co-operation with fellow-workers and supervisors, neatness, personal appearance, application to work and quickness being most frequently mentioned. These qualities are seldom accorded equal importance and where scoring systems operate some of them rate higher than others.

57. Hospitals were asked to describe their method of dealing with those patients who, after a period in the Industrial Unit, are found to be unsuitable for this type of work. It seems that hospitals differ in the extent to which they persevere with patients. In some Units patients are sent away after a few weeks, if unsuitable, the usual argument being that it would be harmful to the patients to keep them in a work-situation with which they could not cope. In these hospitals such patients are re-allocated to less demanding work such as occupational therapy or light domestic duties.

The policy of other Units is to persevere with patients. They argue that every patient can be found work within the Unit, it has, merely, to be simple enough; they also argue that sending patients away from the Unit reduces their self-confidence and their prestige. In consequence every effort is made in these Units to keep the patients there; factors which might cause their work-difficulties are re-considered, reasons for 'failures' are analysed. As a compromise, some Units transfer such patients to other work for short periods and take them back afterwards.

58. With regard to all matters of referring and transferring patients, hospitals differ in the extent to which patients' own wishes are considered. In some hospitals only those patients work in the Unit who ask specifically to do so; in others, patients are sent to the Unit by the staff but only if they are willing to work there; and in others again, even reluctant patients are referred to the Unit. The argument in favour of this last practice is that patients who exhibit great resistance to work are especially in need of it.

8 CONDITIONS AND EQUIPMENT

59. Perhaps the most important aspect of working conditions is the housing of the industrial units. Housing presents problems to a varying extent in the hospitals, as in some cases existing buildings or funds for new ones are available, while in other cases there is a shortage of buildings and no possibility of erecting new ones.

The importance of housing conditions is much stressed in the literature. In outside society it is generally thought to be important that factories should have good conditions according to up-to-date principles: enough light, adequate room and seating arrangements, good decoration etc. These conditions are perhaps even more important to patients who are being taught that work can be a pleasure to them.

60. Each hospital was asked to indicate the type of accommodation occupied by its industrial unit. In several hospitals the industrial unit consists of a number of sections and these may be housed differently. Therefore the following table in which the housing of the hospitals' industrial units is analysed includes those industrial unit sections which are housed separately.

Table IX

Housing Conditions

Type of accommodation occupied by industrial units	Percentage of industrial units
Buildings specially constructed for the purpose	30.0
Parts of hospitals converted for the purpose	47.5
Wards where the patients live	22.5
Total	100.0

61. These percentages have to be regarded with caution as there is no information about the size of each industrial unit section. In other words, there is no evidence that corresponding percentage of patients working in industrial units do so, in fact, under these housing conditions.

6. CONDITIONS AND [illegible]

59. Perhaps the most [illegible] the housing of the industrial [illegible] varying extent [illegible] or funds for new ones [illegible] shortage of buildings [illegible]

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60. Each hospital [illegible] occupied [illegible] industrial units [illegible] unit consists of a number [illegible] differently [illegible] the hospitals [illegible] unit sections [illegible]

[illegible]

Type of accommodation [illegible] by industrial units	[illegible]
Buildings specially constructed for the purpose	[illegible]
Parts of hospitals converted [illegible] the purpose	[illegible]
Wards where the patients live	[illegible]
Total	[illegible]

61. These percentages have to be regarded [illegible] is no information about the size of each [illegible] other words, there is no evidence that [illegible] patients working in industrial units do [illegible] working conditions.

The table shows that the most usual way of accommodating the industrial units is to convert a part of the hospital. This is, naturally, cheaper than erecting new buildings and at the same time can be carried out with satisfying results. During the hospital visits many instances of inventiveness were found: out-buildings, farmhouses, barns, lofts as well as wings of main buildings have been converted.

62. When discussing the advantages generally associated with industrial therapy, it was said that the importance of dividing the patients' lives into working and non-working periods, following the pattern of life in outside society, was much emphasised. This physical division, of course, only exists if the patients leave their wards and work elsewhere. The newly erected, purpose-built units seem to be most suitable to serve this end: their difference from the rest of the hospital and their 'industrial' nature emphasise the division between work and the rest of the patients' daily routine. Those units, or more precisely sections of units, where industrial work is carried out in the wards (nearly a quarter of the total) do not have this possible advantage of industrial therapy. An examination of the questionnaires shows that where industrial work performed in the wards where the patients live, the supervisors are the wards' nursing staff and payments are made in the form of allowances by them. Thus, in such matters, industrial work done in the wards, has a great deal in common with non-industrial hospital work, like utility or domestic duties.

63. Hospitals were not asked to indicate the numbers and types of patients accommodated in the various sections of their units, as this information was considered to be too time-consuming to provide. Thus there is no evidence to show how many patients work on the wards; however, an impression was gained during the hospital visits to the effect that industrial unit sections, accommodated this way, are of a special nature The practice of many hospitals seems to be to obtain simple assembly work on a contract basis, for old, infirm or severely handicapped patients who cannot leave their wards. These types of patients are occupied on humanitarian grounds and simple assembly-work seems suitable for them. Thus, the existence of industrial unit sections accommodated in the wards, emphasises a point made previously, concerning the variety of the nature of industrial therapy and the difficulty of considering it as one single approach.

64. Hospitals were also asked to give information about various features of the working conditions in their industrial units, i.e., about the use of machines etc. and arrangements generally associated with industrial work. The pilot study showed that it would be too difficult for hospitals to give the numbers of patients who use these features and so they were asked only to indicate if these were in use at all, in any part of the unit.

Table X

Working Conditions

Industrial features	Percentage of industrial units
Industrial lighting	67.5
Machine work	60.0
Industrial seating	42.0
Continuous belt process	32.4
Time sheets	27.0
Time clock	21.5

Questions were also asked concerning the availability of certain industrial facilities in the units. It was found that 99% of the units provide 'music while you work', 47% have canteens and 9% have vending machines.

65. Table XI

Power-driven machinery in use at the 74 participating hospitals

Type of machine	Number of machines	Number of machines per industrial unit	Number of patients per machine
Engineering	198	2.7	417
Woodworking	102	1.4	810
Welding	11	0.1	7510
Sewing	141	1.9	586
Packaging	23	0.3	3591
Other	168	2.3	491
Total	643	8.8	128*

* This figure is the number of patients per machine of any kind, not the total of the column above it.

Hospitals were asked for the number of power-driven machines and equipment in their industrial units and the table above is the summary of their answers. The largest single category, according to the table is that of engineering machinery which include lathes, drills, presses etc.

66. The table shows that the large majority of patients do not work with machines: only 1 patient in every 128 has a machine available for work. This result corresponds with the impression gained during visits to the hospitals, that it is the exception rather than the rule to find a unit employing a large proportion of its patients on machine-work. The reasons for the relatively small use made of machines are varied. In some hospitals it is the deliberate policy of the staff not to use machinery either because it is thought unsuitable for their particular patients, or because it is considered 'out of character' for a hospital to mechanise its workshops to a large extent. In other hospitals the staff would like to acquire more machines, but lack of available funds prevents their doing so.

67. The 643 machines, shown on the table above, are not distributed evenly among the 74 hospitals. There are several hospital industrial units with no machines, indeed the table concerned with working conditions in (64) above, shows that only 60% of the units have machine work. There are also a few units with considerably more machines than the 8.8 national average. No noticeable regional variations were found, with the exception of the North-East Metropolitan Region where there are no machines in use at all.

68. It was also asked whether the machines at the industrial units had been bought, donated, installed by contracting firms or hired. Only one hospital had hired machinery and seven hospitals had machines donated to them. The rest of the machines were either bought or installed by contracting firms, with an emphasis on the former.

Group Work

69. Is work organised on an individual basis or on a group basis in the industrial units ? The answer to this question was found to be that both methods are much in use in the large majority of the units. Only 4 hospitals out of 74 answered that they organise no group work and 13 hospitals answered that they organise no individual work. The rest of the hospitals make use of both types of work with a slight emphasis on group work. The reasons why hospitals favour group work were mentioned when the advantages associated with industrial work were discussed. It was said that in the opinion of many therapists, psychiatric patients, especially long-term schizophrenics, greatly benefit from working in groups, as they are forced out of the isolation which is a characteristic of the illness. Also, in several units, work is organised on a group basis because this is considered to be the best method for the completion of many tasks.

Patients as Supervisors and Inspectors

70. A rather different aspect of the industrial units' work-arrangements will be now considered, the extent to which promotion

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for [illegible]
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rule to [illegible]
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of the [illegible]
[illegible]
[illegible]
[

to supervisory and inspection duties is open to the patients. In outside society these two functions are rated more highly than ordinary bench or machine work and they usually carry higher wages and more prestige. It seems a reasonable assumption that patients view these functions similarly; indeed they may even regard the prestige-value of such work as more important than do workers in outside society because there are very few opportunities for them in the hospital to supervise their fellow-patients or to inspect their work.

Table XII

Patients employed in supervisory and inspecting capacities

	Patients employed as Supervisors	Inspectors
Total for 74 Units	124	288
Average per Unit	1.8	3.7
Percentage of all patients in 74 Units	0.1	0.3

This table shows that only a small proportion of patients are engaged in the units on supervisory and inspection work, and thus promotion is open to them to a limited extent. Indeed, in several hospitals there are no patients employed in these capacities. The reasons for the small number of patient-supervisors and inspectors probably lie in two directions. Firstly, the hospital staff consider the great majority of patients, if not all, as unsuitable for these functions. They feel that a staff member has to inspect the goods even if they have been inspected by a patient, and that staff supervision is necessary even where there are patient supervisors. Secondly, in some hospitals the staff does not feel it 'right' for patients to supervise other patients, and argue that patient-supervisors are not respected or obeyed.

9 THE STAFF

Number and Types of Staff

71. The total number of staff working in April 1967 in the 73 Industrial Units (one hospital did not reply to this question) is set out below:

Table XIII

	Full-Time	Part-Time	Whole-Time Equivalent	
			No.	%
Staff Nurses and above	128	119	188	22.9
Student Nurses	82	15	90	11.0
State Enrolled Nurses	95	66	128	15.6
Nursing Assistants	74	111	130	15.9
Total Nursing Staff	379	311	536	65.4
Qualified Occupational Therapists	35	9	40	4.9
Student Occupational Therapists	13	8	17	2.1
Occupational Therapy Helpers	54	67	88	10.7
Total Occupational Therapy Staff	102	84	145	17.7
Industrial Managers (non-nursing)	12	-	12	1.5
Trade Instructors	46	6	49	6.0
Total Industrially Qualified Staff	58	6	61	7.5
Clerks	5	10	10	1.2
Storemen	1	2	2	0.2
Supervisors in Industrial Units	11	8	15	1.8
Others	43	15	51	6.2
Total Other Staff	60	35	78	9.4
	599	436	820	100.0

Note: The method adopted in the foregoing table has been to count two part-time staff as equal to one whole-time equivalent rounding off upwards in columns 2 and 3: it was not considered necessary for our purpose to ask for the hourly detail required in Ministry of Health returns.
Staff patient ratios on page 46 are however calculated on two different bases. On the first, two part-timers are counted as one full-timer as in the foregoing table. On the second, one part-timer is counted as the equivalent of a full-timer, since many units work, say, a 25-hour week, and some part-time staff will therefore be working full-time in relation to the patients in the unit.

72. On this calculation, a whole-time equivalent strength of 820 staff members are deployed in 73 units, an average of 11 per unit.

Nursing Staff Predominate

73. The majority of this number (65.4%) are on the nursing establishment. Moreover, in 61 of the 73 hospitals, nurses continue to wear nursing uniform whilst working in a unit. These two facts may be thought to justify the comment that, typically, industrial therapy appears at present an extension of the nursing function.

74. 17.7% of the staff are on the occupational therapy establishment, 4.9% being qualified, 2.1% students, and the remainder occupational thereapy helpers.

The shortage of qualified occupational therapists is mentioned by hospitals in the Leeds, Sheffield, North-East Metropolitan, South Western, Welsh, and Wessex Regions. Indeed, were it not so generally accepted, this shortage of occupational therapists might well have been remarked upon more.

The distribution throughout the country of the 40 or so qualified occupational therapists employed in units is also uneven. At the participating hospitals, in the Newcastle Region not a single occupational therapist, qualified or unqualified, is so employed; in the Oxford Region one occupational therapist is employed working part-time; in the Leeds Region two are employed each working part-time; both the Liverpool Region and the North-East Metropolitan Region employ one full-time occupational therapist and the South Western, Manchester and South East Metropolitan Regions each employ two. The skill of the qualified occupational therapist is thus seen to be very thinly spread over the industrial therapy field.

75. Only 7.5% of the total are classified as industrially qualified staff. 1.5% of these, 12 in number, are industrial managers about whom more is said on page 66. So far as other industrial staff are concerned, skilled men may be recruited as Technical Instructors, in which capacity they are paid, since May 1966, on an Ancillary Staffs Council rate fixed at 7d an hour above the basic trade rate. A senior instructor is paid 1d an hour more and all are entitled to a plusage of 20/6d for their appropriate trade qualification. The new rate therefore yields something over £16 a week which is sufficient in parts of the country to attract certain tradesmen, often older men who, having more patience than younger men, are well suited to the work.

The total thus employed i.e. 46 full-time and 6 part-time is however not large, averaging less than one per unit, and when it is seen that Wessex employ 11 of these full-time, the North West Metropolitan Region 9, and Manchester 6, it comes as no surprise that very few are employed in other regions - none at all in fact in the East Anglian,

In this calculation, a whole-time ...
part members are employed in 73 ...

... Staff Predominate

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74. 17 % of the staff are on the ...
4.9% being qualified. 2.1% students ...
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75. Only 7.5% of the total are classified ...
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South Western, Birmingham and Liverpool Regions. We have no evidence whether this is because trade instructors are not employed as a matter of policy (for instance the work available may be too unskilled), or whether it is because in the industrial areas of Birmingham and Liverpool the rate is inadequate in the face of competition.

76. The 'other staff', 9.4% of the total, comprises 15 clerks, 3 storemen, a few 'supervisors' on ASC grade, drivers, van-men, cadets, ward orderlies, a printer, a registered disabled joiner and four factory employees paid by their own factory.

In May 1966 there was sanctioned an ASC grade intended to facilitate the employment of unskilled industrial personnel. The rate sanctioned is Grade I, applicable to basic grade domestic staff and porters (currently male 6/2½d per hour: female 4/9, 7/8d per hour) with this difference, that for domestic and portering staff promotion is possible whereas there exists no provision for this within a unit.

What has happened is that the grade has been ignored. At least one hospital has never heard of it, and the questionnaire analysis shows a total of 11 full-time and 8 part-time supervisors employed in 74 hospitals. It is clear from the figures and from comment received that most hospitals have recruited such persons either as nursing assistants or occupational therapy helpers.

The salaries in force in 1967 for nursing assistants, occupational therapy helpers, assistant supervisors in Local Authority Training Centres, and supervisors in charge of schools in mentally subnormal hospitals, are to be found in Appendix C. Also set out as a matter of interest are supervisory rates then actually in force in a light engineering firm in the south-east.

Qualifications of Industrial Unit Staff

77. On the subject of staff qualifications, nearly 23% are State Registered Nurses and 15.6% State Enrolled Nurses: just under 5% qualified occupational therapists, and 7.5% industrial managers or trade instructors. Thus about 50% of industrial unit staff may be regarded as qualified to a greater or less degree, in a relevant sphere, psychiatric nursing, occupational therapy, or an industrial skill.

78. About a quarter of these (102 persons) according to a further question, have had training both in psychiatry and industry, although a considerable number in addition are stated to have had experience in industry; the difficulty here is to agree on what else counts as industrial training besides an indentured apprenticeship. Of the doubly qualified staff, many are male nurses who entered the profession in the thirties during the depression, but the trades to which they have been apprenticed often bear little relation to the type of work with which they are now involved.

The Staff of Cheadle Royal Industries (Ltd.)

79. The staff of Cheadle Royal Industries (Limited) comprises:-

1 General Manager (industrially trained and experienced)

1 Works Manager, concerned also with design and time-study (mental nurse training and industrial experience)

1 Foreman covering also certain welfare functions.

Sheltered Workshop benchwork section:

1 whole-time supervisor

2 part-time supervisors.

Sheltered Workshop machine section:

1 supervisor (mental nurse training).

Four benchwork sections:

1 supervisor each
(Three of the four are housewives trained on the job. The fourth, in charge of the section for very deteriorated patients, is a nurse).

1 technician.

Office:

1 office manager

1 machine accountant

1 secretary to General Manager.

Staff : Patient Ratio

80. An important point to consider in relation to the staffing of the units is the ratio of staff to patients: some therapists would say that the maintenance of a high staffing ratio is the single most important factor in a unit.

No figure is generally accepted and we did not ask for comment on this point, but it is interesting that the two hospitals which have volunteered their views should be closely in agreement. A hospital in the Sheffield Region would like to give more attention to training and suggests 1 : 6; another in East Anglia, to ensure that therapeutic and work standards are equally met, would consider one occupational therapist assisted by one industrial or nursing assistant to every 10-15 patients as ideal.

Cheadle Royal Hospital in fact support a ratio of 1 : 7 on a commercial basis; the staffing ratios in National Health Service hospitals are set out below.

Cheadle Royal Hospital is
beside the starling
nut below.

Staffing Ratios by Region

Region	No. of hospitals	Staff : Patient Ratio counting one P. T. as equal to 1 F. T.	Staff : Patient Ratio counting two P. T. as equal to 1 F. T.
Newcastle	3	1 : 14.6	1 : 19
Leeds	5	1 : 10.8	1 : 13.5
Sheffield	6	1 : 10.9	1 : 13.3
East Anglia	2	1 : 8.6	1 : 9
N. W. Met.	4	1 : 17.4	1 : 21.2
N. E. Met.	2	1: 17.4	1 : 20
S. E. Met.	4	1 : 12.9	1 : 18.6
S. W. Met.	9	1 : 15.3	1 : 19.8
Oxford	3	1 : 14.4	1 : 15
S. Western	8	1 : 11.3	1 : 13.9
Wales	7	1 : 17.4	1 : 19.7
Birmingham	8	1 : 10.3	1 : 12.8
Manchester	3	1 : 11.7	1 : 15.6
Liverpool	3	1 : 26.1	1 : 34.8
Wessex	6	1 : 8.1	1 : 11.2
National Ratio		1 : 13	1 : 16.6

Region	No. of Hospitals
Newcastle	1
Leeds	5
Sheffield	6
East Anglia	2
N. W. Met.	4
N. E. Met.	6
S. E. Met.	1
S. W. Met.	1
Oxford	1
S. Western	1
Wales	1
Birmingham	1
Manchester	1
Liverpool	1
Weaver	1
National Hosp.	1

10 STAFFING PROBLEMS

81. Each hospital was invited to comment on any staffing problems it might have, and as a result 40 responded, 13 stated that they had none, and 21 did not comment. As elsewhere, some respondents replied at length whereas others contented themselves with a word or two. Four chief areas of problem emerged:- shortage, pay, training and staff relationships.

Shortage

22 hospitals complain of shortages of every type of staff, the complaints being both that establishments are too low, and that they are unfilled. One dissident voice is raised; that of the hospital which states "we find we work better when slightly understaffed, the members work at their maximum".

82. The shortage of occupational therapists has already been mentioned: the position in regard to nursing staff is somewhat different. Whereas the occupational therapist picture is one of endemic shortage, the nursing picture portrays uneven experience. Several hospitals, notably in the Oxford, South Western, Manchester and Liverpool Regions state that since their units are staffed from their existing nursing strength they have no problems. On the other hand, hospitals whose nursing establishment is under strength, find this shortage reflected in their industrial units because they adhere to an all-nurse staffing policy. Others still are prevented from recruiting by establishment limitations.

83. Illustrations are to be found in the comments offered, amongst others, by three hospitals. One of these "finds trained mental nurses best to train and assess mental patients in a working situation", and deplores the shortage of such good trained staff. Another hospital "could do with" more trained nurses who have had industrial and foremanship experience. A large hospital north of London points out that the shortage of trained staff, both nursing and occupational therapy, limits the degree of expansion "particularly in the realm of schemes to enable patients at a certain stage of rehabilitation to work out of ordinary hospital settings with nursing supervision in ordinary factory settings".

84. Regarding industrial managers, a Welsh hospital wishing to expand had received no reply to advertisements, and in the course of the research we have heard of other hospitals which have had difficulty in making appointments. We have also received comments on the difficulty of recruiting skilled labour, i.e. engineering technicians or mature tradesmen, due to the grade of salary that may be offered. In fact a number of hospitals would like to obtain

persons with industrial experience of any sort to work alongside nursing staff.

85. The complaint in regard to non-qualified staff, whether nursing assistants, occupational therapy helpers or 'supervisors or instructors of the mentally ill' is not so much that they are unavailable - for at the end of the day the great majority of these will probably turn out to be the part-time housewives 'of sound commonsense and sympathetic personality' normally endemic to the country. It is rather that industrial units may not increase their establishments by employing them. On the other hand one hospital does mention the specific difficulty of recruiting male staff, which attributes to the low pay offered.

Pay

86. Practically every grade of staff employed in an industrial unit is mentioned by one hospital or another as being underpaid. However, in this report it is thought inappropriate to discuss the salary levels of the nursing staff for whom industrial work forms only part of their duties. Similarly occupational therapists despite their tiny numbers hold an established place in psychiatric hospitals where they are still deployed principally in their own Occupational Therapy Departments.

87. One Head Occupational Therapist makes the point that Heads of both Occupational Therapy Departments and Industrial Units should receive recognition of this dual function in their salary.

88. Judging from the replies received and the evidence of visits to hospitals, the deepest frustration of those responsible for organising industrial work lies in their inability to offer what they consider to be an adequate salary to industrial officers or managers.

Some comments are:-

> 'Staffing problems have been very severe throughout the history of the unit. Our chief difficulty has been a failure to obtain from the Ministry an adequate salary rate for an Industrial Therapy Officer with industrial as opposed to nursing experience. Similar remarks apply to other grades of Industrial Therapy staff working under the Industrial Therapy Officer .... The staffing position within the Industrial Therapy Units remains unsatisfactory despite five years of representations to the Ministry and attempts to build up adequate numbers.'

> 'The success of an Industrial Unit depends to a large extent on the quality of the Industrial Manager and present scales of remuneration are not such as to tempt suitably trained and experienced people into the work or to remain in the work.'

nursing staff.

85. The complaint in regard to
nursing assistants, occupational
instructors of the mentally ill
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Some comments are:-

Staffing problems have
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The success of an Industrial Unit
depends on the quality of the
proper grades of remuneration
properly trained and
to remain in the work.

'Salary of industrial officers is too ridiculously low in comparison with other occupational therapy staff.'

'Two years ago HMC recommended that the Industrial Manager's salary should be regraded to Senior Administrative grade. This has been referred to the RHB and discussions are still taking place. The Industrial Manager formulates policy with senior colleagues, controls production, introduces equipment, and this can lead to benefits of a more realistic work tempo for patients, more variety of work and better rates for the job. Our Industrial Manager, who attended a year's course in social history and obtained a London University pass in this subject, has a background which includes experience of production, costing and factory management in various fields, i.e. engineering and drawing office work. His last post before coming to this hospital was as Assistant Manager at a factory where he was connected with plant layouts for a firm of engineering consultants.'

The salary and conditions of industrial staff will be discussed in a later section.

Training

89. Fewer comments on the need for staff training were received than on shortage and pay matters. At present, no national training scheme exists, and in some of the units the work undertaken is so elementary that the need for it has not yet been recognised. On the other hand, one hospital remarks that it could accept more specialised tasks if the staff were experienced in specific industrial tasks. In the meantime, some hospitals have adopted piecemeal expedients to fill the gap, seconding staff to their parent contracting factories to pick up methods and processes. Sometimes a factory will send its own staff to instruct the hospital staff. Elsewhere, again, occupational therapists have been sent on fortnight work study courses. It was noticeable that hospital work study services were seldom mentioned.

90. A hospital in the north of England mentioned specifically that it would find some scheme for the industrial training of nurses-in-charge a great help.

Relationships

91. Some industrial units are staffed solely by nurses: one at least solely by industrially recruited personnel, mainly ex-foremen: between these patterns every sort of combination is to be found. Each staffing arrangement appears to carry its own disadvantages from the point of view of staff relationships.

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Relationships

91. Some industrial units are

mainly by industrially recruited

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arrangement appears to carry

point of view of staff relationships.

92. First, however, it should be repeated in this context that a sizeable number of hospitals relying entirely on their nursing staff state that this means they have no problems. On the other hand, another hospital reports difficulty in getting staff nurses to 'accept and adapt' into an industrial atmosphere: another finds 'resentment of being detailed to carry out duties in an industrial unit': a third that 'some nursing staff who could qualify for Sunday duty payment do not work Sundays when in the Industrial Therapy Unit, and this causes friction'. In a unit in the Wessex Region, the supervisory nursing staff, mostly on part-time, are apt to be called away on nursing duties, especially those in charge of ward groups. Problems arise where nurses on shift work are also supervising industrial therapy. A suburban London hospital, staffed entirely from the nursing strength, finds them difficult to replace for leave and sickness. Again, part-time retired nurses may only work a few hours a week because of the pension regulations and that can lead to difficulty.

93. The task of organising nursing staff is described by a respondent from a Welsh hospital:- 'If a lot of patients are in the Industrial Therapy unit there may not be enough work for the ward nurses. Similarly, if the industrial therapy patients have to return to the wards, say due to a lack of work, there may not be enough work for the industrial therapy helpers to do.' This comment would seem to indicate that in addition to student and pupil nurses who are undergoing training in the unit, trained nursing staff are frequently detailed to attend for temporary terms of duty. They do not specialise in industrial work and their expertise may be small.

94. The above paragraphs relate to units staffed by nurses. When the staff are mixed by occupation yet other difficulties arise, and a selection of comments on these is given below:

> 'The disparity of leave entitlement between occupational therapy staff and nursing staff could lead to difficulties where working alongside each other', remarks a Head Occupational Therapist.
>
> 'Although the occupational therapy programme is supposed to be co-ordinated, senior industrial therapy staff are on a separate establishment and problems of communication, attitude and responsibility occur and tend to recur', says an industrial officer.
>
> 'Difficulties involve relationship of industrial therapy staff with nursing staff in the hospital' writes the respondent from a third hospital, but adds 'this is merely one aspect of the changes of attitude implicit in the development of the concept of rehabilitation. I have no doubt that it will eventually be possible to work out a harmonious relationship with all types of staff.'

92. First, however, it should be [illegible]
sizeable number of hospitals relying [illegible]
state that this means they have no [illegible]
another hospital reports difficulty [illegible]
and adapt' into an industrial atmosphere [illegible]
of being detailed to carry out [illegible]
that 'some nursing staff who [illegible]
do not work Sundays when in the [illegible]
causes friction'. In a unit [illegible]
nursing staff, mostly on [illegible]
nursing duties, especially those [illegible]
Problems arise where [illegible]
industrial therapy [illegible]
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and sickness. Again, [illegible]
few hours a week [illegible]
lead to difficulty.

93. The task of [illegible]
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94. The above paragraphs [illegible]
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and a selection of comments [illegible]

'The disparity of leave [illegible]
therapy staff and nursing [illegible]
where working alongside [illegible]
Occupational Therapist.

'Although the occupational [illegible]
supposed to be co-ordinated, [illegible]
staff are on a separate establishment [illegible]
communication, attitude and [illegible]
tend to recur', says an industrial [illegible]

'Difficulties involve relationship [illegible]
staff with nursing staff in the hospital [illegible]
respondent from a third hospital, but [illegible]
[illegible] only one aspect of the changes [illegible]
[illegible] development of the concept of [illegible]
[illegible] that it will eventually be possible [illegible]
[illegible] relationship with all types of [illegible]

11 THE MANAGEMENT OF THE UNITS

95. It was deemed useful to consider industrial units as businesses as well as therapeutic organisations.

In a business the management function is of great importance and accordingly considerable attention was paid to the management of the units. With regard to day-to-day management, career details of the officer-in-charge were requested. In a later section, information was sought at the policy-making level, although the point must be made that the need for an explicit policy has not everywhere been recognised.

96. First, to the question 'Give title, qualification and salary scale of the person in overall charge of the industrial unit', hospitals named:-

Consultant psychiatrists	2
Senior nursing staff	47
Senior occupational therapy staff	20
Industrial Managers	12
	81

In six hospitals, management is stated as being shared which accounts for the total of 81 managers in 74 hospitals. In two Welsh hospitals, between a senior assistant chief male nurse and head occupational therapist; and between psychiatrist, assistant chief male nurse and industrial manager. In a hospital south of London, industrial manager and deputy chief male nurse are jointly responsible. In a Kent hospital, male patients have a senior assistant chief male nurse, female patients an acting head occupational therapist. A Sheffield Region hospital lists an industrial officer and senior male and female nursing staff. Another combination is that of consultant psychiatrist and industrial supervisor. Our experience suggests that there may exist other examples of co-operative management possibly considered to be too complicated or too informal to mention in a questionnaire..

Senior Nursing Staff Salaries

97. The grades and salary scales of the nurses-in-charge are:-

THE MANAGEMENT OF THE [illegible]

95. It was deemed useful to consid[illegible] as well as therapeutic organisations.

In a business the management func[illegible] accordingly considerable att[illegible] the units. With regard to [illegible] of the officer-in-charge were [illegible] information was sought [illegible] point must be made that [illegible] everywhere been recognised.

96. First, to the question [illegible] scale of the person [illegible] hospitals named -

Consultant psych[illegible]

Senior nursing [illegible]

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Industrial Man[illegible]

In six hospitals management [illegible] accounts for the total [illegible] hospitals, between a senior assistant [illegible] occupational therapist and [illegible] male nurse and industrial manager. [illegible] industrial manager and deputy chief [illegible] sible. In a Kent hospital male [illegible] chief male nurse, female patients [illegible] therapist. A Sheffield Region hospital [illegible] and senior male and female nursing [illegible] that of consultant psychiatrist and [illegible] experience suggests that there may exist [illegible] operative management possibly considered [illegible] too informal to mention in a questionnaire.

<u>Senior Nursing Staff Salaries</u>

97. The grades and salary scales of the nurses [illegible]

Table XV

	Salary Scale April, 1967
1 State Enrolled Nurse	£ 850
9 Charge Nurse or Sister	£ 940 - 1205
18 Assistant Chief Male Nurse, Chief Nursing Officer, or Principal Nursing Officer	£ 970 - 1235
14 Senior Assistant Chief Male Nurse, Chief Nursing Officer or Principal Nursing Officer	£1065 - 1275
4 Chief Male Nurse and Matron (2 hospitals)	£1210 - 2235

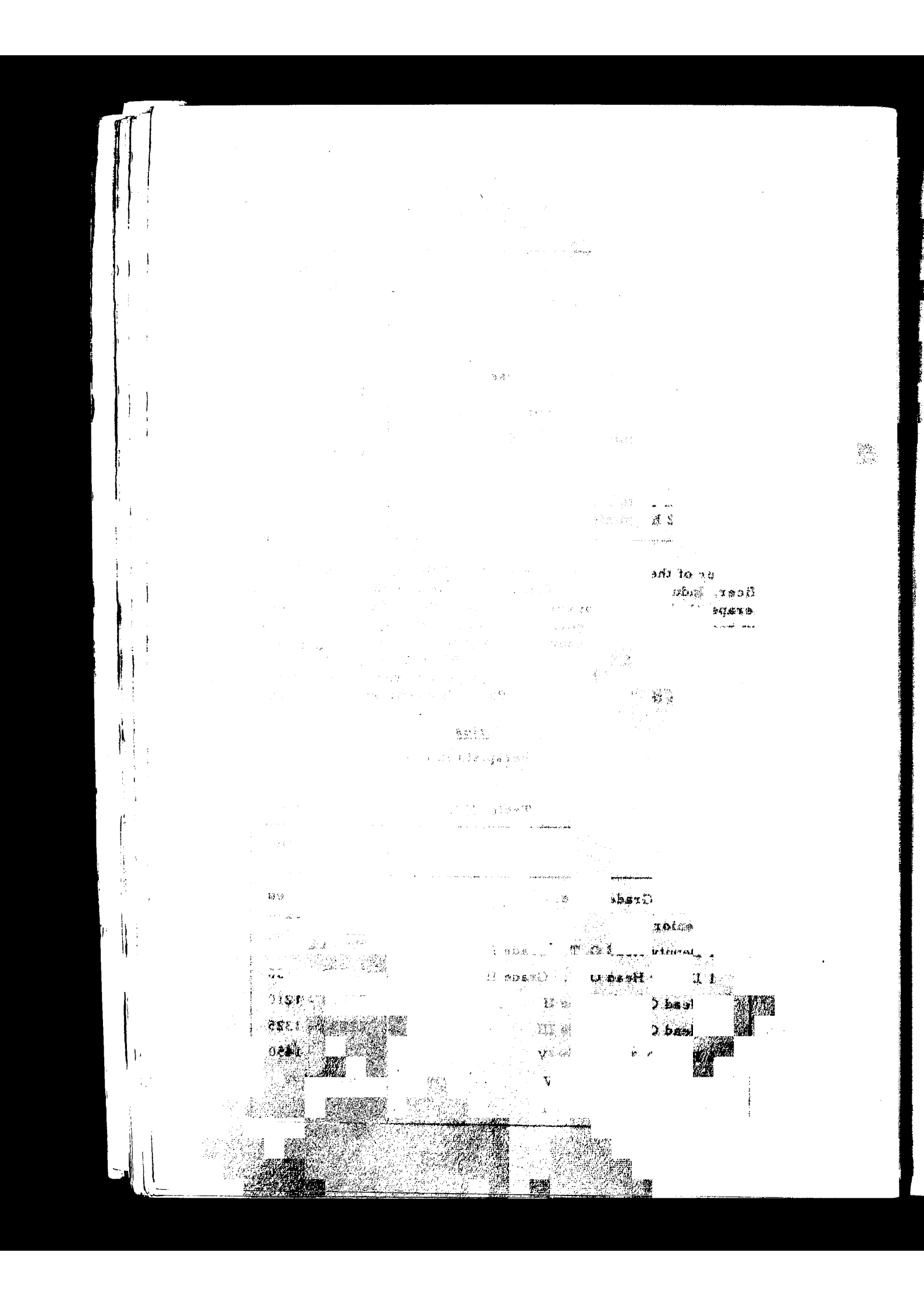
A number of these officers bear additional titles, such as Industrial Officer, Industrial Therapy Officer, Industrial Rehabilitation Officer, Therapeutic Employment Officer and so forth. If the salary which they receive, however, corresponds to the Whitley Council scales, they have been included above. Two officers with nursing qualifications, a Head Work Therapist (£1000 -1250) and Industrial Rehabilitation Officer (£1100 - 1325) appear to receive salaries not identical with the Whitley Council Scales but approximate to them.

Senior Occupational Therapists' Salaries

98. The twenty occupational therapists in charge of units are graded as follows:-

Table XVI

	Salary Scale April, 1967
2 Basic Grade O. Ts.	£ 700 - 900
1 Senior O. T.	£ 840 - 1075
1 Deputy Head O. T. Grade I	£ 860 - 1095
1 Deputy Head O. T. Grade II	£ 890 - 1130
1 Head O. T. Grade II	£ 970 - 1210
4 Head O. T. Grade III	£1030 - 1325
6 Head O. T. Grade IV	£1115 - 1450
1 Head O. T. Grade V	not listed
3 grading unspecified	



99. Many of the salaries paid to nursing staff and occupational therapists may represent the incumbent's personal position on his or her scale and may not therefore necessarily relate directly to the size or character of the industrial unit.

Industrial Managers' Salaries

100. Most industrial managers are at present paid on an ad hoc basis after application to the Ministry of Health. Salaries quoted are: for a retired officer in receipt of a pension £700 p. a.; for an ex-Works Manager £745 - 1005 p. a.; in a unit doing work worth £11, 000 p. a. £1136; in a unit doing work worth £21, 000 p. a. £1200 p. a.

In several cases industrial managers, whatever their title, while holding nursing or other qualifications, have been appointed to posts on an Administrative and Clerical Staff Whitley Council grade.

Two managers graded Senior Administrative Officers (£1355 - 1675 and £1402 - 1734) are RMN, SRN, and RMN, RMPA, MAOT respectively. A third with supplies experience is similarly paid. A general manager with qualifications in psychiatric social work is in receipt of a salary of £1500. Two more are paid on the General Administrative grade (£1061 - 1402).

Responsibility for Policy and its Implementation

101. Next must be considered the question of policy-making for the industrial units.

Who decides what the policy of the unit is to be ? To whom is the 'manager' responsible ? Hospitals were asked this precise question, but it must be admitted that this is not an easy matter to probe by questionnaire method. For if, as has so often been established, the informal patterns of an organisation differ from the formal, how much more is this the case in psychiatric hospitals where the very idea of formal organisation can be suspect lest it suggest authoritarianism. In other words, the answer given may not correspond to the full facts.

However, a number of respondents spelled out what is undoubtedly the correct answer in the formal sense: that clinically the manager is responsible (whether or no through his departmental head) to the physician superintendent if there be one in post or otherwise to individual consultant psychiatrists; and for matters of business and administration through the group secretary to the HMC. In greater detail, so far as concerns clinical responsibility, the managers in 26 hospitals claim responsibility to the physician superintendent or his deputy, and in 12 more to consultants with a special responsibility for industrial therapy.

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In fourteen hospitals the manager states he is responsible to his departmental head, that is to say Principal Nursing Officer or Head Occupational Therapist, without any mention of consultants, group secretaries or administration of any sort.

On the administrative side five managers, on the contrary, state 'Group Secretary' without any reference to the Medical or Nursing arms. One respondent states that she is responsible to nobody direct as far as the running of the unit is concerned. Three sub-committees are mentioned, an Industrial and Occupational Therapy Sub-Committee, a Bureau Employment Committee and what on paper sounds a very full fledged body 'chaired by the Physician Superintendent and composed of Group Secretary: Finance Officer: Principal Nursing Officer: Farm Manager: Catering Superintendent: Horticultural Superintendent: Consultants: Group Engineer: Chief Occupational Therapist: and two Assistant Principal Nursing Officers'. We were told that in practice this committee meets irregularly.

102. What is to be made of this information ? Not too much from the bare figures. What can be added as a result of observation is that, provided that the Physician Superintendent or his deputy are genuinely interested in industrial therapy, then evidently direct responsibility to the highest administrative level carries many advantages. If responsibility is towards a psychiatrist specially appointed to concern himself with the unit, then the expectation will be great, amounting almost to certainty, that he will be interested. However, if clinical responsibility is towards each psychiatrist in respect of his own patient alone, then contact can at times be minimal firstly because of the sheer pressure of work on psychiatrists because of the low level of staffing and secondly because not all psychiatrists are interested in industrial therapy.

103. The second observation which may be made is that if a nursing officer reports solely to his or her Principal Nursing Officer, Matron or Chief Male Nurse, then presumably all suggestions, requests for equipment and so forth must be presented through normal administrative channels with their competing claims, unless special provision is made for attention to the needs of the unit.

104. Policy with regard to industrial therapy will also be discussed at some stage by the Hospital Management Committee. Hospitals were therefore asked to state whether or no they had set up special committees or whether they leave discussion of industrial therapy to the agenda of routine management committee meetings. It was found that 51 hospitals in fact do this and that 23 have set up

committees. 9 of these 23 committees include a member or members drawn from open industry. [1]

105. To complete the picture, Regional Hospital Boards are also concerned in policy matters, especially when finance for capital projects is involved. One or two regions have also appointed, or are considering appointing, regional industrial therapy advisers. The Ministry of Health, it is understood, regards the industrial therapy movement as being in the experimental stage, and would like as much experiment to take place as possible until a clearer pattern emerges.

106. As a limited company, Cheadle Royal Industries (Limited) has a Board of Directors. This consists of a President, Chairman and five other members. Two of these are members of the Hospital's Board of Management. One is the Medical Superintendent. Two at least are prominent industrialists. One is a lawyer. The secretary to the company combines this duty with that of secretary to the Hospital Board of Management.

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[1] Theoretically there may be persons on the management committee drawn from industry, but in practice very few practising management-side persons, if any, are members although a number of experienced trade unionists are included in HMC membership. See Hospital Management Committees. Acton Society Trust 1957.

12 WORK UNDERTAKEN BY INDUSTRIAL UNITS

107. The work undertaken by industrial units is of three main categories: first, sub-contract work; second, the manufacture of products which the unit markets on its own account; and third, other work such as internal work for the hospital. Information was sought regarding all these types of work with the aim of presenting a broad yet detailed picture of the activities in progress in the 74 units.

Sub-Contract Work

108. Hospitals were asked to list their sub-contracts by number of contracts, type of work and approximate value. As a result the research enquiry has come into possession of a great amount of useful and even fascinating information which does not, in the main, lend itself however to quantification. For instance, some hospitals have specified the name of their contractor rather than the type of work they receive from him. Some contracts are continuous: with others it is difficult to say where one contract ends and another begins, so that for example, to compare the length of runs cannot be attempted. This is a pity, because one of the impressions it was hoped to verify was the extent to which units are obliged to undertake numerous short runs, which add to their organisational and economic difficulties (see appendix, however).

109. However, greater precision will be achieved when the problem is considered from the angle of the patients, and when the analysis of the lists of patients working in the units comes off the computer in 1968. Data relating to 7,000 patients are being broken down into various categories: that for work performed will be listed under the following heads:

1. Bench and assembly work, including folding, glueing, labelling, stapling, preparing and hand packing - paper products, cardboard boxes, plastic bags, toys, games, cosmetics, CSSD packs, and similar products.

2. Metal and electric assembly.

3. Wiring, soldering, heat sealing.

4. Skilled woodwork, including cabinet and furniture making.

5. Unskilled woodwork, such as making seed-boxes and palettes, mending beercrates, chopping and bundling firewood and woodwork assembly.

6. Sewing machine work.

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... The work undertaken by commercial ... sub-contract work ... the unit contracts on its ... internal work for the hospital ... these types of work with ... of the activities in ...

... Work

... hospitals were asked to list their ... contracts, type of work and approximate ... enquiry has come into possess... useful and even fascinating information ... itself, however, to quantification ... hospitals have specified the name of their ... of work they receive from firm... with others it is difficult to say where ... so that for example, to compare ... This is a pity, because one ... was the extent to which ... short runs, which add to their ... (see appendix, however).

... However, greater precision will ... considered from the angle of the pattern ... of patients working in the ... Data relating to 7,000 patients ... categories: that for work performed ... following heads:

1. Bench and assembly work, including ... labelling, stapling, preparing and ... products, cardboard boxes, plastic ... cosmetics, CSSD packs, and similar ...

2. ... and electric assembly.

3. ... soldering, heat sealing.

4. ... woodwork, including cabinet and ...

5. ... work, such as making seed ... boxes, crates, chopping and ... assembly.

7. Engineering (machine) work.

8. Other machine work.

9. Supervision. Inspection. Checking.

10. Clerical work. Typing. Storekeeping. Printing.

11. General labouring, including car-wash, concrete block-making, painting, cleaning and all other heavy manual work.

12. Dismantling and salvaging, e. g. telephones.

13. Knotting and sorting yarn or rope. Net making. Weaving. Carpet-making.

14. Other, including fly-tying, teamaking, pottery.

Applying these same categories to those contracts the nature of which it is possible to identify, the following general statements may be made about the nature of the work performed in the units.

By far the greatest proportion of work done throughout the country falls under the heading of light assembly and bench work. Some hospitals have over 40 different jobs of this sort on the go in the course of a year. Others have continuous contracts. In open industry, this is work which is usually performed by women. In about 26 hospitals, so far as may be judged, the assembly is of metal or electrical components, rather than paper, cardboard and plastic goods.

Some 14 hospitals undertake contracts involving simple woodwork (others also do this work but not for outside contractors): while in seven hospitals the woodwork appears to merit the description 'skilled', e. g. cabinet making.

Light engineering involving machining is performed in eight hospitals at least; and sewing machines are used in four more.

In only four hospitals, apparently, do the contracts involve heavy labouring. Most of this sort of work is evidently internal work for the hospital, although one or two hospitals do sell concrete paving and similar products to the outside world.

Some seven hospitals go in for the work described under Number 13 above, and at least 9 for dismantling operations, chiefly telephones. Enterprising hospitals make jewellery, upholster invalid chairs, make walking aids for hospitals, soft toys, perm. hats for local hairdressers, and cut patterns, all under contract.

7. Engineering (mechanical) work

8. Other machine work

9. Supervision [illegible] checking

10. Clerical work [illegible] observing

11. General labour [illegible] cleaning, collecting and all other heavy work

12. [illegible]

13. Nursing and [illegible] of sick persons

14. Other [illegible] specify]

Apply for the [illegible] time to engage
which is [illegible] labouring
may be [illegible] the work

By far the [illegible] as an adult come [illegible]
fairly [illegible] the apprenticeship and [illegible]
hospitals have [illegible] lots at 17 or [illegible]
course of a [illegible] particular is [illegible]
industry [illegible] chiefly performed by
about [illegible] aged, the [illegible]
metal or [illegible] non-ferrous
plastic [illegible]

Some [illegible] the [illegible]
[illegible]ctors also do [illegible] on
seven hospitals [illegible]
skilled' e.g. [illegible]

Light engineering [illegible]
hospitals [illegible]

In only four hospitals [illegible]
labouring. Most of the [illegible]
the hospital, although one or two [illegible]
and similar products [illegible]

Some seven hospitals [illegible] described under Domestic above, and at item 9 for domestic [illegible] operations, chiefly [illegible]. Heatexpiring hospitals make jewellery, [illegible] toys, plaster [illegible] make walking aids for hospitals, [illegible] perm, bats for [illegible] hairdressers, and car patterns, all [illegible] contractors.

At Cheadle Royal Hospital, some 25% of the work currently performed is Group I sub-contract work, light assembly and similar operations, i. e. making containers: packing dusters, electrical components and board: folding tax forms: cutting shapes from greaseproof paper: labelling plastic bags: putting centre pages in Christmas cards, tie-strings on plastic aprons and borders on wall-paper patterns.

Own Manufacture

110. The products manufactured and marketed in 1966 by 30 out of the 74 industrial units may be found tabulated in Appendix A. Fifteen hospitals make wooden articles ranging from firewood to kitchen cabinets: six make concrete products: seven paper products: three soft toys: one makes Wendy Houses, another home-made cakes, and another mackerel fishing lines. Worth noticing is the manufacture in a Welsh hospital of a whole range of envelopes and folders, of which the sale value is given as £12, 000 p. a. A hospital in the north itemises goods to the value of £2, 501 sold in the course of the year.

Cheadle Royal Industries (Ltd.) manufactured and marketed carnival goods, industrial disposable hats, cake frills and rosettes. This represented some 75% of production.

Other work such as internal work for the hospital

111. About 50 hospitals undertake jobs for the hospital, hospital group, or region, and these too may be found listed by region in Appendix A. Here the variety is greater and besides the manufacture of the articles listed above as being for sale, includes furniture making and repair: upholstery: paper bag making: printing: glazing: the making of mops, mats and brushes.

It is worth observing from this list that a good number of jobs of extreme simplicity suitable for deteriorated patients have been picked up on home ground: stamping medical certificates, labelling bottles, making up CSSD packs: stapling sheets together, etc. etc. Certain hospitals report difficulty in procuring enough of this contract work of a simple repetitive nature, and it might prove possible, say, for many more Executive Councils in the General Practitioner Service to arrange for the stamping of their medical certificates to be done in psychiatric hospitals; likewise all CSSD packs and cytology kits, already undertaken in so many hospitals, might be similarly directed.

13 PROBLEMS OF WORK SUPPLY

112. What are the chief problems which confront those who are endeavouring to provide a suitable work-load for the patient workers in their units ? To obtain information on this point, comments were invited from the participating hospitals with the result that 59 of them responded, often, with care and at length, six replied that they had no problems, and nine did not answer. These remarks, considered in conjunction with the numerical answers which were received on the subject of shortage of work, availability of transport and storage facilities, and with certain limited data in our possession on the size of contracts, will be considered in this section.

Continuity

113. It is clear that the over-riding problem is, simply, to maintain an adequate supply of suitable work. This means that the work should be continuously available, and, for most units, that it should offer a range of variety from the simplest of repetitive tasks up to quite complex ones.

As to adequacy and continuity of supply, no fewer than 24 hospitals find this a problem. Five add that the seasonal character of the work presents additional difficulties, particularly from January to April. During this period those who are able to, undertake their own manufacture, while others again arrange to have simple tasks available which serve hospital utilities. 'Such work', writes one respondent, 'will bridge the gaps of slack time but will re-open the problem of incentive'. Presumably at this hospital the work done for the hospital is less well paid than is contract work, for few hospitals have a completely integrated work plan with consistent pay relativities as between the industrial unit and hospital departments: one or two do, however.

It is worth mentioning also the case of the Female Division of another hospital which 'had to refuse work because the cases of raw materials, or the finished products, are too heavy for the women to lift'. Most of the units in the survey place men and women at work together, for the social atmosphere induced by mixing the sexes is held to be one of the advantages of industrial therapy. It would evidently be an advantage for considerations of work supply also, if in this hospital men and women attended the same work-place.

Shortage of work in 1965 and 1966

114. It was known of course before the research was contemplated that work supply was proving a problem, and when the survey was commissioned in 1966, it was anticipated that the credit squeeze

would result in industrial contraction. A question was therefore inserted in the questionnaire in which hospitals were asked if they had been short of work in 1965 and again in 1966, in the course of which the squeeze started. The result of this question is tabulated below.

Table XVII

	Whether or no the Industrial Unit was short of work in 1965 and 1966						
Region	No. of Hospitals	1965 Yes	1965 No	1965 N/A	1966 Yes	1966 No	1966 N/A
Newcastle	3	2	1	0	2	1	0
Leeds	5	2	3	0	2	3	0
Sheffield	6	4	2	0	3	3	0
E. Anglia	2	0	1	1	1	0	1
N. W. Met	4	1	3	0	3	1	0
N. E. Met.	3	1	1	1	1	2	0
S. E. Met.	4	2	2	0	3	1	0
S. W. Met.	9	2	7	0	4	5	0
Oxford	3	3	0	0	2	1	0
S. Western	8	4	3	1	3	4	1
Wales	7	3	2	2	3	3	1
Birmingham	8	2	6	0	1	7	0
Manchester	3	1	2	0	0	3	0
Liverpool	3	2	1	0	1	2	0
Wessex	6	4	1	1	3	2	1
	74	33	35	6	32	38	4
Private Hospital	1		1			1	

N/A here equals Not Applicable since the unit was not in operation during the year in question.

This result is thought to be important. In 1965 before the squeeze, 33 units were short of work at some period during the year, but 35 were not: in 1966, after the squeeze had started, 32, that is to say one less unit than in the previous year, were short of work while 38 were not. In other words, the squeeze did not on balance grossly affect the supply of work in an adverse direction as might have been expected. (This does not mean to say that a number of units were not severely hit. They were, one being put out of action altogether). But in half the hospitals, it would seem, the ingenuity of the manager or the strength of the relationship he had built up with his contractors was sufficient to ensure that his unit was not worse off in 1966 than in 1965.

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None the less, in both years nearly half the units in the survey did suffer interruptions in their work supply, which for mentally ill patients can be a disturbing matter.

Variety in the Work Supply

115. As to variety in the work supply, 17 hospitals pointed to the difficulty they had in procuring a wide enough range. The interesting point to emerge was that whereas ten hospitals emphasised the lack in their locality of enough easy repetitive work, the seven others were unable to lay hands on work which they considered difficult enough. In one or two cases continuity had evidently had to be bought at the expense of variety: the units needed work, the firms had long contracts to offer, and that was that.

116. The whole question of variety of work, and length of contracts, is one which in the researchers' view would repay further investigation. As already mentioned, it was hoped to obtain enough precise information about unit contract work to calculate the average length of run of the work supplied. Although a national calculation cannot be undertaken, enough information has come to hand to show that many units must be struggling with a multiplicity of small contracts. Some hospitals deal with orders of which the average annual value per contract comes out at £33, or £44, or £64. Individual jobs worth £9, and £1 a week are quoted. Viewed administratively, such runs must be a serious nuisance, adding to invoicing, storage and transport costs and detracting from the time available for the training of the patients.

But on the other hand, is it not the case that these short runs provide the variety that is required ? Several hospitals suggest this.

Or could the requisite variety be created by a unit taking on more complex and better paying jobs, breaking them down for the less advanced patients and leaving them intact for the more advanced patients ? Could more jigging be introduced ? Certainly a number of ingenious jigs and devices have been observed. For example, some ex-foremen had welded specially long handles on to pairs of pliers in such a manner that patients on a certain job are able only just to close them to the proper distance for the work. Factory workers, it was said, would use ordinary pliers and squeeze them carefully to the right distance, but severely mentally ill patients require the extra jigging otherwise they would squeeze and squeeze and ruin the workpiece and the pliers.

However, the average annual value of the contracts of a number of hospitals lies in the £100 - £300 range, and that of one or two in the £500 - £800 range. It is noticeable that these latter figures appertain to hospitals which have well established units, and which

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Distance, Transport and Storage

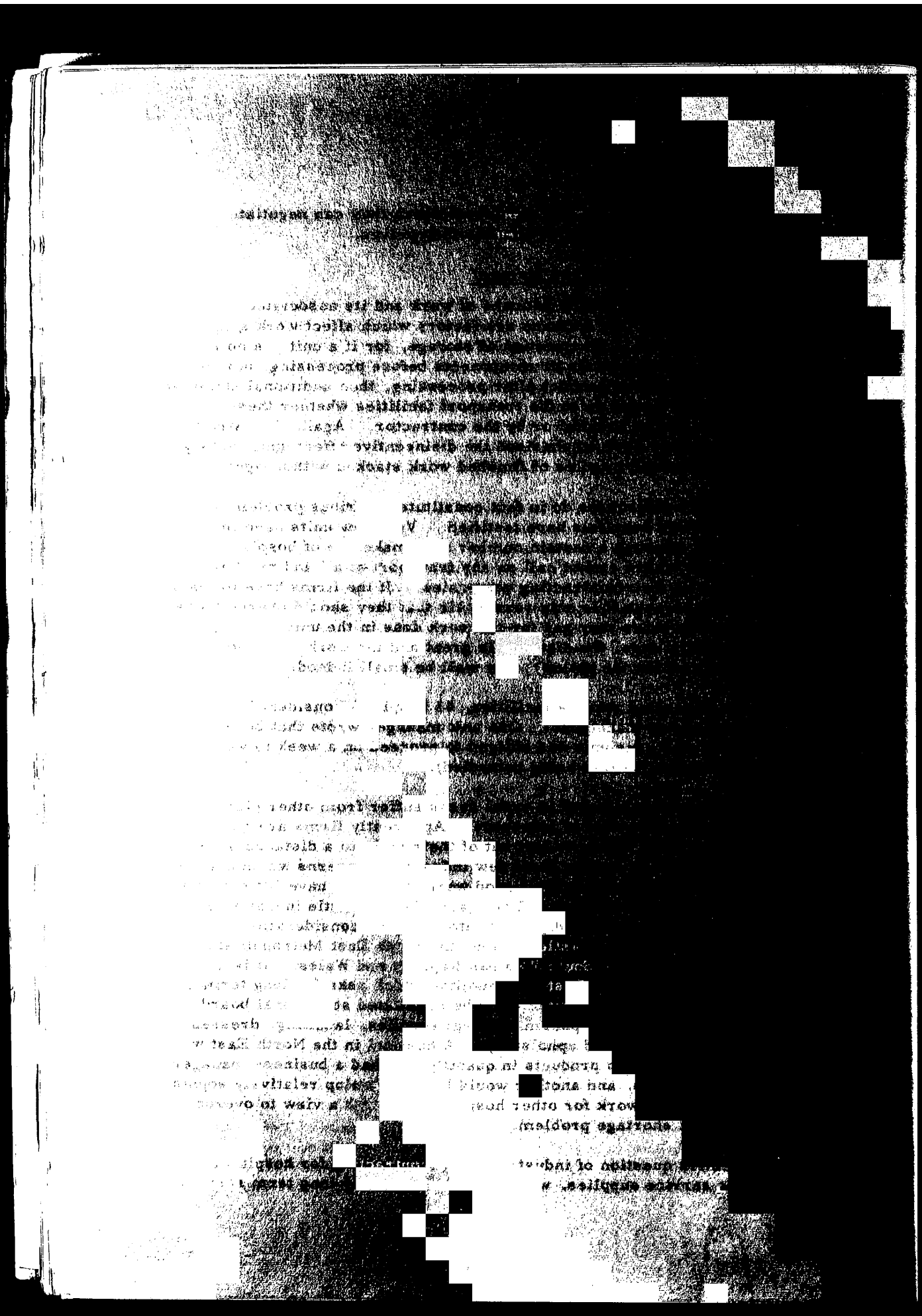
117. Distance from the sources of work and its associated problem of transport over this distance are factors which affect work supply. Also connected is the question of storage, for if a unit has no space to store raw materials or components before processing, nor to store the finished product after processing, then additional strain and expense is thrown on to the transport facilities whether these are provided by the hospital or by the contractor. Again, industrial psychologists have emphasised the disincentive effect upon factory workers caused by piles of finished work stacked within sight.

Transport difficulties do in fact constitute a serious problem to which fifteen hospitals have testified. Very few units have their own van, and although a certain number may make use of hospital transport others cannot call on any transport at all and must rely entirely on their contracting companies. If the firms have to make special journeys it is only reasonable that they should charge these against the price they pay for the work done in the unit; and if, in country districts, the distance is great and the work bulky, the residue left for the patients may well be small indeed.

118. Regarding storage facilities, 43 hospitals considered their storage space inadequate. One unit manager wrote that because of the lack of it, his unit was obliged to proceed on a week to week basis (but the situation was being remedied).

119. Hospitals situated in rural areas suffer from other disadvantages beside the cost of transport. Apparently firms are quite unwilling to let their product out of their sight to a distance of, say, 15 - 20 miles. Again, those few industrial concerns which are sited in the country easily recruit good workers and so have little need to put work out to hospitals. Yet again, there is little industry to rehabilitate an improved patient into. These considerations affect particularly the Newcastle Region, the South East Metropolitan, parts of Leeds, the South Western Regions and Wales. It is a hospital in the South East Metropolitan which asks for long term contracts for hospital supplies to be negotiated at regional board level for wardrobes, pharmaceutical supplies, labelling, dresses, furniture, chairs and upholstery. A hospital in the North East would like to sell its own products in quantity if it had a business manager to organise this, and another would like to develop relatively sophis - ticated sewing work for other hospitals, all with a view to overcoming their work shortage problem.

The entire question of industrial units contracting for hospital and public service supplies, with a view to providing long term stand-by



work for patients, is in the view of the researchers also one which could profitably be pursued further.

Competition

120. Hospitals in the South West Metropolitan Region report increasing competition from each other as more units are opened up. In the Manchester/Liverpool conurbation, there is thought to be overlapping and competition for work as between psychiatric hospitals and local authority centres and other welfare organisations for the aged or disabled. Generally speaking, however, the impression remains that competition is not such a grave problem as a few years ago it was feared it would be, but unit officers remain noticeably reluctant to disclose their contractors to other units.

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14 SOME ASPECTS OF POLICY

This survey has been described as primarily fact-finding and this remains its chief purpose. But many of the survey answers in their turn pose further questions. In order to promote the discussion of these we put forward below some observations, some of which are summarised on page 73. First we discuss the internal administration of the units; later we touch upon the place of industrial therapy in relation to the whole field of rehabilitation and sheltered work however provided.

Staffing the Units

121. Which occupational grade of staff should run industrial units ? This question was not included in the survey and indeed could not be dealt with by survey method. We incline to the view of previous observers[2] that the enthusiasm of industrial unit staff is the prime requisite and that this is happily much in evidence. But if the whole question is to receive further discussion, as it will, the following points may be thought relevant.

122. First may be considered the occupational therapists. Their contention has been noted that their training, uniquely, specialises in the instruction and assessment of patients in the working situation: but this contention does not go unchallenged in the service. Also it has been observed that the creative, original talent possessed by individual occupational therapists can be linked with commercial skills so that patients produce pleasing and genuinely marketable products as a complement to routine sub-contract work.

123. On the other hand, two women Head Occupational Therapists of long hospital service have mentioned their distaste for the business of negotiating for work, a dislike generally not shared by men Head Occupational Therapists. It is also the case that the hospital with one of the most highly developed Occupational Therapy departments in the country has been advertising for an industrial officer. And we have received comment to the effect that probably conventionally trained occupational therapists are not the best people to supervise industrial therapy because they have been trained in the idea that occupational therapy is recreational and a matter of hobbies, and they prefer an atmosphere of recreation to one of industrial discipline.

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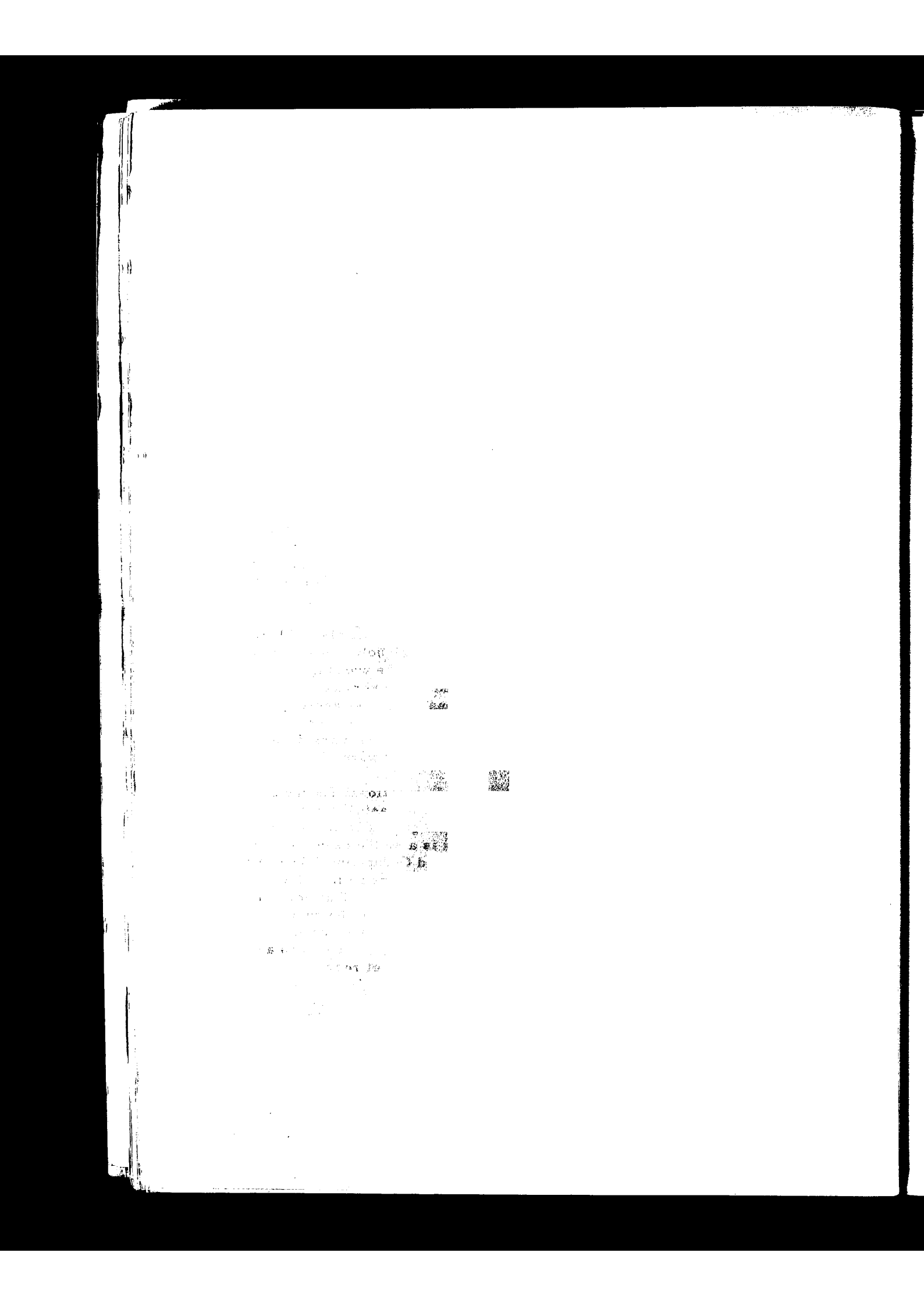
[2] A Personal Survey of Industrial Therapy in the Psychiatric Hospitals of the Sheffield Region. Br. J. of Psychiatry Vol. 112. No. 491 Oct. 1966 ADM Douglas, et al.



124. Yet the national shortage of occupational therapists renders these considerations largely academic. In March, 1967, there were 2, 567 occupational therapists on the Register of the Council for Professions Supplementary to Medicine (private communication, Registrar). There were at 30 September 1965 the whole-time equivalent of 1, 311 occupational therapists employed in National Health Service hospitals of all types. (Annual Report of the Ministry of Health Cmd 3326). By 30 September 1966 the number was 1, 356, representing a fractional rate of increase. Of these a mere 50 or so are engaged in the industrial therapy field covered by our survey, and on the trend of the figures above, there is likely to be little slack on which to base an increase.

So far as concerns occupational therapists and looking towards the future, the question would seem to be not whether or not they should run industrial units, but how best to utilise the occupational therapist's specialist skill in the assessment of patients, in collaboration with specialist industrial staff; and how best to turn the creativity possessed by so many of them to the advantage of the patients in an industrial as well as a recreational setting.

125. Concerning nursing staff, it is the case that certain hospitals, among them Cheadle Royal, have as a matter of policy replaced nurses by other staff, on the ground that nurses are too protective. (But at Cheadle Royal overall nursing cover is ensured). On the other hand, the managers of ITO workshops regret the absence of nursing cover when trainees relapse.

126. Another point in favour of employing nursing staff is that, if many short-stay psychiatric cases are in future to be treated in general hospitals rather than psychiatric hospitals and if industrial therapy, one of the more hopeful developments in these hospitals and largely pioneered by nursing staff, is to be excluded from the nursing function, then recruitment will suffer.

127. Whatever the eventual staffing patterns may turn out to be, the fact is that the majority of industrial units (47 out of 74) are headed by nurses at present, and nurses are bound to play a predominant part in the management of units within the foreseeable future. The survey shows that many nurses have had industrial experience and this is all to the good. But some of it is irrelevant, say, mining or an apprenticeship in organ making; most of it is at the wrong level, that is to say shop floor rather than managerial, and all of it is out of date if they have been in the hospital service for a number of years which they must have been to have achieved their present seniority.

[redacted]

Industrial Training for Nurses ?

128. For these reasons it seems well worth considering the suggestion for the industrial training of Nurses-in-Charge, put forward by a hospital in the North.

What form should this take ? Possibly, courses of further education in technical colleges and similar institutions, on subjects such as costing and work study, are not the best answer. For many staff members of remote hospitals technical colleges may be too distant, the subject matter couched in the terms of open industry would be only partly relevant, and it may be thought unrealistic to expect a busy industrial unit manager to go off to night school.

Valuable and strictly relevant training might however be obtained within the hospital service itself, by a scheme of in-service attachments to selected hospitals. Such hospitals will have thought through techniques in the various areas of expertise which constitute a thriving unit: observation and grading of patients; grading of work; jigmaking; mechanisation; costing; work study, incentive study, and so on. Patients throughout all the psychiatric hospitals of England and Wales would benefit if these methods could be disseminated throughout the service by an in-service training scheme.

Career Structure for Industrial Staff

129. The third possibility is to introduce industrially qualified staff either at management level, or supervisor level, or both. The survey shows only twelve such managers in post, and when visiting hospitals we received an impression of dissatisfaction at the recruitment conditions of these.

130. Most of the salaries paid are ad hoc arrived at by the Whitley Division of the Ministry of Health which takes into account what it conceives to be the responsibilities of the job together with appropriate relativities within the hospital service. For instance, the relationship to the occupational therapist's salary structure is known to be considered. The procedure has entailed two major drawbacks, namely, a low level of salary and unreasonable delay.

131. On the score of inadequacy, the ad hoc salaries compare unfavourably with those for posts most similar in local authority work, that is to say, the management of Adult Training Centres for the Mentally Sub-normal, where managers may be graded A. P. Grade 11/111 on a scale £1,020 - 1,435 p. a.

Moreover, Whitley Council ad hoc salaries, can be shown to have had a detrimental effect on experimental schemes introduced into the National Health Service. A case in point was the recruitment

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of domestic superintendents in order to relieve nursing staff of non-nursing duties. Just when the experiment was introduced, and required persons of the highest professional competence and personal quality to get it off the ground, ad hoc salaries were proposed at a quite unrealistic level, and the situation was not improved until this occupational group was taken into the Administrative and Clerical Staffs Whitley Council.

132. On the score of delay, one hospital in the survey speaks of frustration over a period of five years. Another has been negotiating for an increase for the past two years. One research worker, whose experience in this field goes back nine years, has seen the protracted correspondence attendant on the eventual award of a salary of £700 p. a. to an ex-production manager, with Remploy experience, who built up a flourishing unit in an ex-LCC hospital and later moved to a post in the field of rehabilitation carrying a salary of over four times that amount.

133. In view of all these considerations, it may be that national salary scales and a proper career structure ought now be contemplated. Has not the experimental period run its course ? Some units have been going for ten years and have developed to a point at which the salaries available just do not meet their case.

134. This is not the place to enter into detail but the following points may be thought relevant:

i. To head a sizeable unit on the industrial side, a man at middle management level is required first, to talk to contracting firms at the right level and second to be capable of development, innovation and mechanisation. To quote again, industrial therapy 'demands new knowledge and skills, for example, costing, stores and stock control, production techniques, inspection, packaging methods and materials, plastics, vacuum forming, basic electronics, engineering, etc.' It would be tragic if industrial units were to repeat the experience of those responsible for another handicapped group, the blind, perpetuating anachronistic processes after it has been proved that the blind are quite capable of, and themselves prefer, much more modern, and mechanised, work.

ii. The Sheltered Workshop Division of the Ministry of Labour is currently advising Local Authorities to appoint good managers for their Sheltered Workshops, for whom they may have to bid up to £2, 000 p. a. Improved methods in Sheltered Workshops are having the effect of reducing the cost of a sheltered workshop place year by year: one of them even runs at a profit.

iii. The Ministry of Health is concerned with health, and not, primarily, industry. So, broadly speaking, are hospitals. Perhaps management committees could invite the Ministry of Labour to provide assessors to help them when appointing senior industrial personnel.

Industrial work in and out of hospital

135. As Professor Peter Townsend remarked in his paper to the government conference on the social services (New Society December 14, 1967), most social planning in Britain is narrowly departmental, conceived within administrative and not functional boundaries.

For no group can this fact produce more complications than for the mentally ill. Within the province of the Ministry of Health, the central department chiefly responsible, the mentally ill person is explosed to the barriers of the tripartite framework of the National Health Service, especially on discharge from hospital when liaison with the general practitioner and the local authority services requires a great expenditure of time and effort to achieve. One example of these difficulties may be found in the field of the new local authority hostels for the mentally ill, which suffer from a lack of close co-operation with referring hospitals. (Departmental Paper on Hostels for the Mentally Ill, addressed to Local Authorities. July 1966).

136. When he seeks work in the community, the mentally ill person becomes the concern of the Ministry of Labour and also of the local authorities and certain voluntary organisations acting as the Ministry's agents. Two aims are distinguished; industrial training with a view to full rehabilitation to open industry; and the provision of sheltered employment for those judged incapable of such rehabilitation. These aims are clearly differentiated in the Ministry's thinking and reflected in its own administrative arrangements, in that two quite distinct divisions are concerned, namely the Rehabilitation Section and the Sheltered Employment Section.

137. The pioneering work with the Ministry of Labour has been done in the field of rehabilitation, the Medical Research Council Social Psychiatry Research Unit studying the work of the Ministry's Industrial Rehabilitation Units: it will be recalled that of the patients discharged from our 74 participating hospitals, some 6% of the men go to IRUs and fewer women (see page 20). Points to make are that IRUs are few in number taking the country as a whole, that following the above research they have adopted a policy of limiting the intake of mentally ill to 1 : 3 physically disabled, and that they carry a training grant for a period. The training is regarded as short-term, but as the result of a recommendation of the recent Inter-Departmental Working Party on Industrial

Rehabilitation, is no longer restricted to 12 weeks. However, this relaxation was not intended especially to accommodate the psychiatrically disabled, nor to lead to any lowering of the threshold of acceptance in IRUs of these cases.

138. Also attracting Minister of Labour training grants are the Industrial Therapy Organisations at Epsom and Hanwell sponsored by private firms and individuals as well as leading psychiatrists and major charitable foundations, and conceived with the idea of providing a longer period of training, (the Ministry of Labour insists on an absolute bar at 12 months), but numerically even sparser than the IRUs and capable of dealing with barely a fraction of discharged patients - and yet, like the Local Authority hostels, not always taken up to full capacity. The rehabilitation workshop of another voluntary organisation, Birmingham Industrial Therapy Association (BITA) was recognised by the Ministry for the same kind of assistance from 2 January 1967. A similar project known as a local authority rehabilitation and assessment centre (LARAC) run by the London Borough of Croydon as part of its community welfare services, commenced operations on 29 March 1967. These rehabilitation channels deal to a great extent with the patients for whom industrial therapy inside the psychiatric hospitals was originally conceived, typically, the long-stay chronic schizophrenic, the acute phase of whose illness is now burnt out, and whose residual disability might be classed as institutional neurosis.

139. But within the last few years it has become evident that two other main classes of patient entering Industrial Therapy Units may be distinguished:- the short-stay, who in 1965 and 1966 numbered more than half the new entrants, and those who, workwise, are capable of earning much more than the £2 to which Ministry of National Insurance regulations restrict them, but who, possibly on account of social rather than working limitations, cannot be regarded as likely material for rehabilitation into open employment. Our survey shows that an average of 35 patients per unit are estimated to be suitable for 'sheltered work' if this were available. But evidently respondents have used the term in its general sense rather than the technical sense of disabled persons' legislation.

However, provided that on testing they achieve the required standard, a significant proportion of these patients will become the concern of the Sheltered Employment section of the Ministry of Labour, which is responsible under the Disabled Persons Employment Act for the provision of sheltered work. This is provided nationally through Remploy, of whose labour force the figures show that 7.3%, the fourth highest category, are the mentally ill. It is also provided, locally, through local authorities or voluntary bodies; so far as the hospitals are concerned, at Bristol as at Cheadle Royal approved sheltered employment is provided by voluntary organisations (not hospital management committees) which have been set up for the purpose.

[redacted]

140. It is against this background that should be read the answers to the question asked of our 74 participating hospitals, whether or no they are in contact with sheltered workshops or training centres administered by a local authority. The outcome is that 28 hospitals are: but 46 are not. We do not know, from the questionnaire, whether there are, in the area surrounding each hospital, any sheltered workshops or training centres yet in existence to be in contact with.

141. But sheltered employment need not be in a workshop at all. In April 1964 the Ministry gave experimental recognition, as 'sheltered employment', to a novel arrangement by ITO (Bristol) Ltd. to send groups of mentally handicapped persons out to employment under special supervision in ordinary factories. ITO (Bristol) Ltd. acts as the employer, paying wages and providing the special supervision necessary, and the firms concerned pay ITO at agreed rates for the work done and also make a contribution towards the employer's share of National Insurance contributions. The ITO claims deficiency grant from the Ministry towards the difference between the cost of wages plus its administrative costs and the income received from the firms These experimental arrangements have proved generally satisfactory, and the out-working scheme is regarded as making a significant contribution to the resettlement of mentally disabled persons at a cost very much lower than that of conventional sheltered employment; no capital expenditure is required, and the Ministry's deficiency grants are much lower per capita than the normal run of sheltered workshops. The Ministry has accordingly given final approval to the Bristol experimental project.

142. Taken together with the hospital units, the facilities enumerated above make up the total provision of industrial work and training for mental patients. But as with the hospital units, the external provision is also largely experimental and the question what to do next over the whole field is becoming one of urgency.

It is in order to help to clarify ideas that the following suggestions are tentatively advanced.

First, the great need of the moment is an intensification of discussion at local, even specific project, level between psychiatric hospitals, local authorities, and the Ministry of Labour about what is to happen to discharged psychiatric patients who cannot take up open employment. Probably they will find that increased sheltered work provision is required. In the first place, there is the evidence of our figures given above (page 21), which shows that these patients are silting up hospital industrial units. Added to this, there is the limited success rate of the industrial therapy organisations, demonstrating that at the present state of psychiatric knowledge it is not possible invariably to choose patients suitable for this type of

rehabilitation. Since the start of these schemes in 1964 up to 30 September 1967 there have been 941 admissions to the workshops, 339 placings in employment from them, and 406 terminations for other reasons (Ministry of Labour Gazette, November 1967). When visiting ITO s we were told by their managers that they would like to see sheltered workshops in the locality to which they can send patients who cannot make the grade, rather than return them to hospital.

143. If then, sheltered work is so much needed, how and where is it to be provided ? It is an axiom of current thinking that it shall be provided in the community. Here mention must again be made of the Bristol scheme (141) which the Ministry of Labour would gladly see copied in other suitable areas. As to fixed workshops, how fast can the local authorities provide these ? The Mental Health Act 1959 also lays upon them the duty of providing hostels and lodgings and there is once again a national financial squeeze. What is to happen to patients in the meantime ? A recent research study issued by the Psychiatric Rehabilitation Association illumines the picture of what is happening at present. Of 174 patients treated for schizophrenia and discharged to known addresses in London E. 1 and N. 16, 45% were untraceable within twelve months of discharge and 33% of the remaining 55% were completely unoccupied during the day. Some spend much of the time trying to sleep, some walk about, and others sit on public seats or occasionally in a cafe. If occupation is beneficial for patients inside hospital, presumably it is equally so when they are discharged.

Even supposing finance and buildings were available, will there be enough suitable staff ? Will a proliferation of workshops increase unnecessarily difficulties of work supply ? In the face of these problems perhaps the administrative niceties of the Cheadle Royal set-up will repay further scrutiny. The top section of the Cheadle Royal Industrial Unit is a Ministry of Labour approved workshop attended not only by Cheadle Royal's own in-patients and National Health Service in- patients from neighbouring hospitals accommodated in a Cheadle Royal villa, but also by day patients and by local authority trainees who either travel from their homes to work or live in the Physician Superintendent's house which has been converted into a local authority hostel.

Might not this pattern, with local modifications, be adopted elsewhere until local authority provision can catch up ? This would mean upgrading the top section of certain industrial units to become sheltered workshops with local authority backing, and the point is put forward that it might be more important to achieve a genuine industrial tempo with genuine industrial conditions inside a unit, even if this may still be within hospital grounds, then to insist upon the siting of such workshops outside hospital grounds but perhaps without the strong industrial backing which certain units have now

after a number of years achieved, and which, in fact, may be hard to achieve in scattered workshops dispersed in certain areas of the country.

144. To summarise, it does look as if the dual strain of living and working in the community unsupported is proving too much for many discharged patients. Perhaps one cannot do better than repeat what Bennett and Wing wrote in 1963 'At the moment, the emphasis is on returning patients to their homes and previous work as soon as possible; residual handicaps, which are frequently present when the patient is discharged, are not much studied. However, the increasing admission rate shows that psychiatric disorders are often cyclical, if not chronic. This fact should be taken into account when planning treatment, and it may necessitate the increasing use of after-care facilities, such as sheltered workshops and hostels, for an increasing proportion of discharged patients.'[3]

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[3] Trends in the Mental Health Services, Pergamon Press, 1963.

15 POINTS FOR DISCUSSION

145. Simple patient records should be kept in each industrial unit. Basic data, such as the date of entering and leaving the unit, and a record of pay earned, would be of value not only to research but to each hospital wishing to clarify its objectives and assess performance (section 1).

146. The function of each unit should now be critically appraised and purposefully decided (35). We have the impression that many units have no clear policy.

147. If short-stay patients are apt to find industrial work too simple and boring (38) should they attend industrial units ? Should they be found more complex or more interesting or more mechanised tasks ? Perhaps more typing and commercial training could be introduced if this is not already provided in the occupational therapy department.

148. It is possible that piece rate payment should be more widely used, in view of its incentive effect and the consideration that it lessens patients' dependence upon staff. (44 et seq.)

149. It would seem equitable that the range of industrial unit earnings should be related to the range of earnings available to patients placed on domestic, maintenance and estate duties (32).

150. Are industrial units mechanised enough ? Is the scarcity of machinery a matter of choice or of necessity, caused by lack of funds or administrative support ? (65 et seq.)

151. How can the skill of the occupational therapist best be utilised in the future in industrial therapy ? (75)

152. Is there a need for further formal training for any of the grades of staff employed in industrial units ? (128)

153. There may be a case for the introduction of a national salary scale and career structure for industrial personnel in the units. Could this be achieved without damaging the flexibility of the present arrangements ? Should it be done in conjunction with the staff of the sub-normality hospitals and local authority-provided training centres and work-shops ? (129 et seq.)

154. The attention of hospital architects should be drawn to the need for adequate storage space for industrial units. (118)

155. The assurance of a sufficient and varied supply of work is a necessity for industrial units, particularly the most remote. To fill in gaps between sub-contracts, can more hospital and other government service work be introduced ? Is it desirable that hospitals shall make and market their own goods to a greater extent ? What are the obstacles which impede these two sources of work ? (115, 119) Are they insuperable ?

APPENDIX A

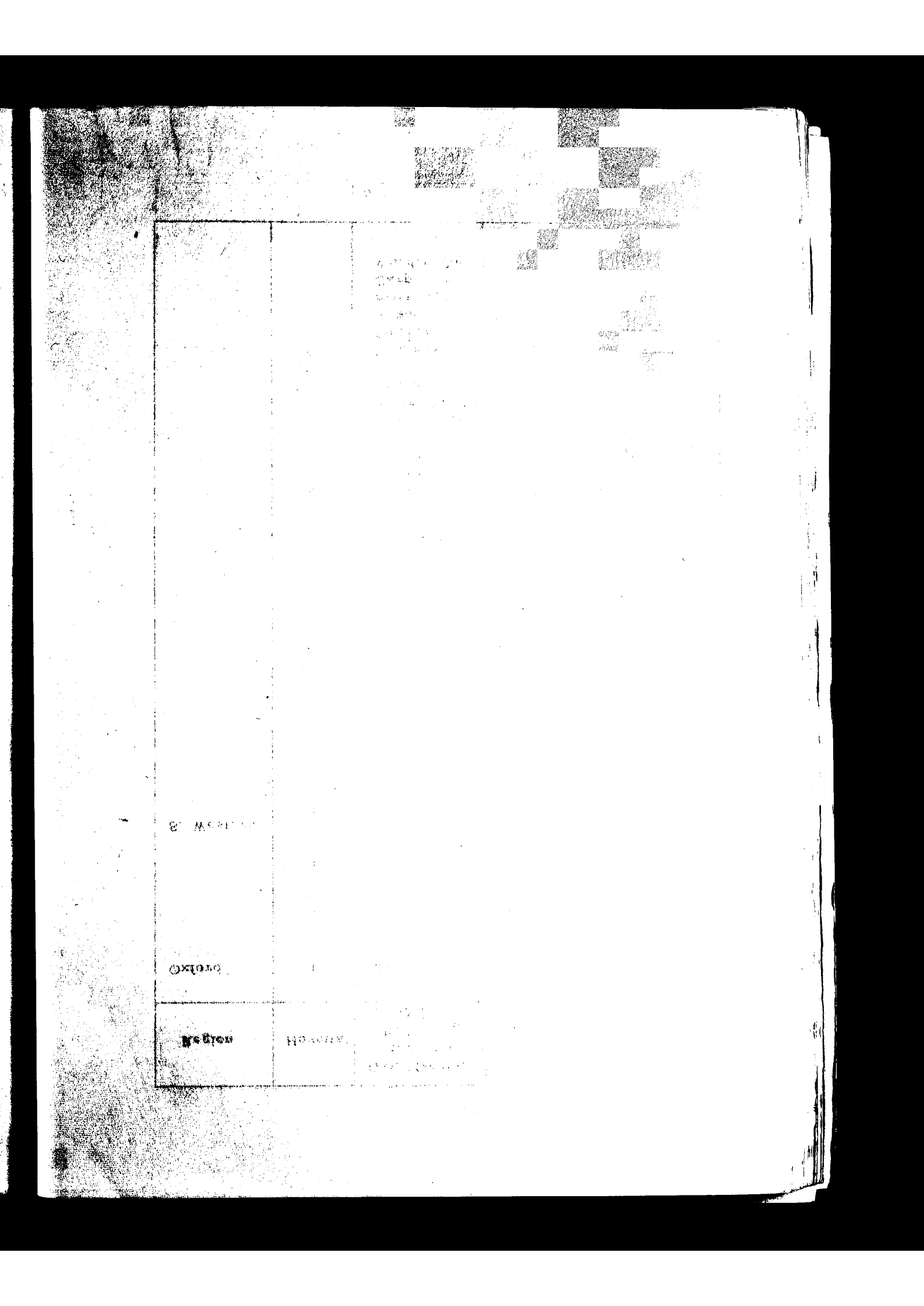
WORK PERFORMED OTHER THAN SUB-CONTRACT WORK

Region	Hospital	Own Manufacture and Marketing (Q. 21)	Other Work, e.g. internal work for Hospital (Q. 22)
Newcastle	1	Nil	Nil
	2	Concrete Slabs	None stated.
	3	Nil	Printing. Car Wash.
Leeds	1	Palettes. Soft Toys	Repairing ward furniture.
	2	Nil	Packing Dressing packs Book-binding. Stamping Medical Certs.
	3	2,000 Christmas Crackers	CSSD Packs: Labelling bottles: Packaging for Pharmacy: Making X-ray folders.
	4	Nil	None stated.
	5	Nil	Brown paper bags for internal refuse disposal department.
Sheffield	1	Nil	Nil
	2	Nil	Nil
	3	Nil	Printing for hospital.
	4	Bundles of firewood	Minor furniture repairs: Printing 95% Group Stationery.
	5	Nil	Racks: Staging: Stage Equipment: Label Dispenser for Pharmacy.
	6	Nil	Stapling roneoed sheets for hospital departments.
East Anglia	1	Not known	Not known
	2	Nil	None stated.
N. W. Met.	1	Nil	None stated.
	2	Nil	Stationery: Envelopes: 5,000 Gift Bags: 104,000 meal tickets p. a.: 160 Christmas programmes.

Region	Hospital	Own Manufacture and Marketing (Q. 21)	Other Work, e.g. internal work for Hospital (Q. 22)
N. W. Met. (continued)	3	Wendy Houses	All hospital printing: outside original printing: Hospital furniture repair: Mfre. 1,500 bedside lockers: Wardrobes: Picture glazing and framing: Brick laying and plastering.
	4	Nil	Fitting castors to lockers.
N. E. Met.	1	Nil	Dressing pack collation: Packing dressings: Heat sealing bags.
	2	Nil	None stated.
	3	Dolls Houses	
S. E. Met.	1	Plant Troughs: Tubs: Dog Kennels, etc. etc. (14 products)	90,000 paperbags: 1,250 Case paper folders: Christmas Cake Boards: Floor mops: Concrete blocks: Carpentry: Concreting: Painting.
	2	Soft Toys	Swabs: Face Cloths:
	3	Nil	Concrete slab-casting: Wardrobes: Numbering Time Cards: Tagging labels for garden.
	4	Nil	None stated.
S. W. Met.	1	Nil	
	2	Nil	None stated.
	3	Nil	None stated.
	4	Car wash leathers: Concrete products.	Bibs for patients Picture framing.
	5	Coffee Tables: Stools Children's chairs	Printing for group: Brushes: brooms: Picture framing: Theatrical scenery: Repairing chairs.
	6	Nil	None stated.
	7	Nil	Carpentry: Maintenance.
	8	Nil	None stated.
	9	Nil	Serving and machining.

	Hospital	
N. W. Met. (continued)	1	
N. E. Met.		
S. E. Met.		
S. W. Met.		
	6	Nil
	7	Nil
	8	Nil
	9	Nil

Region	Hospital	Own Manufacture and Marketing (Q. 21)	Other Work, e.g. internal work for Hospital (Q. 22)
Oxford	1	Nil	Paper and carrier bags for shop and stores: Hats: Crackers.
	2	Nil	Garden furniture: Printing: Jig-making: Greenhouse and landscape gardening.
	3	Nil	Hospital repairs.
S. Western	1	Nil	None stated.
	2	Plastic covered coat hangers.	None stated.
	3	Cupboards: Kitchen units Flower pot stands: Coffee tables etc.	Car wash: renovation of furniture and garden seats
	4	Concrete articles: kerbs: slabs: Garden seats.	None stated.
	5	Pot scourers: Place mats: Christmas cards: Coat hangers.	Printing.
	6	Windmills: Furry bears: Firewood: Dressing stools: Floor mops: Picture frames.	Included in previous column.
	7	Nil	None stated.
	8	Chain link fencing: Rubber link mats: Aprons: Carpentry: Wooden Toys	Some, not distinguished from sub-contract work



Region	Hospital	Own Manufacture and Marketing (Q. 21)	Other Work, e.g. internal work for Hospital (Q. 22)
Wales	1	Nil	Painting ward and garden furniture: Marking linen: Book-binding.
	2	Nil	None stated.
	3	Library Ticket holders.	None stated.
	4	X-ray envelopes and wallets and case folders of various sizes, designs, and qualities. Sale value £12,000.	Renovation of ward wooden furniture, also tubular furniture.
	5	Nil	None stated.
	6	Nil	General hospital work value £1,200.
	7	Homemade cakes	Assembling cytology kits.
Birmingham	1	Seed trays: Plant troughs: Seed boxes: Firewood: Golf balls: Novelty bows	None stated.
	2	Nil	Reseating chairs for local church.
	3	Shopping bags: Soft toys: Cement blocks and slabs: Seed boxes: Bow Ties	Contract labour to outside firms: Cervical cytology assembly for Regional Hospital Board.
	4	Tool boxes: Coffee tables: Toys: Boxes: Pelmets: Bookcases: Noticeboards: Firewood.	Furniture repair and small wooden article manufacture.

Region	Hospital	Own Manufacture and Marketing (Q. 21)	Other Work, e.g. internal work for Hospital (Q. 22)
Birmingham (continued)	5	Nil	Making tools and jigs for outside industry and own use: Pump valves for hospital boiler house.
	6	Nil	None stated.
	7	Nil	Gumming path. lab. sheets Catering dept. forms.
	8	Nil	Nil.
Manchester	1	Nil	None stated.
	2	Nil	None stated.
	3	Miscellaneous goods to value over £2,501 (for breakdown see Appendix B)	Work completed for hospital valued at over £150. (for breakdown see Appendix B)
Liverpool	1	Concrete slabs: Bricks: Firewood: Sprilting boxes	Assembling cytology kits.
	2	Nil	2,000 Ottomans for patients' use.
	3	Nil	Printing: Furniture repair: Making bibs: Doormats: Mops: Brushes: Hospital signs.
Wessex	1	Firewood: Christmas crackers: Link mats	Painting: Decorating: Roadmaking.
	2	Dolls clothes: Dry flies: Mackerel fishing lines	Crackers: Christmas decorations: Packing dressings.
	3	Misc.: Carpentry to order: Shrub Tubs: Bird Tables: Shoe Repair: Seed boxes: Firewood	Wardrobe manufacture: Pelmet making.

Region	Hosp.	
Birmingham (continued)		
Manchester		
Liverpool		
Wessex		

Region	Hospital	Own Manufacture and Marketing (Q. 21)	Other Work, e.g. internal work for Hospital (Q. 22)
Wessex (continued)	4	Nil	None stated.
	5	Firewood: Carrier bags	Making envelopes: Rubber case notes: Making furniture: picture frames, etc.
	6	X-ray envelopes: Wallets: Folders	None stated.

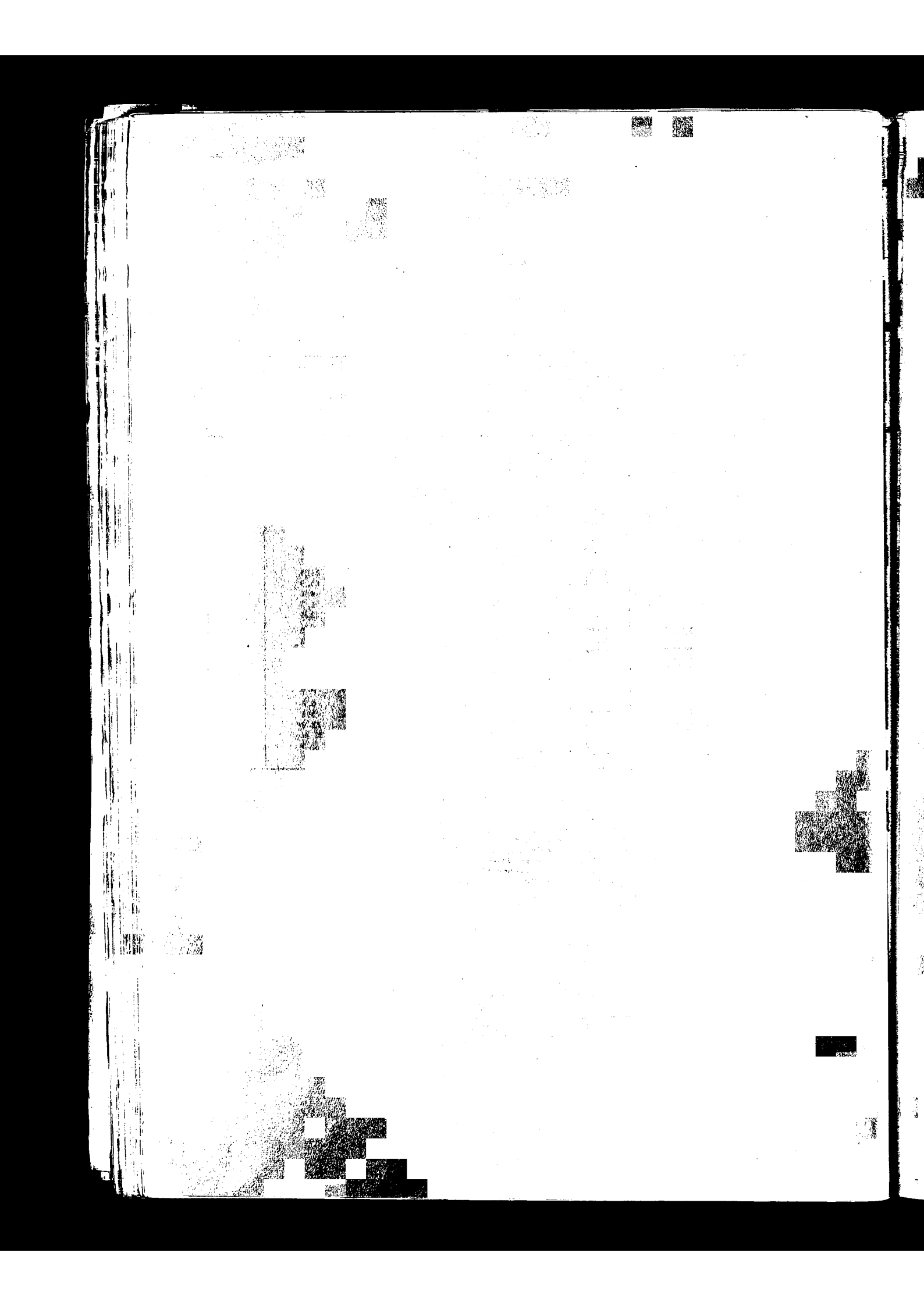
APPENDIX B

PATIENTS' AVERAGE PRODUCTIVITY

Region	Hospital	Gross Income year to 31.3.66 (Q. 24)	Total paid to patients (Q. 25)	Patient Hours Worked (Est.) (Q. 11)	Own Mfre. (Q. 21)	Other: inc. work for hospital (Q. 22)	Patients' average Productivity in pence per hours (Q. 24) / (Q. 11)	Remarks
		£	£	Hours	Yes/No	Yes/No		
Newcastle	A	2,669	1,369	N.A.				
	B	1,044	2,395	193,320	Yes	No	1.3	
	C	N.A.	N.A.	121,875	No	Yes	N.A.	
Leeds	A	4,554	2,625	737,024	Yes	Yes	1.5	
	B	3,800	2,371	84,500	No	Yes	10.8	
	C	3,977	2,500	467,000	Yes	Yes	2.0	
	D	2,303	1,843	64,000	No	No	8.7	
	E	9,321	7,089	200,000	No	Yes	11.1	
Sheffield	A	9,131	9,131	512,550	No	No	4.3	
	B	1,577	1,577	54,000	No	No	7.0	
	C	8,596	7,145	513,760	No	Yes	4.0	
	D	4,277	3,255	181,610	Yes	Yes	5.6	
	E	2,733	3,079	138,800	No	Yes	4.7	
	F	4,010	4,010	130,959	No	Yes	7.3	
E. Anglia	A	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	
	B	5,000	4,750	144,268	No	No	8.3	
N.W. Met.	A	9,031	8,592	302,027	No	No	7.1	
	B	3,027	1,294	112,000	No	Yes	6.5	
	C	9,315	4,245	80,000	Yes	Yes	27.9	
	D	10,584	5,957	194,552	No	Yes	13.0	
N.E. Met.	A	5,354	5,399	259,250	No	Yes	4.9	
	B	N.A.	N.A.	N.A.	No	No		
	C	10,993	5,374	N.A.	Yes	Yes		
S.E. Met.	A	1,655	1,598	80,000	Yes	Yes	5.0	
	B	2,784	2,572	209,990	Yes	Yes	3.1	
	C	7,500	7,500	350,000	No	Yes	5.1	
	D	4,354	4,237	110,000	No	No	9.5	
S.W. Met.	A	N.A.	N.A.	N.A.				
	B	2,851	2,016	60,000	No	No	11.4	
	C	18,337	14,133	326,400	No	No	13.5	
	D	1,334	840	N.A.	Yes	Yes	N.A.	
	E	4,512	4,016	267,700	Yes	Yes	4.0	
	F	3,760	3,730	N.A.	No	No	N.A.	
	G	11,712	9,289	588,625	No	Yes	4.8	
	H	9,142	8,716	660,000	No	No	3.3	
	J	11,448	10,237	294,440	No	Yes	9.3	
Oxford	A	2,119	2,119	N.A.	No	Yes	N.A.	
	B	4,885	2,604	155,360	No	Yes	7.5	
	C	4,818	3,298	116,000	No	Yes	10.0	
S. Western	A	3,057	2,745	67,500	No	No	10.9	
	B	5,273	4,847	N.A.	Yes	No	N.A.	
	C	4,298	3,871	1,423,800	Yes	Yes		
	D	825	426	36,000	Yes	No	5.5	
	E	296	254	236,600	Yes	No		
	F			N.A.	Yes	No		
	G	9,578	9,719	240,000	No	No	9.6	
	H			392,877	Yes	Yes		

Region	Hospital	Gross Income year to 31.3.66 (Q.24)	Total paid to patients (Q.25)	Patient Hours Worked (Est.) (Q.11)	Own Mfre. (Q.21)	Other: inc. work for hospital (Q.22)	Patients' average Productivity in pence per hours (Q.24)/(Q.11)	Remarks
		£	£	Hours	Yes/No	Yes/No		
Wales	A	2,261	1,702	81,250	No	Yes	6.7	
	B	416	53	N.A.	No	No	N.A.	
	C	10,000	9,800	N.A.	Yes	No	N.A.	
	D	19,000	9,000	198,900	Yes	Yes	22.9*	
	E	2,011	1,722	206,400	No	No	2.33	
	F	N A.	N.A.	N.A.	No	Yes	N.A.	
	G	511	511	N.A.	Yes	Yes	N.A.	
Birmingham	A	6,683	3,146	849,135	Yes	No	1.9	
	B	2,012	1,750	102,048	No	Yes	4.7	
	C	6,608	5,462	337,562	Yes	Yes	4.7	
	D	3,553	3,310	39,780	Yes	Yes	21.4	
	E	1,751	979	35,280	No	Yes	11.9	
	F	2,886	2,538	150,744	No	No	4.6	
	G	1,660	1,502	238,316	No	Yes	1.7	
	H	2,663	4,979	267,800	No	No	2.4	
Manchester	A	3,600	3,420	288,750	No	No	3.0	
	B	2,023	1,728	149,860	No	No	3.2	
	C	6,166	3,488	540,000	Yes	Yes	2.7	
Liverpool	A	7,151	5,554	403,785	Yes	Yes	4.2	
	B	7,000	6,300	839,400	No	Yes	2.0	
	C	5,112	6,300	321,568	No	Yes	3.8	
Wessex	A	2,770	380	100,000	Yes	Yes	6.6	
	B	2,737	2,289	173,550	Yes	Yes	3.8	
	C	10,935	6,532	218,400	Yes	Yes	12.0*	
	D	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	
	E	5,938	3,950	260,000	Yes	Yes	5.5	
	F	4,467	4,467	162,000	Yes	No	6.6	

Note: This table is intended to serve as an illustration rather than as an arithmetically precise comparison between hospitals. Two factors in particular preclude accuracy. First, the figures given in the Patient Hours Worked column are estimated figures. Second, certain hospitals (the two known to us are starred), include a materials as well as a labour content in their Gross Income figure, and this is reflected in their Patients' Average Productivity figure. Since, as mentioned above, this table is merely a guide, a further approach to the hospitals for more information was not considered justified.



APPENDIX C

CERTAIN RELEVANT SALARIES (1967)

1.	Nursing Assistants over 21	£570 x 5 x 695. 42 hours
2.	Occupational Therapy Helpers aged 20 or over	Working under supervision
	Working not more than 4 3-hr. sessions per week	25/3d per session (8/5d per hour)
	Over 12 up to 32 hours per week	Pro Rata to £565 plus 10%
	Over 32 hours per week	Pro Rata to full time rate
	Full-Time (36 hours)	Flat Rate £565 per annum
3.	Local Authority Adult Training Centre	
	Instructor/Supervisor Technical Grade III	£860 - 1,020 per annum
	Local Authority Junior Training Centre	
	Assistant Supervisor	£575 - 860 per annum (if the Assistant Supervisor is unqualified the maximum of the scale is £820 per annum)
4.	Mentally Sub-Normal Hospital School	
	Assistant Supervisor	£575 x 8 x 860 (same as above. Also subject to £40 abatement if unqualified)

The appropriate qualifications are (1) Diploma of the National Association of Mental Health (2) Diploma of the Training Council for Teachers of the Mentally Handicapped (3) Qualifications other than above.

5.	Actual salaries in force in light engineering in South East	
	Foreman, Assembly Shop,) Women operatives)	£850 - 1,200 per annum
	Charge-hand, male	£15 - 18 per week
	Charge-hand, female	5/6d - 6/-d per hour (say £12 per week)
	Foreman, skilled. Tool room.	£1,000 - 1,500 per annum
	Charge-hand, male	7/6d - 9/6d per hour, or £15 per week upwards.

APPENDIX D

THE QUESTIONNAIRE

For our purposes the term Industrial Unit comprises purpose-built units, converted premises and those sections of wards or occupational therapy departments engaged in industrial work.

NAME OF HOSPITAL . . . . . .

Hospital Code [ ][ ][ ][ ] (1–4)

Card Sequence Number [1] (5)

PATIENTS

1. Please state number of patients in hospital during week ending 8th April, 1967.

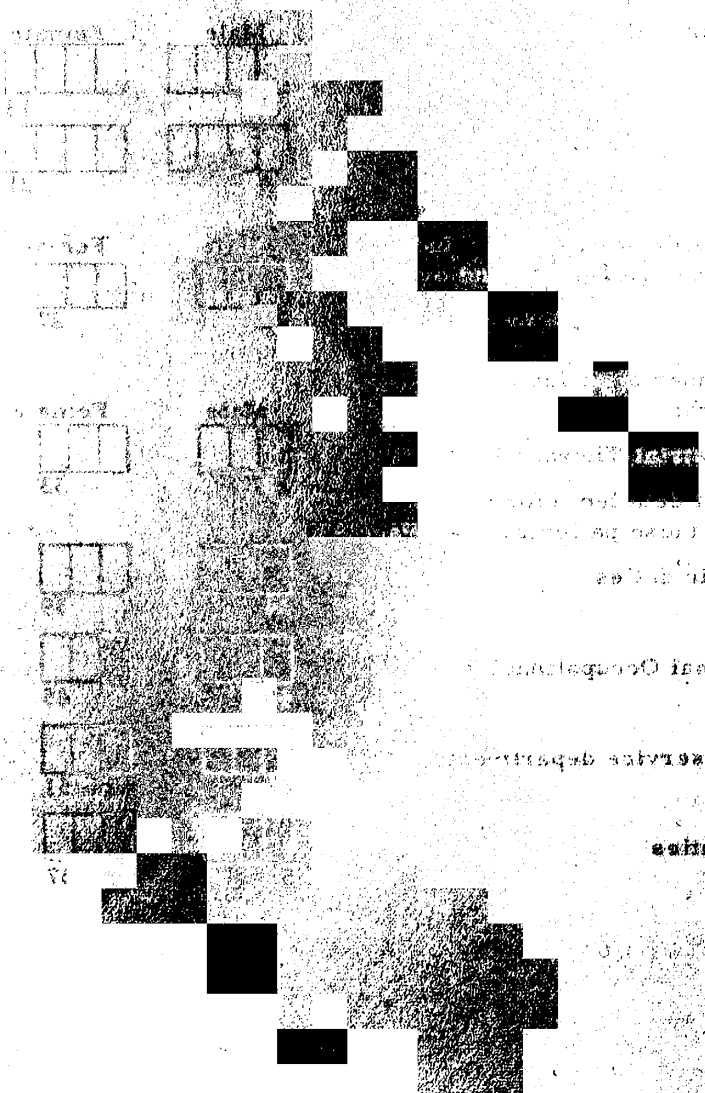
	Male	Female
(i) In Patients	[ ][ ][ ][ ] (6)	[ ][ ][ ][ ] (13)
(ii) Day Patients	[ ][ ][ ][ ] (14)	[ ][ ][ ][ ] (21)

2. Please state number of patients included in Question 1, who are aged 65 and over

Male	Female
[ ][ ][ ] (22)	[ ][ ][ ] (27)

3. Please state number of patients in the Hospital who work:-

	Male	Female
(i) In the Industrial Therapy Unit (Please list detailed information regarding these patients. See Page 97)	[ ][ ][ ] (28)	[ ][ ][ ] (33)
(ii) On domestic duties	[ ][ ][ ] (34)	[ ][ ][ ] (39)
(iii) At traditional Occupational Therapy	[ ][ ][ ] (40)	[ ][ ][ ] (45)
(iv) In hospital service departments	[ ][ ][ ] (46)	[ ][ ][ ] (51)
(v) On other duties	[ ][ ][ ] (52)	[ ][ ][ ] (57)



4. Of the patients living in hospital, state the number who are working outside:-

	Male	Female
(i) Individually	58	61
(ii) In groups	62	65

5. How many more patients would you consider placing in the Industrial Unit if enough work were available ?

Male	Female
66	69

Hospital Code [ ][ ][ ][ ] (1–4)

Card Sequence Number [2] (5)

6. How many new patients entered the Industrial Unit in:-

	LONG STAY (over 2 years)		SHORT STAY (under 2 years)	
	Male	Female	Male	Female
1965	[ ][ ][ ] (6)	[ ][ ][ ]	[ ][ ][ ]	[ ][ ][ ] (17)
1966	[ ][ ][ ] (18)	[ ][ ][ ]	[ ][ ][ ]	[ ][ ][ ] (29)

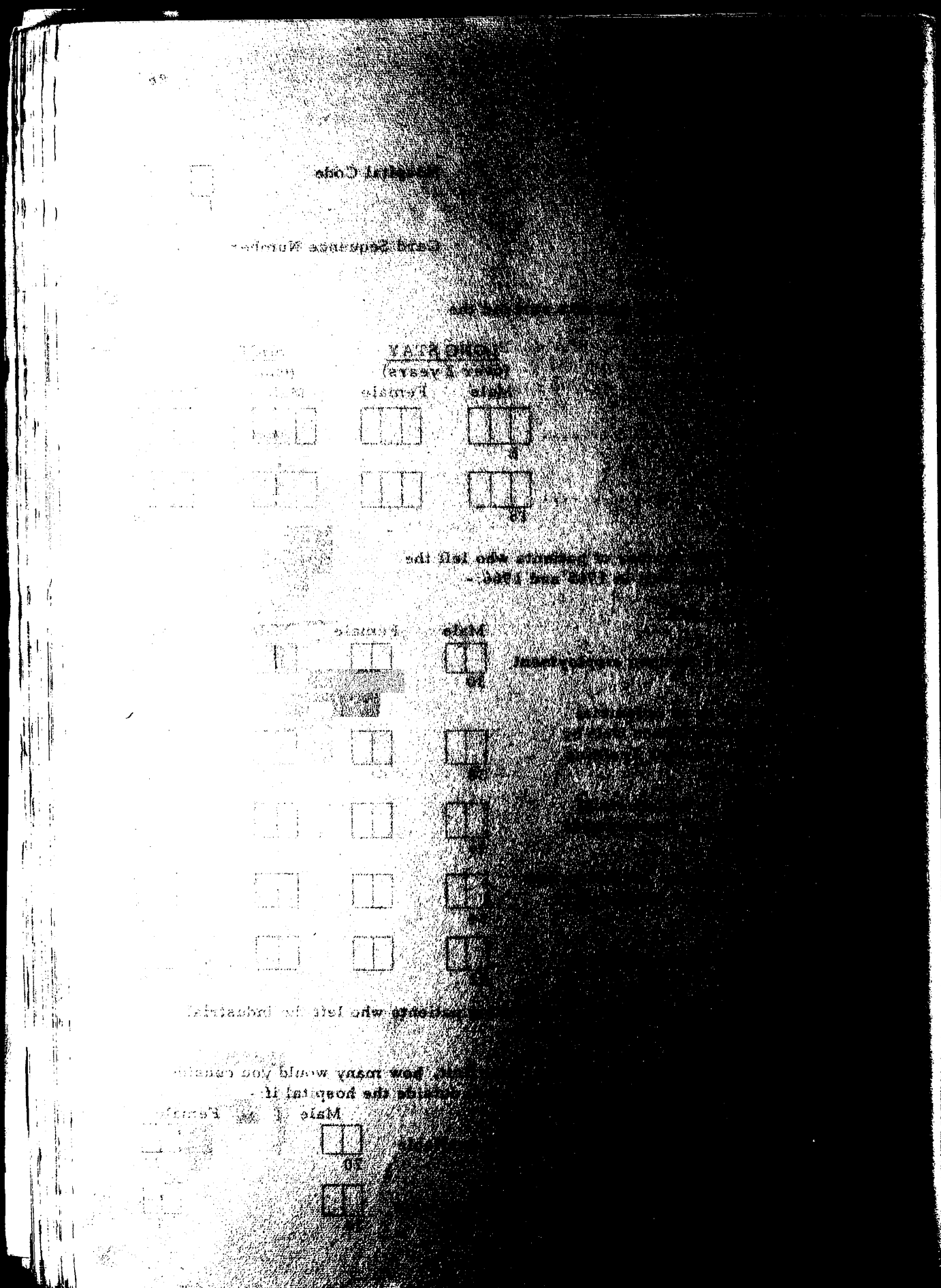
7. State the number of patients who left the Industrial Unit in 1965 and 1966:-

Reason Left	Male	Female	Male	Female
To take up open employment	[ ][ ] (30)	[ ][ ]	[ ][ ]	[ ][ ] (37)
To go to an Industrial Rehabilitation Unit or Government Training Centre	[ ][ ] (38)	[ ][ ]	[ ][ ]	[ ][ ] (45)
To go to an Industrial Therapy Organisation (ITO)	[ ][ ] (46)	[ ][ ]	[ ][ ]	[ ][ ] (53)
To go home, but not to take up gainful employment	[ ][ ] (54)	[ ][ ]	[ ][ ]	[ ][ ] (61)
To remain in Hospital	[ ][ ] (62)	[ ][ ]	[ ][ ]	[ ][ ] (69)

Please list information regarding patients who left the Industrial Unit in 1966. (See page 97)

8. Of patients now in the Industrial Unit, how many would you consider capable of limited industrial work outside the hospital if:-

	Male	Female
(i) Sheltered employment were available	[ ][ ] (70)	[ ][ ] (73)
(ii) Hostel accommodation were available	[ ][ ] (74)	[ ][ ] (77)



Hospital Code [ ][ ][ ][ ] (1–4)

Card Sequence Number [3] (5)

PAYMENTS

9. How many patients in the Industrial Unit are paid by:-

	Male	Female
(i) An allowance rather than a wage	[ ][ ][ ] (6)	[ ][ ][ ] (11)
(ii) Time fixed within the Unit	[ ][ ][ ] (12)	[ ][ ][ ] (17)
(iii) Time rate weighted for punctuality, attendance, application to work, neatness, etc.	[ ][ ][ ] (18)	[ ][ ][ ] (23)
(iv) Piece rate fixed by price offered by manufacturer.	[ ][ ][ ] (24)	[ ][ ][ ] (29)
(v) Piece rate fixed by work measurement in the Unit	[ ][ ][ ] (30)	[ ][ ][ ] (35)
(vi) Other methods	[ ][ ][ ] (36)	[ ][ ][ ] (41)

If other, please specify.

10. If incentive increases, or bonus payments are made, please specify:-

11. Approximately how many patient hours were worked in the Industrial Unit during the financial year 1.4.65 - 31.3.66

Male [ ][ ][ ][ ][ ][ ][ ] (42–48)

Female [ ][ ][ ][ ][ ][ ][ ] (49–55)

12. Is the level of pay in Hospital service departments and elsewhere consciously related to Industrial Unit level of pay [ ] (56)

Enter:- 1 for Yes 2 for No

13. Is indigent pocket money allowance paid in your Hospital? [ ] (57)

Enter:- 1 for Yes 2 for No

14. If the answer to Question 13 is yes, is this kept separate from Industrial Unit payment? [ ] (58)

Enter:- 1 for Yes 2 for No 3 for N/A

Hospital Code

1

Card Sequence Number

6

Male

than a wage

6

12

18

24

30

36

Male

42

Female

49

55

Hospital Code [ ][ ][ ][ ] (1–4)

Card Sequence Number [4] (5)

STAFF

15. How many members of the staff were engaged in the Industrial Unit in the week ending 8th April, 1967.

		F/Time	P/Time
(i)	Nurses:		
	Staff Nurses & Above	[ ][ ] (6)	[ ][ ] (9)
	Student Nurses	[ ][ ] (10)	[ ][ ] (13)
	State Enrolled Nurses	[ ][ ] (14)	[ ][ ] (17)
	Nursing Assistants	[ ][ ] (18)	[ ][ ] (21)
(ii)	Qualified occupational therapists	[ ][ ] (22)	[ ][ ] (25)
(iii)	Student occupational therapists	[ ][ ] (26)	[ ][ ] (29)
(iv)	Occupational therapy helpers	[ ][ ] (30)	[ ][ ] (33)
(v)	Technical instructors	[ ][ ] (34)	[ ][ ] (37)
(vi)	Clerks	[ ][ ] (38)	[ ][ ] (41)
(vii)	Storemen	[ ][ ] (42)	[ ][ ] (45)
(viii)	Supervisors in Industrial Units (ASC grade)	[ ][ ] (46)	[ ][ ] (49)
(ix)	Other (including non-patient workers) Please specify:-	[ ][ ] (50)	[ ][ ] (53)

STAFF Cont'd

16. Do Nursing staff wear uniform in the Industrial Unit?

Enter:- 1 for Yes 2 for No

☐ 54

17. How many members of the staff have had previous training BOTH in industry, and in dealing with psychiatric patients ?

☐☐ 55 56

Please specify:-

18. Give title, qualification and salary scale of the person in overall charge of the Industrial Unit.

19. Please comment on your staffing problems, if any ?

STAFF [illegible]

16. Do Nursing staff wear uniform [illegible]
Unit?

Answer: [illegible] for Yes [illegible] No

17. How many [illegible]
Previous training [illegible]
in dealing with [illegible]

Please specify:

18. Give title, qualification and [illegible]
of the person in overall charge
Industrial Unit:

19. Please comment on your nursing [illegible]
if any ?

Hospital Code [ ][ ][ ][ ] (1–4)

Card Sequence Number [5] (5)

WORK

20. Please give information relating to sub-contracting work undertaken in 1966.

Type of Work	Number of Contracts	Approximate Value

21. List products which the Industrial Unit manufactured and marketed on its own account in 1966.

22. Please list any work done by the Unit in 1966 not included in Questions 20 and 21, e.g. internal work for the Hospital.

23. How are prices fixed:-

1. By accepting prices offered by the Manufacturer [ ] (6)
2. By negotiating prices with the Manufacturer [ ] (7)
3. By a costing process [ ] (8)

Enter:- 1 for Yes 2 for No

If 3, please describe.

20. Please give information [illegible]
work undertaken in [illegible]

Type of Work [illegible]

21. List products which [illegible]
manufactured [illegible]
account in [illegible]

22. Please list [illegible]
1966 not include [illegible]
e.g. internal [illegible]

23. How are prices fixed [illegible]

1. By accepting prices [illegible]
Manufacturer

2. By negotiating prices with [illegible]
Manufacturer

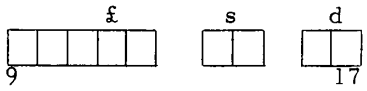
3. By a costing process

Enter:- 1 for Yes [illegible] 2 for [illegible]

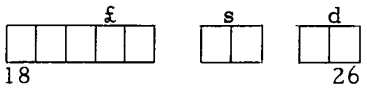
If 3, please describe.

WORK Cont'd

24. What was the gross income received by the Unit in the financial year ended 31. 3. 1966

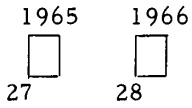


25. What was the total amount paid to patients in the financial year ending 31. 3. 66



26. Was the Industrial Unit short of work at all in 1965 and 1966

Enter:- 1 for Yes 2 for No



27. Please comment on problems of work supply, if any ?

WORK

24. What was the gross income received
by the Unit in the financial year
ended 31. 3. 1966

25. What was the [illegible] in
patients in the [illegible] year
ending 31. 3. 6

27. Please [illegible] on
work

Hospital Code [ ][ ][ ][ ] (1–4)

Card Sequence Number [6] (5)

CONDITIONS

28. Where is the Industrial Unit housed ?

Enter:- 1 for Yes 2 for No

(i) In building specially constructed for this purpose [ ] (6)

(ii) In part of hospital converted for this purpose [ ] (7)

(iii) In the wards where the patients live [ ] (8)

29. Which of the following methods are in use:-

Enter:- 1 for Yes 2 for No

(i) Individual Work [ ] (9)

(ii) Group Work [ ] (10)

(iii) Continuous Belt process [ ] (11)

(iv) Machine Work [ ] (12)

30. How many patients are employed:-

(i) In a supervisory capacity [ ][ ] (13–14)

(ii) In an inspecting capacity [ ][ ] (15–16)

31. Does the Industrial Unit have the following items:-

Enter:- 1 for Yes 2 for No

(i) Music while you work [ ] (17)

(ii) Industrial seating [ ] (18)

Hosp[illegible]

Serial [illegible]

CONDITIONS

[illegible]. **Where is the Industrial Unit housed?**

Enter: 1 **for Yes** 2 for No

(i) In **building** specially constructed for the [illegible]

(ii) In **part of** hospital [illegible]

(iii) In the wards [illegible]

29. **Which of the following** [illegible]

Enter: 1 for Yes [illegible]

(i) Individual Work

(ii) Group Work

(iii) Continuous Belt produc[illegible]

(iv) Machine Work

30. **How many patients are em**[illegible]

(i) In a **supervisory** [illegible]y

(ii) In an [illegible] capacity

31. [illegible] Unit ha[illegible] following [illegible]

[illegible] 1 for Yes 2 [illegible]o

[illegible]

CONDITIONS Cont'd

31. Cont'd.

(iii) Industrial Lighting [ ] 19

(iv) Time clock [ ] 20

(v) Time sheets [ ] 21

(vi) Canteen [ ] 22

(vii) Vending Machine [ ] 23

32. Are the patients paid:-

Enter:- 1 for Yes 2 for No

(i) By the ward staff [ ] 24

(ii) By the Industrial Unit Staff [ ] 25

(iii) By the Finance Office Staff [ ] 26

33. Do the patients receive their pay:-

Enter:- 1 for Yes 2 for No

(i) In wage packets [ ] 27

(ii) As loose change [ ] 28

34. Please enter the number of the following power driven machines or equipment available:

(i) Engineering (Lathes, drills, presses, etc.) [ ][ ] 29 30

(ii) Woodworking (saws, etc.) [ ][ ] 31 32

(iii) Welding [ ][ ] 33 34

CONDITIONS

Commercial Lighting

(v) Time clock

(vi) Canteen

(vii) Vending Machine

32. Are the patients [illegible]

Enter- [illegible]

(i) By the [illegible]

(ii) By the [illegible]

(iii) By the [illegible]

33. Do the patients receive [illegible]

Enter- [illegible]

(i) In wage packets

(ii) As loose change

Please enter the number of the [illegible]

(i) Engineering (Lathes, drills

(ii) Woodworking (saws, etc.)

CONDITIONS Cont'd

34. Cont'd.

(iv) Sewing etc. [ ][ ] 35 36

(v) Packaging [ ][ ] 37 38

(vi) Other [ ][ ] 39 40

35. Was the machinery:-

1. Bought [ ] 41

2. Donated [ ] 42

3. Installed by Contracting Firms [ ] 43

4. Hired [ ] 44

Enter:- 1 for Yes 2 for No

36. Does the Industrial Unit have:-

1. Its own transport

2. Use of hospital transport [ ] 45

3. No transport

Enter 1, 2 or 3

37. Does the Industrial Unit have:-

1. Separate storage space [ ] 46

2. Adequate storage space [ ] 47

Enter:- 1 for Yes 2 for No

CONFIDENTIAL

34. Cont'd.

(iv) Sewing etc.

(v) Packaging

(vi) Other

35. Was the ma[illegible]

1. Bought

2. Donated

3. [illegible]

4. Hired

Enter [illegible]

36. Does the industrial [illegible]

1. Its own transport

2. Use of [illegible] transport

3. No transport

Enter 1, 2 or 3

37. Does the industrial unit have

1. Separate storage space

2. Adequate storage space

Enter:- 1 for Yes 2 for No

Hospital Code [ ][ ][ ][ ] (1–4)

Card Sequence Number [7] (5)

POLICY AND COMMENTS

38. Please describe the system of referring patients to the Industrial Unit.

39. Please describe the system of assessing patient's work and progress in the Industrial Unit.

    Who makes the assessment ?

40. What is your policy regarding patients who do not respond to the Industrial therapy ?

41. Has there been any reduction in the use of drugs for patients working in the Industrial Unit in comparison with those not so employed.

    Enter:- 1 for Yes 2 for No [ ] (6)

42. If the information required in Question 41 is not available, would you be prepared to co-operate in a six months trial to see if there is any significant reduction in the use of drugs for patients in the Industrial Unit ?

    Enter:- 1 for Yes 2 for No [ ] (7)

43. Has your Unit any contact or co-ordination with sheltered workshops or training centres administered by a local authority

    Enter:- 1 for Yes 2 for No [ ] (8)

44. Please state to whom the Manager of the Industrial Unit is responsible.

… Hospital …

… Care Scheme

POLICY AND …

Please describe the system of refe… to the Industrial Unit.

Please describe the system of asse… work and progress in the Industrial Unit.

Who makes the assessment ?

What is your policy regarding pati… respond to the industrial therapy ?

41. Has there been any reduction in the use … for patients working in the Industrial … comparison with those not so employed ?

Enter:- 1 for Yes 2 for No

42. If the information required in Question … available, would you be prepared to … in a six months trial to see if there is … significant reduction in the use of drugs for patients in the Industrial Unit ?

Enter:- 1 for Yes 2 for No

Has your Unit any contact or co-ordination with sheltered workshops or training centres administered by a local authority

Enter:- 1 for Yes 2 for No

… the Manager of the Industrial …

POLICY AND COMMENTS Cont'd

45. Is a special Committee concerned with the Industrial Unit ?

Enter:- 1 for Yes 2 for No ☐ 9

46. If answer to Question 45 is yes, do any members come from open industry ?

Enter:- 1 for Yes 2 for No ☐ 10

47. What are the aims of your Industrial Unit ?

48. Please give comments on the therapeutic value of industrial work concerning long stay and short stay patients.

Patients in the Hospital who worked in the Industrial Therapy Unit during the week ending 8th April, 1967.

Patient's Name or Number	Sex	Date of Birth	Date Admitted	Diagnosis	Hours worked that week	Pay that week	Type of work (including office work)

N. B. Schizophrenia
Depression (all types)
Neurosis (excluding depression)
Subnormality and Other.

Patients who left the Industrial Unit in 1966.

Patient's Name or Number	Sex	Date of Birth	Date Admitted to Hospital	Diagnosis

N. B. Schizophrenia
Depression (all types)
Neurosis (excluding depression)
Subnormality and Other.

Patients in the [illegible]
during the week [illegible]

Patient's Name or Number	[illegible]

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