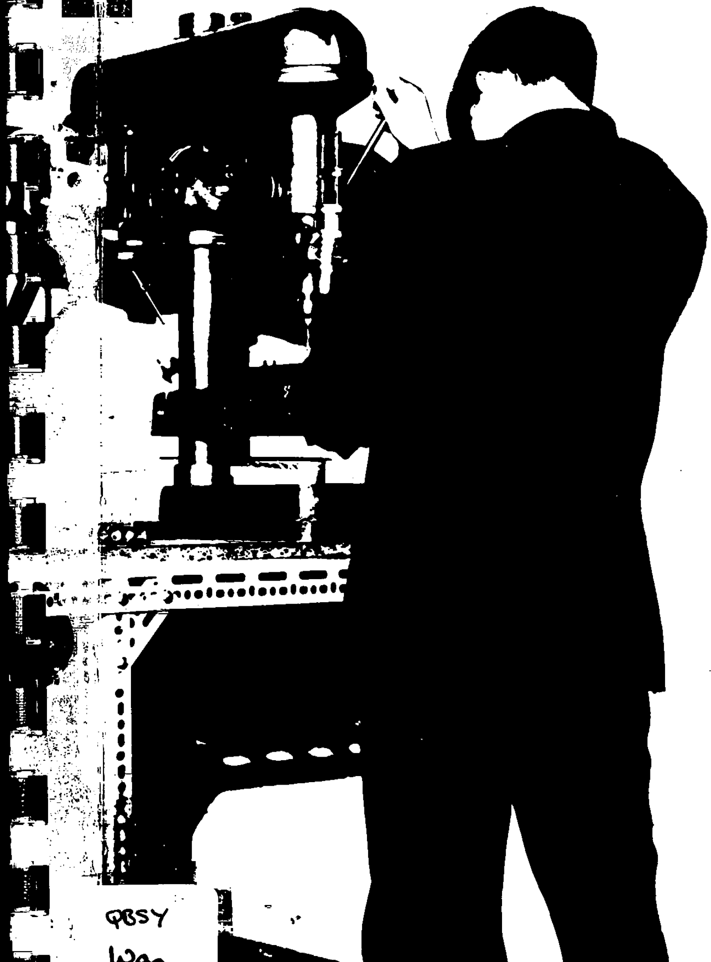
Industrial Therapy in Psychiatric Hospitals

A King's Fund Report Supplement



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INDUSTRIAL THERAPY IN PSYCHIATRIC HOSPITALS

SUPPLEMENT ON PATIENT DATA

An analysis of data relating
to patients in industrial
units and a comparison with
some Ministry of Health
statistics

by Nancy Wansbrough MA
Agnes Miles BSc PhD

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The Steering Committee and authors of the report wish to express their warmest thanks to the staffs of the hospitals who provided the information on which it is based. The ready response given to this extra demand on their time and goodwill was indispensable in ensuring the validity of the findings.

November 1969

Note: The term 'Ministry of Health' is used in this report for what is now the Department of Health and Social Security since that was its title at the time of collecting the data.

FOREWORD

This report is a valuable sequel to the King's Fund's Survey of Industrial Therapy in Psychiatric Hospitals. It supplements the previous report by describing some of the characteristics of patients attending the industrial units obtained firstly from a census of those at work in the units during one week; and secondly, by an analysis of those who left the units during one year. Both sorts of data are needed in order to evaluate adequately the operation and effects of industrial units (or any other new psychiatric facility): Mrs Wansbrough and Dr Miles have therefore planned a project that will serve as a guide to further research or the assessment of new services within the hospital.

The information they were able to obtain on the patients was necessarily limited by the scale of a project that aimed to survey all industrial units in England and Wales; and the staff available and quality of the records varied from unit to unit making it impossible to obtain data from all those collaborating in the initial survey, in which 74 hospitals recorded, among other facts, the aims and policies of their units; their staffing and organisation; their methods of payment and work undertaken. However, over 70% of these hospitals were still able to undertake the more arduous task of completing a census of patients, and 50% provided data on patients who had left the unit during the previous year. As far as can be judged this substantial sample was not biased towards the better units, to the larger hospitals or geographically. Incidentally, on the data available in the two reports it seems as if it should be possible to test further the representativeness of the patient sample: if, for example, Table III of the first report and Table II of the second are compared it can be seen that the ratio of men to women attending all 74 industrial units and those in the present sample is nearly identical.

The questions about patients who attend an Industrial Therapy Unit that need to be answered are what effect does attendance have on their future capacity to obtain employment outside the hospital; does it expedite discharge from hospital and does it affect their clinical outcome? If so, to what characteristics of the patients do these effects relate? These broad questions can be broken down to more specific ones: (1) whether, for example, the introduction of Industrial Therapy Units reduces the incidence of institutionalism by retraining the long-stay patient in realistic working habits; by diminishing the apathy, withdrawal and stereotyped behaviour so typical of the institutionalised; and by maintaining working habits in medium-stay patients who are likely to remain in hospital for some or many months; (2) can long-stay patients be trained up to industrial working standards and be discharged to open or sheltered employment; and if so, what are the characteristics of the patients and of the industrial units that relate to such an outcome; (3) is industrial therapy positively therapeutic in

terms of improving outcome by relieving clinical symptoms and improving social behaviour - i. e. whether it is a useful adjunct to milieu therapy.

The report begins to answer some of these questions by describing the age, sex, duration of stay and broad diagnostic categories of patients attending the units during one week and then comparing the patients on these characteristics with those who leave the unit, and by similarly relating some features of the unit, such as method of payment, length of stay in the unit and hours worked, to discharge. It has also been possible to make the further comparison with the Department of Health and Social Security's census of resident patients and with other annual statistics the Department publishes on age, sex and duration of stay of patients in mental hospitals.

As the aims of the different units included in the survey are varied it is only possible at this stage to infer some general trends. The findings suggest that many units are catering for long-stay patients, either as a means of preventing institutionalism or as part of a programme of milieu and social therapy. Nevertheless, there are some indications that the more positive aims of maintaining or retraining in working habits with a view to the patient becoming capable of competing for work in industry are also operating. The statistics on the age, sex, length of stay and diagnosis of patients in the units indicate that there is a high proportion of elderly and long-stay patients in the units; but compared with the last census of patients resident in the mental hospitals, the elderly are under-represented and patients with a shorter duration of stay in hospital are over-represented in the units; the mean duration of stay of residents is considerably higher (about 11 years) than the patients in the industrial units. This suggests that there is also a general trend to occupationally rehabilitate the younger and shorter-stay patients. Similarly, when diagnosis is considered there are more schizophrenics in the units than in the hospitals, but their mean length of stay in hospital is considerably less than that of all hospital schizophrenics. There may therefore well be an overall policy of concentrating particularly on those patients in whom the prospect of obtaining a job outside hospital is best. These observations, however, are only tentatively mentioned here as the last census of resident patients was in 1963, but this is now being updated and might well provide an opportunity to evaluate further the valuable data in this report.

A census undertaken at a specific point in time will, of course, also tend to indicate a high proportion of long-stay patients at the expense of short-stay ones (e. g. depressives) that have a relatively high turnover.

Whereas the first part of the report described the patients attending the units and will therefore reflect their various policies, the second part gives some important pointers to the patients' outcome as well.

Proportionately more depressives were found to be discharged from the units and hospital than were the schizophrenics. When these figures are compared with the Ministry of Health's in-patients statistics in 1966 (Statistical Report No. 4), about twice as many schizophrenics are seen to be discharged from the industrial units as are discharged from all mental hospitals; similarly, about half as many industrial unit patients with depression are discharged as are hospital ones, which implies again that schizophrenics are preferentially selected for treatment in the industrial units, and those that are referred do better than those who are not. Other comparisons also indicate that a higher proportion of shorter stay patients are passing through units than through the hospitals.

The effectiveness of units in rehabilitating and training patients will relate to factors such as payment, type and variety of work, hours of work, opportunities for acquiring special skills and so on. The interaction between these characteristics of the units, the clinical characteristics of the patients and outcome form an important part of the analysis of their operation and effectiveness. What level and method of payment produces the best results, for example? In evaluative studies there has been no attempt to relate outcome to costs (in terms of personnel as well as finance) and this can be an important practical consideration. Though this report was not designed specifically to answer these types of questions Mrs Wansbrough and Dr Miles have provided a number of interesting tables and pertinent comments relating to them, in the light of which current policies regarding payment of patients are manifestly quite inappropriate if industrial therapy is to develop its full potentiality. The type of work they have shown to be predominantly undertaken in the units must also be limiting what might be achieved: for the most part it is monotonous and repetitive. The report makes it very evident that there is a need for more research into both the type of work that is most suited to different sorts of patients, that which is best for training purposes and that which is therapeutic. In this connection the report comments interestingly on another area of enquiry: the way in which progress in training may be promoted (and assessed) in terms of increasing speed and complexity of work. The report makes clear that at present the work in units is surprisingly lacking in variety and few attempts appear to have been made to encourage and inculcate new skills or to relate work done to the occupational opportunities available in the locality. However, the desirability of doing this depends on whether an industrial therapy unit is intended primarily to engender and improve working habits in patients who have lost them, or to prepare patients for jobs appropriate to their skills and aptitudes. Maybe training in such industrial skills is more economically undertaken on discharge by other organisations such as the Industrial Rehabilitation Units. Nevertheless, there must be a level of monotony which the patient, who had previously been a skilled worker, is unable to tolerate - the possible lines of future enquiry the report suggests are numerous.

This report is a very useful contribution to the description and evaluation of one aspect of our psychiatric services, and the need for research of this kind is pressing. Mrs Wansbrough's and Dr Miles's methods and their results will assist and encourage others undertaking similar studies.

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INTRODUCTION

The analyses contained in this short paper form an integral part of the research survey on Industrial Therapy commissioned by King Edward's Hospital Fund in 1966, the main results of which were published in September 1968.*

From the outset it was recognised that the collection of personal data concerning the patients working in the units would add to the value of the survey. Accordingly, when the questionnaires were sent out in March 1967, hospitals were asked to give particulars relating to two categories of patient: first, those at work in their industrial unit for the week ending 8th April 1967; and secondly, those who had left the unit in the course of the year 1966 (see Main Report, pp. 12 and 97).

In the event this task proved to be beyond the capacity of all the hospitals which had participated in the survey, despite the remarkable good will displayed by them towards the research in general: either the staff or the records were lacking, or both. It was in only a few cases that, despite the guarantee of research anonymity, psychiatrists forbade the disclosure of particulars on the ground that these were confidential. The Main Report was based on the answers from 74 hospitals (there is a total of 100 hospitals with industrial units); the results analysed below were provided by 54 out of these 74 hospitals in the case of the Patients at Work 1967 list, and by 37 out of the 74 for the Left in 1966 patients. They relate to 7,232 Patients at Work in 1967 and 2,399 patients Left in 1966. In nearly every table a large group of unknowns for that particular characteristic detract from its value. Also discrepancies in absolute totals, though too small to bear upon the results, create an untidy impression. Despite these shortcomings, it was considered proper to proceed to the analysis of these data which, originally scheduled for inclusion in the Main Report, could not be programmed, computed, tabulated and written up in time for this, but it must be emphasised that they only really make sense when studied in conjunction with it.

The Sample

1 Patients at Work 1967. The sample of 54 hospitals is therefore a self-selected one, but numerically it is a large one (73%). It was examined for bias. For instance, the expectation was that those units which provided the information would have been those which we have come to regard as the 'best' units. In the event this was not always so. It appeared to be more a case of a hospital having somebody available

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* Industrial Therapy in Psychiatric Hospitals
London King Edward's Hospital Fund for London 1968
In the remainder of the present book the above is called the 'Main Report'.

to do the job at the time. Even in hospitals where there was good record keeping there was not invariably somebody to be spared to go through the records.

The units were also inspected for bias from the point of view of geographical distribution and of size of hospital. It was found that each hospital region was represented in the sample, two regions achieved 100% representation because each participating hospital provided Patients at Work lists. On the other hand, the North East Metropolitan, Oxford and East Anglian regions were each represented by only one hospital. Otherwise the Patients at Work lists were pretty evenly distributed throughout the regions.

The size of the hospitals which did provide Patients at Work lists was compared with the size of those not providing such lists, since it might be expected that only the smallest hospitals would be able to comply with the request. This expectation also was not fulfilled, as may be seen from Table I below. Columns 1, 2 and 3 show that the majority of hospitals in all size groups up to 1900 provided lists, and moreover, all three hospitals in the 2100-2299 size group complied also.

2 Patients Left Unit in 1966. This sample of 37 hospitals, also of course self-selected, is smaller and represents exactly 50% of the participating hospitals. These records are less accessible, reaching back into the past, and in fact a small number of units were too new to have them.

This sample was examined in the same manner as the previous one. Looking at it from our own knowledge of the units, we see that some of the 'best' units have again been unable to collaborate. Geographically, each region is again represented, four regions by only one hospital and, at the other end of the scale, four regions by four hospitals, the highest number, the remaining regions having two or three hospitals represented. Again, inspection of the Size of Hospital table, columns 4 and 5, discloses a remarkably even spread among size groups of hospitals able, and unable, to provide Patients Left lists.

Table I

Size of Hospital	Hospitals Able to Provide Patients at Work List	Hospitals Unable to Provide Patients at Work List	Hospitals Able to Provide Patients Who Left Unit in 1966 List	Hospitals Unable to Provide Patients Who Left Unit in 1966 List
100 - 299	2	1	0	3
300 - 499	6	2	4	4
500 - 699	5	2	3	4
700 - 899	9(1)*	5	7	6
900 - 1099	8(1)*	5	6	6
1100 - 1299	10	1	5	6
1300 - 1499	2	1	1	2
1500 - 1699	3	2	3	2
1700 - 1899	5	2	5	2
1900 - 2099	0	1	0	1
2100 - 2299	3	0	3	0
2300 - 2499	1(1)*	1	0	1
	51 + 2	23	37	37
	74		74	

* including 3 additional hospitals which provided Patients at Work lists although unable to participate in the Main Survey.

It was only when the report on this analysis had been submitted that a new factor emerged. This was the publication of the Ministry of Health's in-patient statistics for the years 1964, 1965 and 1966. Evidently these offered possibilities of comparison which should enhance the value of our own figures. The report was therefore held up to insert certain comparisons in Part II.

At the same time the opportunity was taken to refer to the Census of Patients in Psychiatric Beds which took place on December 31, 1963, the report on which was published by Eileen Brooke, MSc DPA, Statistician at the Ministry, in 1967. These census figures are therefore over three years earlier than ours against which they are set in Part I below: but they are the latest available.

1 PATIENTS AT WORK 1967

Hospitals sent in data regarding 7,232 patients working in the industrial units at the time of the inquiry. Of this number 4,255 or 58.7% were male and 2,977 or 41.1% were female patients. (Of a small percentage of patients the hospitals omitted to show whether male or female). The fact that more male than female patients are employed in the industrial units could be taken as indicating that many hospitals' conception of their function is that of rehabilitation: that the hospital authorities feel that women patients can leave the hospital even if they are not employable outside as they can return to their families, while men patients can only be discharged if they can earn their living, at least to a limited extent (see Main Report, p. 16, para 22).

One consequence of this distribution of the sexes in the units is that there is much need for the type of work which is suitable for men. In most units the patients are engaged on simple assembly work (e.g. making Christmas crackers, paper bags, boxes, etc. - this will be discussed later) which is more suitable for women, indeed in open industry it is mostly women who do these jobs. The men in the units need more 'male jobs', where strength and energy are required and which are generally associated with 'manliness'.

Table II

Age Groups of Patients in the Industrial Units

Age	Male		Female	
	No.	%	No.	%
- 15	13	0	4	0
- 20	45	1	27	1
- 25	115	3	69	2
- 35	329	8	161	5
- 45	674	16	360	12
- 55	765	18	447	15
- 65	627	15	520	17
65+	369	9	453	15
Unknown Age	1,318	31	936	31
Total	4,255	100	2,977	100

Table II shows that the majority of patients in the units were in the higher age-groups; in fact 64% of patients whose ages were known were found to be over 45, and 76.5% over 40. In this respect, as between the sexes, there were rather more female patients among the over

sixty-fives. This finding conforms to the overall pattern in psychiatric hospitals. There were very few regional variations. In every region the majority of patients in the industrial units were in the over 40 age groups. In a few regions (5, 8 and 13) the largest single age group for male patients was not the 51 - 65 as usual but the 41 - 50 (alternative age group table not included here but available).

Why are more older rather than younger patients placed in the industrial units? The reason is probably that these units are established mostly for long-term patients, especially those who have already been in the hospitals for many years. These patients are typically over 45 years of age.

This age distribution has several implications. Firstly, the large majority of the male and single female patients had occupations before they were admitted to the hospital. Any work the industrial unit offers will, therefore, be seen by patients in the light of their past experiences. It is quite reasonable to suppose that a patient who comes from a middle-class or skilled working class occupation would regard unskilled and simple industrial unit jobs differently from patients who worked on similar jobs before. Secondly, when patients leave the industrial units they are likely to be middle aged or elderly and instead of having a long working life ahead of them, have only a limited number of years before retirement age. This fact will influence their chances of employment, their ambitions and expectations.

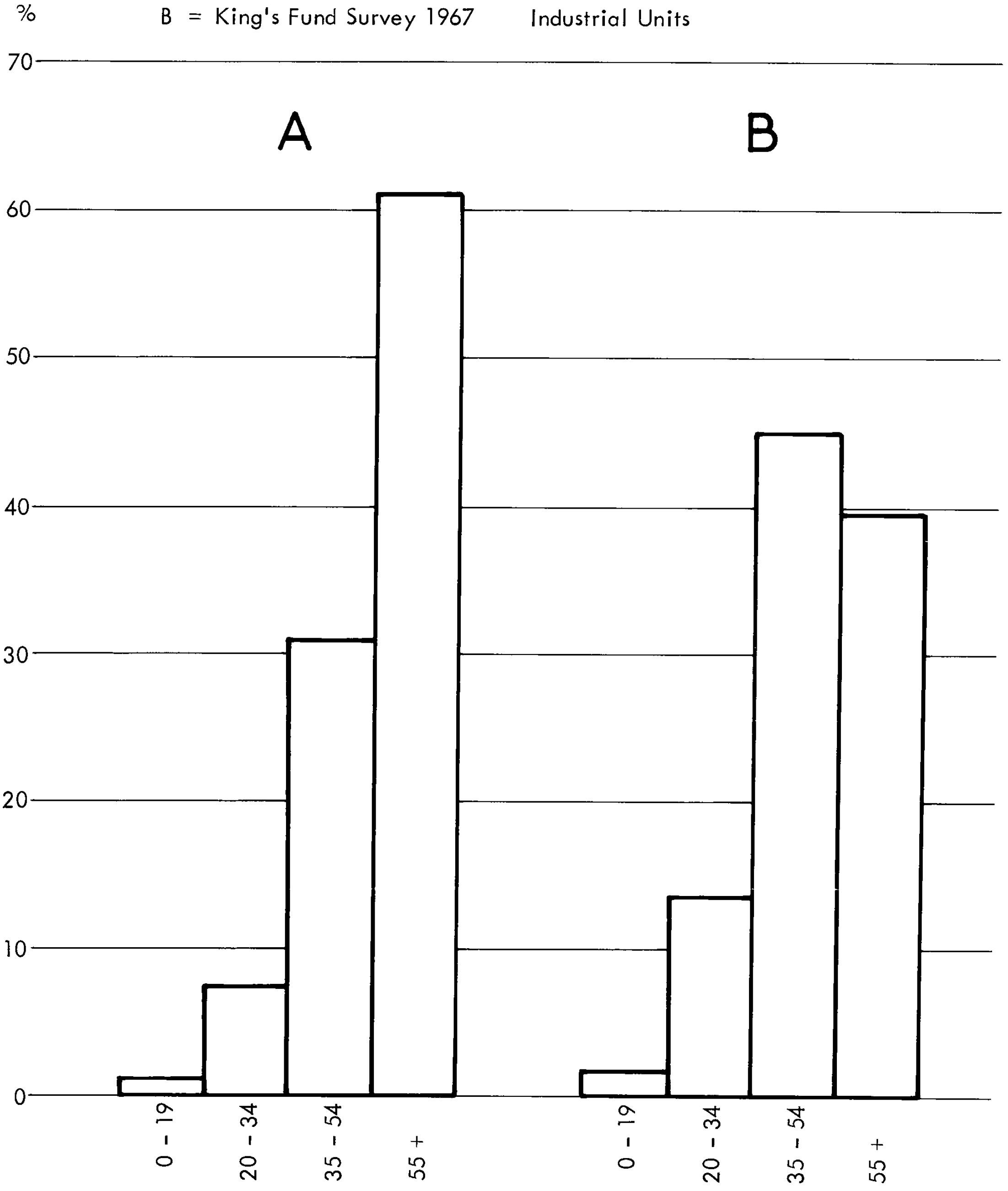
What has been written above refers to the King's Fund Survey figures alone. But it is interesting to look at these in comparison with the figures of the 1963 Census, as shown in Diagram I. A very different picture is to be seen. In each of the three age groups except the highest, proportionally more patients are employed in the units than the proportion for that age group of total residents would warrant. In other words, the proportion of elderly patients employed in the units may be high; but the proportion of elderly patients resident in psychiatric hospitals is higher.

Figure B in this table also illustrates that the 35 - 54 age group at 45% comfortably exceeds the 55 and over age group at 39.5% of the total industrial unit population. However, when the sexes are separated as in Table II it may be seen that this is true for male patients, but that for female patients the two highest age groups predominate.

DIAGRAM I

AGE DISTRIBUTION OF PATIENTS IN PSYCHIATRIC HOSPITALS COMPARED WITH THAT OF PATIENTS IN INDUSTRIAL UNITS

A = Census of 1963 p 24 Psychiatric Hospitals
B = King's Fund Survey 1967 Industrial Units



The figures from which this illustration is composed are taken, in the case of the census, from a table on page 24. The King's Fund Survey figures are derived from Table II above.

Table III

Length of stay of Industrial Unit Patients in the Hospitals

Mean Figures

Hospital Regions	Male		Female
1	12.1	years	6.2
2	11.3		9.9
3	8.9		10.0
4	7.9		6.5
5	7.5		8.1
6	-		-
7	11.8		11.5
8	6.3		6.0
9	10.5		7.2
10	11.1		7.1
11	9.9		8.5
12	11.8		10.2
13	10.4		7.1
14	12.0		8.5
15	7.2		7.8
All Regions	9.2		7.6

Table III shows by region the mean length of stay in the hospitals of patients who work in the industrial units. It confirms the finding of the previously published Report that industrial units have been established primarily for long-stay patients and that it is only recent practice to admit short-stay patients to the units. The lowest mean figure on this table is 6.2 years and the highest is over 12 years. An examination of the actual figures showed that these patients typically stayed in the hospitals for over five years.

An interesting fact concerning the sex-differences in these figures is that in eleven out of fifteen regions the male patients had stayed in hospital longer than the female patients.

Table IV

Known Length of Stay in Hospital of Patients in the Industrial Units

	Male		Female	
	No.	%	No.	%
Under 2 years	617	24	486	27
2 - 5 years	511	20	386	22
5 - 10 years	422	16	344	19
10 - 20 years	609	24	347	19
Over 20 years	402	16	237	13
Total	2, 561	100	1, 800	100

Table IV shows the known length of stay in hospital of patients working in the industrial units. Unfortunately this information was not provided in respect of some 40% of our sample comprising 1, 694 male patients and 1, 177 female patients, which accounts for the totals being that much smaller.

Table IV figures gain in interest when considered in conjunction with the 1963 census figures set out in Table V below. Together they show that the short-stay population of under two years hospitalization is under-represented in the industrial units, but not by so much as might have been supposed (Males: Census 29%, Units 24%, and Females: Census 32%, Units 27%). For the three middle length of stay groups covering 2 - 20 years in hospital the reverse is the case and proportionately more patients, both male and female, are employed in the units. Understandably, the over 20 years length of stay group is again under-represented in the units, for this group will include many elderly and bed-ridden patients.

Table V

1963 Census. Length of Stay in Hospital

	Male		Female	
	No.	%	No.	%
Under 2 years	16, 105	29	23, 888	32
2 - 5 years	6, 448	12	9, 419	13
5 - 10 years	6, 183	11	8, 101	11
10 - 20 years	11, 238	20	12, 326	17
Over 20 years	15, 412	28	19, 557	27
	55, 386	100	73, 291	100

Table VI

Prevalence in the industrial units of short-stay patients (under 2 years in hospital) by hospital region

Region	Male		Female	
	Total No. of Short-Stay Patients	% of all Industrial Unit Patients	Total No. of Short-Stay Patients	% of all Industrial Unit Patients
1	23	17	13	10
2	23	11	34	19
3	65	16	41	12
4	6	17	18	24
5	38	10	50	15
6	0	0	0	0
7	99	22	89	29
8	23	8	27	10
9	9	15	17	27
10	28	14	12	14
11	45	11	25	13
12	70	14	65	22
13	51	16	17	23
14	43	15	35	18
15	94	21	43	11

In the Main Report, attention was drawn (on p. 19) to the fact that in 1965 and 1966 the new entrants to the industrial units who were short-stay patients outnumbered those who were long-stay patients. The above table elaborates this theme by pointing to how far this process has gone in each region. The single hospital in Region 6, the North East Metropolitan, stands out as having no short-stay patients at all. Region 7, South East Metropolitan, by contrast, employs the highest percentage. In ten regions the percentage of female short-stay patients employed is higher than the percentage of males.

However, it must be remembered with regard to this and other regional tables that some regions are represented in this part of the research by very few hospitals and greater importance should be attached to overall figures.

Table VII

Diagnoses of Patients Working in the Industrial Units

Diagnosis	Male No.	Male %	Female No.	Female %
Schizophrenia	2,773	65.3	1,725	58.0
Depression	466	10.9	586	19.7
Neurosis	51	1.1	79	2.6
Other	833	19.6	522	17.5
Unknown	133	3.1	65	2.2
Total	4,256	100	2,977	100

The largest single diagnostic category in Table VII is schizophrenia. It is somewhat more prominent in male than in female patients, whereas the second largest category, depression, is more prominent in female patients. A very small proportion of patients in both sexes fall into the third category, neurosis. This is the pattern of diagnostic categories in all hospital regions.

Table VIII

Diagnostic Groups. 1963 Census.

Diagnosis	Male and Female No.	%
Schizophrenia	61,978	46.6
Depression *	53,061	40.0
Neurosis	2,639	2.0
Other	15,217	11.4
Total	132,895	100.0

* This group includes the category 'Reactive Depression' (numbering 1,819) which in the Census coding is classified with the Neuroses. The change has been made here to enable comparison with the Fund's diagnostic classification which expressly excluded all depressions from the neurosis category.

When Table VII is compared with the Census figures in Table VIII it can be seen not only that schizophrenics are absolutely the most numerous category, but that relative to the other categories in the whole mental hospital in-patient population, they are also markedly over-represented in the units. Correspondingly the depression category is under-represented. The 'other' category, embracing sub-normality, alcoholism and the various disorders of behaviour and character is, like schizophrenia, over-represented.

What does this mean? Does it mean simply that schizophrenics are more likely to be long-stay, and to find their way into the hospital's unit? And depressives short-stay, so short that they have not time to go to the units? Or do the figures reflect calculated decisions on the part of psychiatrists that industrial work is more suitable for schizophrenics than for depressives? If so, what is the basis for such belief? Certainly a good deal of research on industrial work in relation to schizophrenics has already been conducted. So far as we are aware no corresponding studies have concentrated on the value of industrial therapy for depressives.

Further light on this question may be thrown by a study of Diagram 2 setting out side by side, for three main length of stay groups, the percentage distribution of patients by diagnosis. The Census figures refer to males and females taken together. The King's Fund Survey treats the sexes separately, but it will be observed that the patterns for each sex are very similar.

It will be seen from the three figures that the industrial units cater specially for the 2 - 10 years hospitalization group, who are over-represented in the units for all four diagnoses and both sexes.

1963 CENSUS FIGURES FROM TABLE 19

PERCENTAGE DISTRIBUTION OF MALE AND FEMALE PATIENTS BY DIAGNOSIS

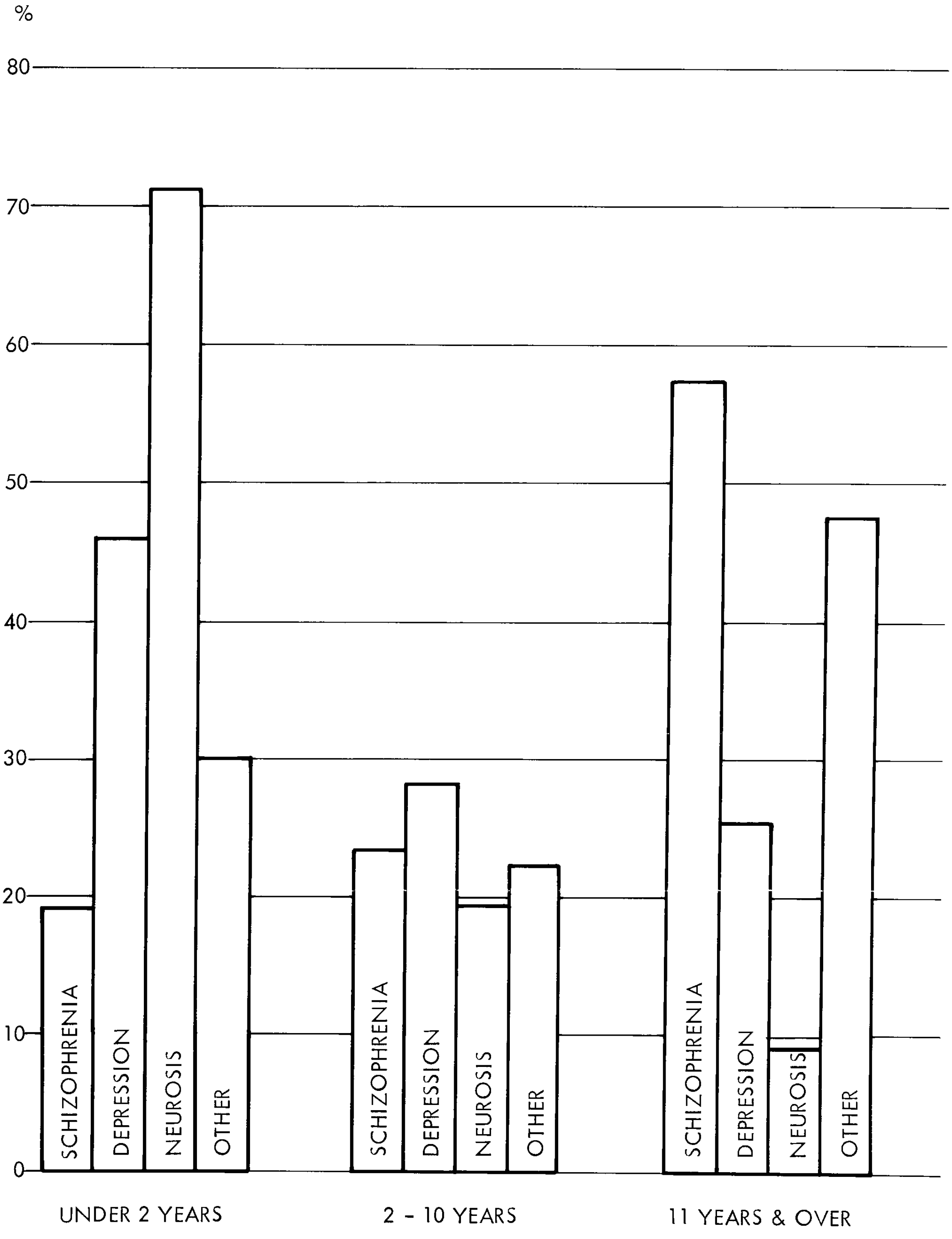


DIAGRAM 2 Fig B

1967 INDUSTRIAL UNITS KNOWN LENGTH OF STAY

PERCENTAGE DISTRIBUTION OF MALE PATIENTS BY DIAGNOSIS

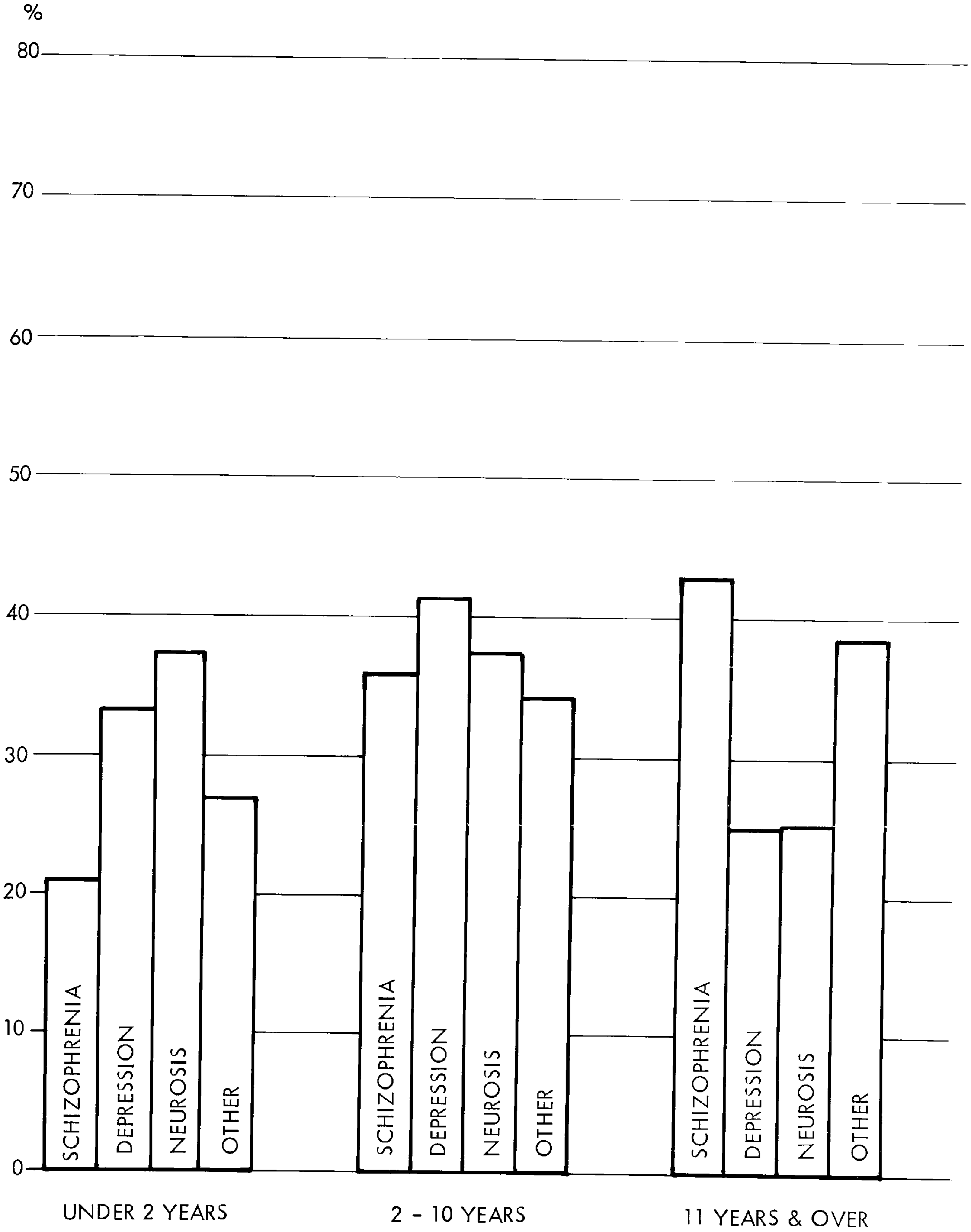


DIAGRAM 2 Fig C

1967 INDUSTRIAL UNITS KNOWN LENGTH OF STAY

PERCENTAGE DISTRIBUTION OF FEMALE PATIENTS BY DIAGNOSIS

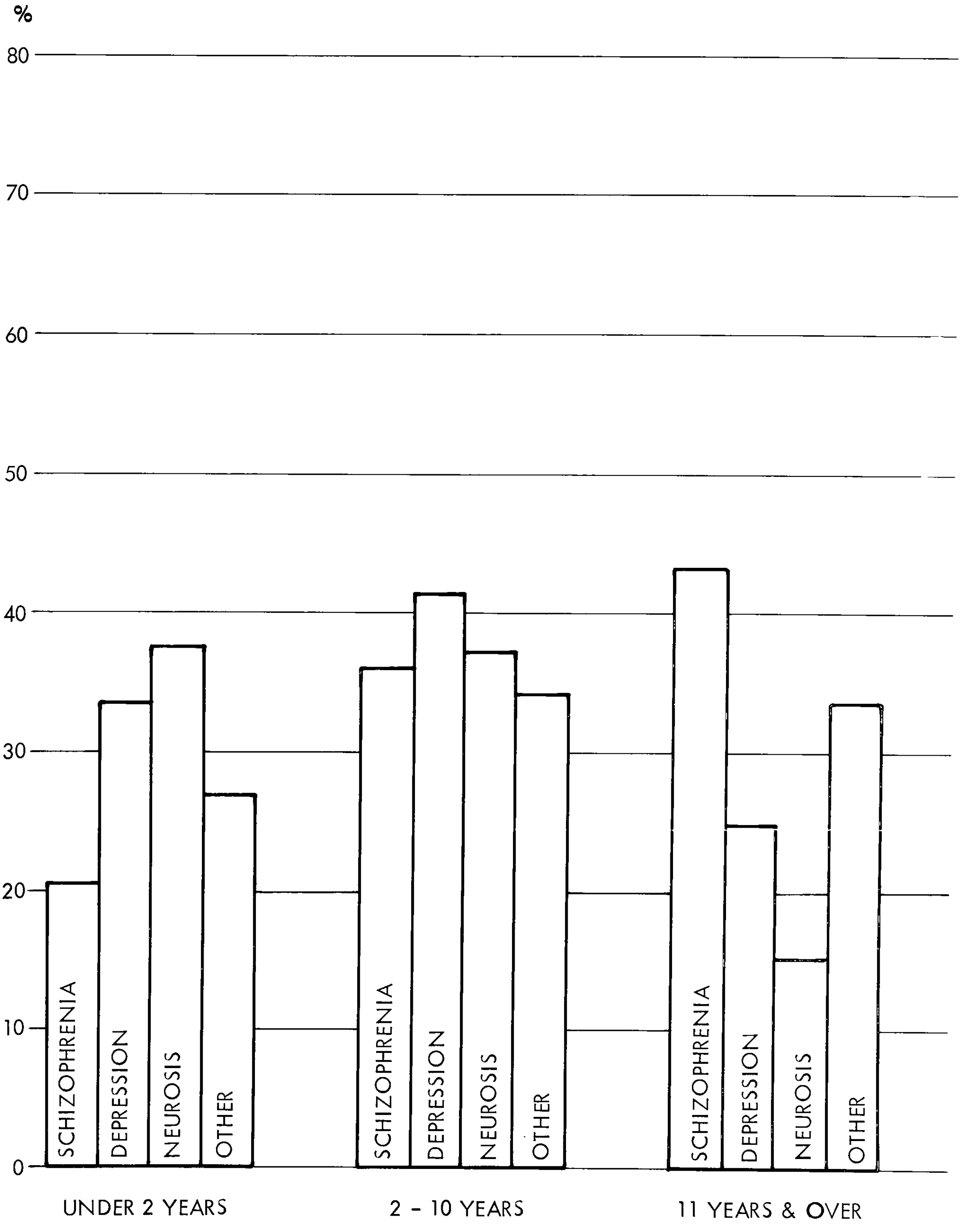


Table IX

Diagnosis and Age of Patients Working in the Industrial Units

(Percentage Figures)

Patient Age Group	Schizophrenia		Depression		Neurosis		Other		Unknown		Total
	M	F	M	F	M	F	M	F	M	F	
- 15	62	100	8	0	8	0	23	0	0	0	100
- 20	56	41	2	7	2	15	40	30	0	7	100
- 25	65	64	6	9	3	1	23	25	3	1	100
- 35	74	68	6	10	1	2	17	20	2	0	100
- 45	78	67	5	13	1	4	15	15	1	1	100
- 55	70	61	9	18	1	3	18	17	1	2	100
- 65	54	53	18	25	2	3	24	18	2	1	100
65+	40	39	29	39	1	3	29	21	1	1	100
Unknown	66	65	8	14	1	2	18	15	7	5	100

When the diagnostic categories are examined separately in each age group an interesting pattern is found regarding schizophrenic patients. Schizophrenia is more prominent in the middle age groups than in the younger and older ones. The proportion of patients suffering from depression is larger in the older age groups than in the younger and middle ones. In the diagnostic category of neurosis the only relatively high figure is the proportion of female patients of under 20 years.

Table X

Payment to Patients in the Industrial Units

Hospital Regions	Mean pay per week Male Patients shillings	 Female Patients shillings
1	7.5	8.9
2	11.8	10.9
3	16.0	14.1
4	17.1	10.9
5	11.7	9.0
6	17.8	13.3
7	14.6	11.1

- continued -

Table X

Payment to Patients in the Industrial Units
(continued)

Hospital Regions	Mean pay per week Male Patients shillings	 Female Patients shillings
8	15.7	15.6
9	14.0	10.6
10	20.0	17.5
11	11.5	9.8
12	11.4	9.0
13	15.0	9.5
14	9.7	11.3
15	10.8	8.2
All Regions	12.9	11.0

Table X shows the mean amounts of weekly earnings of patients working in the units, by hospital regions. The most interesting feature of the table is that it shows that patients in psychiatric hospitals receive very low weekly money, even in the industrial units. The maximum a patient is allowed to earn under present regulations is 39/11d p.w. but the mean amount in no case exceeds £1 and can be as low as 7/6d. The mean earning of all patients (male and female) in all regions is 11. 9½d per week. These figures of course include high and low individual earnings; however, a study of the actual payments made to the patients showed that the means are not comprised of very high and very low figures, but rather that the majority of payments are around the means.

Another interesting feature of the table is that female patients, in general, receive less money than male patients. This is so in 12 out of 15 hospital regions and can be regarded as a fairly consistent pattern. (The exceptions are regions 1 and 14, where female patients receive more money, and region 8 where there is hardly any difference between amounts paid to male and female patients.) There is no obvious reason: female patients have not in the past at any time been demonstrated to be worse workers than the male patients. On the contrary, as most jobs in the industrial units are more suitable for them, it can be argued that they are better fitted to their work and are happier doing it than are the male patients. Nor do female patients have less expenses than male patients: the hospitals provide the necessities of life equally for all patients and pocket money is, presumably, equally welcome to both sexes.

Similarly, in many hospitals there seems no immediately visible

reason for paying the patients so little. The allowed sum, 39/11d p.w. is relatively small and it seems curious that hospital authorities, while trying to use money as work-incentive, reduce this sum. Of course differences between individual good and bad workers have to be observed and some hospitals have developed scoring systems of great complexity and logic, equating 100% capability with normality and a payment of 39/11d and working down the range of ability from there. But the mean amounts could be a great deal higher. (However, in a few hospitals payments are held at a low level in order to keep the total income of a working patient in receipt of social security benefits below the amount of the wage he could hope to earn in open employment, thus retaining the incentive to leave the hospital.)

Explanations of both these features may well be in long custom: it is the tradition to pay male employees more than female employees and very little to patients in general.

Table XI

Mean Number of Hours Worked per week by Patients in the Industrial Units

Hospital Regions	Hours
1	25
2	28.4
3	23.5
4	21.0
5	23.1
6	23.3
7	25.3
8	22.7
9	15.7
10	24.4
11	25.0
12	25.0
13	30.1
14	27.3
15	20.9
All Regions	24.4

Table XI shows the mean number of hours worked per week. The figures include full-time and part-time work. In most hospitals some of the patients work full-time, that is 25 - 30 hours per week and others work part-time, which may be as little as two afternoons per week. The hospital returns show that in all regions, with the exception of region 9, the majority of patients in the industrial units worked

approximately 25 hours per week. The regional variations of mean figures express the varying proportions of part-time workers in the units.

Table XII

Type of Sub-Contract Work carried out by Patients in the Industrial Units

	Type of Work	Number of Patients No.	%
1.	Bench and Assembly Work	4,466	61.7
2.	Metal Assembly	305	4.2
3.	Wiring, Soldering	90	1.2
4.	Skilled Woodwork	11	0.2
5.	Unskilled Woodwork	197	2.7
6.	Sewing-machine Work	52	0.7
7.	Engineering	73	1.0
8.	Other Machine Work	42	0.6
9.	Supervision, Inspection	90	1.2
10.	Clerical and Printing	50	0.7
11.	Labouring, Car-Wash, etc.	71	1.0
12.	Dismantling and Salvaging	154	2.1
13.	Yarn, Rope, etc.	128	1.7
14.	Other	149	2.1
	Unknown	1,364	18.9
	Total	7,242	100

Table XII gives precision to the description of the industrial sub-contract work performed in the units, which is set out on pages 56 - 58 of the Main Report and commented upon in following pages.

It confirms that assembly work forms overwhelmingly the major part of all work done, Type 1 accounting for 75% of known work and including folding, gluing, labelling, stapling, preparing and hand packing paper products, cardboard boxes, plastic bags, toys, games, cosmetics, CSSD packs and similar products;- and Type 2, accounting for a further 5.2% (also of known work), consisting of the assembly of metal and electrical components, probably a little more complex.

Why is assembly so popular? Is it that it is the only work available? And transportable? - being so often synonymous with outwork? On the other hand is it considered the only work suitable for industrial units, and therefore the only work sought after by those in charge? Is it, in fact, the only type of work which an industrially unskilled nurse

or occupational therapist in charge could trust himself to do, let alone his patients? So far as we are aware, no research has been done and there are no findings current in the literature advocating a predominance of assembly work. It will be recalled that some respondents commenting (p. 61) on variety in their work supply found it hard to get enough easy repetitive work, while others found it hard to get enough difficult work.

Pursuing the question of suitability further, it is probably true that few would question its appropriateness as occupation for very deteriorated patients. The question arises when it is considered as part of an on-going rehabilitative process for the less deteriorated. Apart from the social and behavioural benefits of rehabilitation in the milieu of an industrial unit (which of course have value but which we are not discussing here), the question may be asked: How does a patient make progress on this type of work? It is submitted that the answer must be

(1) By doing it faster

(2) By going onto more complex work

The alternative must be stagnation.

Working Faster

It has been remarked that Type 1 work outside hospital is normally done by women, often outworkers. It is also true that in open industry this type of simple repetitive work is usually remunerated on a straight piecework basis: indeed may only be tolerable when tied to a strong financial incentive.

Turning to the units, what do we find? That straight piecework is precluded by the 39/11d limit because it is practically impossible to devise a realistic piece-rate with a £2 earnings ceiling. The alternative financial incentive method, whereby an incentive bonus scheme is used and jumps in earnings are scaled down, involves more paper work, but might be appropriate. In fact very little use of either method is made (see Main Report, p. 35) nor is the £2 limit much stretched in average terms (pp. 15 - 16).

Apart from financial incentive, in few units visited were there output records to be observed, chalked up on slates as in open industry, and acting as incentive as well as record.

What else is done to increase the speed of work? In one unit, one of the most highly industrialised in the country, it is held that it is the atmosphere of general industrial bustle, accentuated by the whir of machinery from the machine shop, that makes for a good tempo. And (as the Ford philosophy used to hold) one does not need too much room: a certain physical proximity helps to produce the bustle. In this unit payments are kept low and are on a time basis.

The question of speed has been considered at length because slowness, the retardation of psycho-motor reflexes, is one of the most damaging characteristics of schizophrenia in relation to working capacity.

Progressing to more complex work

Besides working faster, there is a second way in which a patient may make progress, and that is by advancing to more complex work. But, since over 80% of the known work done in the units is Type 1 and Type 2, the chances are that the only type of work available for him to advance to will be work in these categories. Under 3% of the patients use sewing machines, work with engineering plant or other machinery. Only 3.5% are engaged on woodworking contracts. Table XII shows the small proportions engaged on other work.

Why is more complex and challenging work not provided in the units? One factor may be the absence of skilled supervision in many units.

With regard to Type 12 an interesting point may be noted. It used at one time to be believed that destructive work of this sort was unsuitable for psychiatric patients, and that these would benefit more psychologically by creative work. This view was not expressed to us in the course of visits: rather the opinion was put forward that theoretical considerations of this sort do not enter the mind of a man at work, patient or no.

Table XIIIa

Type of Sub-Contract Work carried out by Male Patients according to their diagnosis

Type of Work	Schizo-phrenia No.	Depres-sion No.	Neurosis No.	Other No.	Unknown No.	Total No.
1	1,474	281	27	468	62	2,312
2	198	10	1	39	12	260
3	56	7	1	18	1	83
4	7	2	0	2	0	11
5	129	22	4	34	1	190
6	6	2	0	3	2	13
7	49	5	2	11	0	67
8	25	4	1	10	0	40
9	30	4	4	8	0	46
10	21	5	0	1	0	27
11	43	1	0	19	0	58
12	82	11	1	26	2	122
13	67	8	0	13	1	89
14	31	1	0	6	7	45
15	279	103	38	175	45	640

Table XIIIb

Type of Sub-Contract Work carried out by Female Patients according to their diagnosis

Type of Work	Schizophrenia No.	Depression No.	Neurosis No.	Other No.	Unknown No.	Total No.
1	1,221	441	57	381	46	2,146
2	23	11	0	7	3	44
3	3	2	0	2	0	7
4	0	0	0	0	0	0
5	5	0	0	2	0	7
6	25	12	2	0	0	39
7	3	1	0	2	0	6
8	2	0	0	0	0	2
9	22	14	3	4	1	44
10	16	3	1	3	0	23
11	12	0	0	1	0	13
12	21	3	0	6	2	32
13	27	6	1	4	0	38
14	69	18	4	13	0	104
15	297	75	11	97	13	493

It was decided to analyse the type of work done with reference to the diagnosis of the patients performing it, to see if any particular type or types of work are associated with any particular diagnoses. But no such pattern is discernible, following an examination of Tables XIIIa and b, together with Table XII already referred to. On the one hand assembly and bench work predominate overwhelmingly: on the other hand schizophrenia, and the absolute figures of the tables illustrate these facts yet again.

It is noteworthy that only 4 female patients suffering from neurosis or depression, out of a total of 665, are engaged on clerical or printing work; and only 17 on supervision and inspection. It might have been supposed that these categories of work would have been suitable for many patients suffering from these illnesses.

2 PATIENTS DISCHARGED FROM UNIT AND HOSPITAL 1966

As is evident from what has already been written, this research cannot be of a sort which yields up an absolute success rate. None the less the analysis of the detailed lists for which we asked provides interesting pointers so long as the qualifications as to the differing uses of units are not forgotten. For example, some hospitals state specifically that their units are designed to give occupation for elderly long-stay patients and not as a means of rehabilitation. These qualifications understood, and in so far as the existence of a group of 'successful' patients is conceded, the data concerning them are to be found in this section. Part 2 analyses, by age, diagnosis and length of stay, the patients discharged both from unit and hospital; and where appropriate compares these with the discharge figures for 1966 for all mental hospital in-patients as stated in the Ministry of Health's Statistical Report, Series No. 4.

Table XIV

Age Groups of Patients Discharged from Industrial Unit and Hospital

Age	Male No.	Male %	Female No.	Female %
- 15	4	0	4	1
- 20	32	3	15	3
- 25	123	11	45	8
- 35	202	19	72	14
- 45	229	21	103	19
- 55	184	17	93	17
- 65	124	12	53	10
65 +	39	4	55	10
Unknown Age	140	13	92	17
Total	1,077	100	532	100

Table XIV shows the age distribution of patients who were discharged from the industrial units and the hospitals. Comparing the figures with those in Table II which set out the age groups of patients still at work in the units, it will be seen that, for both male and female patients, the proportions of Discharged from Unit and Hospital patients in the four lowest age groups (omitting the under 15 age group) exceed the corresponding proportions in the Patients at Work lists. In other

words, up to the age of 45 proportionally more patients leave hospital than remain at work in the units. Thereafter the relativities are reversed. The interesting point is that this pattern corresponds roughly with that shown in Table XXV for the transferred patients. This might seem to indicate that the younger patients are moved about while patients over 45 tend to remain in the units.

Table XV

Diagnoses of Patients Discharged from Industrial Unit and Hospital

Diagnosis	Number of Patients			
	Male		Female	
	No.	%	No.	%
Schizophrenia	503	46.8	217	40.8
Depression	237	22.0	187	35.2
Neurosis	47	4.4	41	7.7
Other	194	18.0	73	13.7
Unknown	96	8.8	14	2.6
Total	1,077	100	532	100

Table XV sets out the diagnoses of patients discharged from industrial unit and hospital. It shows clearly, taken in conjunction with Table VII, that the 'success' rate for patients diagnosed as suffering from depression or neurosis is greater than that for patients suffering from schizophrenia. This is true for both sexes and is most marked in the case of the depression diagnoses. However, a further analysis of long-stay patients only, to be found in page 34 produces a contrary result.

Table XVI

Length of Stay in the Hospital of Patients Discharged from Industrial Unit and Hospital

Length of Stay	Number of Patients			
	Male		Female	
	No.	%	No.	%
Under 2 years	765	71.0	321	60.4
2 - 5 years	90	8.4	61	11.4
5 - 10 years	25	2.4	25	4.7
10 - 20 years	14	1.3	15	2.8
Over 20 years	6	0.5	5	1.0
Unknown	177	16.4	105	19.7
Total	1,077	100	532	100

Table XVII

Length of Stay of Patients Discharged from Industrial Unit and Hospital

Mean Figures

Hospital Regions	Male	Female
1	0.0	3.4
2	2.0	2.7
3	1.2	2.7
4	1.0	2.8
5	1.4	1.8
6	-	-
7	-	7.1
8	1.5	2.2
9	1.0	1.1
10	1.4	1.3
11	3.1	5.1
12	1.5	1.7
13	5.2	-
14	2.1	2.2
15	1.7	2.1
All Regions	1.8	2.8

Table XVI illustrates clearly the situation in the units to which attention was drawn in the Main Report, namely that a high proportion of short-stay (under two years) patients are at present passing through the units. 71% of the male patients, and 61% of the female patients discharged from unit and hospital, are in fact short-stay patients. Nevertheless sizeable percentages of longer stay patients are also discharged: it is noticeable that these proportions in the longer stay groups (above two years) are higher for women than for men.

Table XVII gives the same information regionally and shows that in each region (with the one exception of Region 10) female patients discharged from unit and hospital are longer-stay than the male patients thus discharged.

One or two high mean figures stand out in this table also: a 7.1 average length of stay for female patients in Region 7, a 5.1 figure also for females in Region 11 (which also records the highest figure for men), and a 5.2 average length of stay for males discharged from Region 13.

So much for the straightforward analysis in terms of length of stay of patients leaving industrial units. But evidently this information will carry much greater interest if set against corresponding data for all the patients who left hospital in the corresponding period. The problem is how to do this effectively and yet with validity, for a simple comparison tells us nothing: we know that this will show a proportionally higher discharge rate among long-stay unit patients because proportionally more such patients are placed in the units in the first place.

Accordingly it was decided to undertake comparisons within the two long-stay groups comprising 2 - 10 years, and 11 years and over. The results were as follows:

Duration of Stay Group 2 - 10 years

		Male	Female
1.	Total patients engaged in Industrial Therapy 1967	933	730
2.	Total patients in hospital 1963	13,476	18,037
3.	Total engaged in Industrial Therapy who left Unit and Hospital 1966	115	86
4.	Total patients left hospital 1966	1,277	1,351
5.	3 as a percentage of 1	12.32%	11.78%
6.	4 as a percentage of 2	9.47%	7.49%

Thus a higher percentage of both male and female patients in the 2 - 10 year length of stay groups left hospital and unit than the corresponding percentage for all patients. These differences in proportion were found on testing to be statistically significant; that for women being highly significant.

Duration of Stay Group 11 years and over

		Male	Female
1.	Total number receiving Industrial Therapy 1967	1,011	584
2.	Total number in Hospital (census) 1963	24,426	29,200
3.	Total number from Industrial Therapy who left Unit and Hospital	20	20
4.	Total discharges from all Hospitals 1966	599	678
5.	3 as a percentage of 1	1.97%	3.42%
6.	4 as a percentage of 2	2.45%	2.32%

For the male patients, the differences in proportion are not statistically significant: for female patients the difference is on the borderline of statistical significance. It is evident that for this length of stay group the differences between the two percentages are very slight: industrial therapy does not appear to affect the issue. A comment on the method employed must be inserted here. Figure 2 in each calculation is taken from the Census of 31 Dec. 1963, three and a quarter years before our own Census of April 1967. It may be objected that the total hospital population will have shrunk since 1963 because of active discharge policies, and that the percentage figures will be consequently invalidated. Fortunately this is not so. The 2 - 10 year and over 11 year length of stay groups will not be greatly affected because only some 3% of all discharges in 1966 were from these groups, the vast majority of 97% being short-stay (under 2 years) discharges.

Table XVIII

Male Patients Leaving, by Diagnosis and Length of Stay 1966

I

Industrial Units, King's Fund Survey

	All known durations		Under 2 years		2 - 5 years		Over 5 years	
	No.	%	No.	%	No.	%	No.	%
All known diagnoses	826	100	706	85.5	83	10.0	37	4.5
Schizophrenia	415	100	339	81.7	49	11.8	27	6.5
Depression	216	100	198	91.7	11	5.1	7	3.2
Neurosis	37	100	35	94.6	2	5.4	0	0.0
Other	158	100	134	84.8	21	13.3	3	1.9

II

All Hospitals
Ministry of Health Statistical Report Series No. 4.

	All known durations		Under 2 years		2 - 5 years		Over 5 years	
	No.	%	No.	%	No.	%	No.	%
All known diagnoses	60,870	100	58,994	96.9	928	1.5	948	1.6
Schizophrenia	16,197	100	15,121	93.3	480	3.0	596	3.7
Depressive Psychosis	19,750	100	19,494	98.7	151	0.8	105	0.5
Psychoneuroses	7,739	100	7,685	99.3	37	0.5	17	0.2
Other	17,184	100	16,694	97.1	260	1.5	230	1.4

Table XIX

Female Patients Leaving, by Diagnosis and Length of Stay 1966

I

Industrial Units, King's Fund Survey

	All known durations		Under 2 years		2 - 5 years		Over 5 years	
	No.	%	No.	%	No.	%	No.	%
All known diagnoses	416	100	311	74.8	60	14.4	45	10.8
Schizo-phrenia	177	100	120	67.8	33	18.6	24	13.6
Depression	152	100	128	84.2	15	9.9	9	5.9
Neurosis	35	100	26	74.3	5	14.3	4	11.4
Other	52	100	37	71.1	7	13.5	8	15.4

II

All Hospitals
Ministry of Health Statistical Report Series No. 4

	All known durations		Under 2 years		2 - 5 years		Over 5 years	
	No.	%	No.	%	No.	%	No.	%
All known diagnoses	87,228	100	85,198	97.7	968	1.1	1,061	1.2
Schizo-phrenia	18,744	100	17,889	95.4	378	2.0	507	2.6
Depressive Psychosis	38,773	100	38,294	98.8	259	0.7	220	0.5
Psycho-neuroses	14,449	100	14,362	99.4	64	0.4	23	0.2
Other	15,262	100	14,683	96.2	268	1.8	311	2.0

Tables XVIII and XIX which analyse by diagnosis and length of stay those patients who left the units, and those patients who left hospital, are however set out in full since it is thought that the picture which they portray is of interest in itself. But the same qualifications apply here as have been discussed in the preceding paragraphs: evidently the 'success' rate in the longer stay groups of the units will appear relatively high because of the preponderance of those patients in the units. In order to get a more meaningful impression, a calculation similar to that on page 30 was made, in this case taking both sexes together.

Long-Stay Schizophrenia Over Two Years

1.	Total over two-year Schizophrenics receiving Industrial Therapy 1967 (print-out)	958
2.	Total over two-year Schizophrenics in hospital 1963	50,059
3.	Number of over two-year Schizophrenics left Industrial Therapy 1966	133
4.	Number of over two-year Schizophrenics left Hospital 1966	1,076
5.	3 as a percentage of 1	13.9%
6.	4 as a percentage of 2	2.1%

Long-Stay Depression Over Two Years

1.	Total over two-year Depressive patients receiving Industrial Therapy 1967	444
2.	Total over two-year Depressives in Hospital 1963 (plus reactive depression)	10,452
3.	Number of over two-year Depressives left Industrial Therapy and Hospital 1966	42
4.	Number of over two-year Depressives left Hospital 1966	735
5.	3 as a percentage of 1	9.5%
6.	4 as a percentage of 2	7.0%

From these calculations relating to long-stay schizophrenic patients, and long-stay depression patients, a result stands out quite sharply, viz. that some 14% of long-stay schizophrenic patients left the units in 1966, as against 2% of the total long-stay schizophrenic population.

And that for the long-stay depression group, a very different result is shown, 9.5% leaving the units but as many as 7% leaving hospital. On this calculation long-stay schizophrenics must benefit more from industrial therapy than do long-stay depression patients.

Yet a further calculation relating to all schizophrenic patients and all durations of stay showed that 16.4% of industrial unit patients left during the year, but over 50% of all hospital patients. This latter high figure is of course caused by the great weight of short-stay patients who are in and out of hospital without any reference to the industrial units. This result, contrasting so strongly with that for the long-stay patients above, helps to fill in the whole canvas.

Table XX

Male Patients Leaving, by Known Age and Length of Stay
1966

I

Industrial Units and Hospitals, King's Fund Survey

	All Known durations No.	%	Under 2 years No.	%	2 - 5 years No.	%	5 - 10 years No.	%	11 and over No.	%
All ages	900	100	765	85	90	10	25	3	20	2
- 19	36	100	34	94	2	6	0	0	0	0
20 - 34	310	100	270	87	35	11	5	2	0	0
35 - 54	398	100	333	84	35	9	16	4	14	3
55 +	156	100	128	82	18	11	4	3	6	4

II

All Hospitals

Ministry of Health Statistical Report Series No. 4

	All Known durations No.	%	Under 2 years No.	%	2 - 5 years No.	%	5 - 10 years No.	%	11 and over No.	%
All ages	60,870	100	58,994	97	928	1	349	1	599	1
- 19	3,510	100	3,475	99	34	1	1	0	0	0
20 - 34	17,534	100	17,260	99	205	1	47	0	22	0
35 - 54	24,500	100	23,733	97	349	1	176	1	242	1
55 +	15,326	100	14,526	95	340	2	125	1	335	2

Table XXI

Female Patients Leaving, by Known Age and Length of Stay 1966

I

Industrial Units and Hospitals, King's Fund Survey

	All known durations No.	%	Under 2 years No.	%	2 - 5 years No.	%	5 - 10 years No.	%	11 and over No.	%
All ages	427	100	321	75	61	14	25	6	20	5
- 19	19	100	18	95	0	0	1	5	0	0
20 - 34	111	100	97	87	9	8	4	4	1	1
35 - 54	191	100	142	74	28	14	12	7	9	5
55 +	106	100	64	60	24	23	8	7	10	10

II

All Hospitals

Ministry of Health Statistical Report Series No. 4

	All known durations No.	%	Under 2 years No.	%	2 - 5 years No.	%	5 - 10 years No.	%	11 and over No.	%
All ages	87, 228	100	85, 199	98	969	1	382	0	678	1
- 19	3, 853	100	3, 832	100	18	0	3	0	0	0
20 - 34	21, 686	100	21, 507	99	143	1	27	0	9	0
35 - 54	33, 475	100	32, 888	98	306	1	111	0	170	1
55 +	28, 214	100	26, 972	94	502	2	241	1	499	2

The information set out in the above four tables relates to the same patients who have already been analysed above. Here the breakdown is by age and length of stay, and the absolute numbers, alongside their percentages, have been retained since it is thought that in themselves these are of interest as they stand.

In summary, the picture depicts the rapid turnover of short-stay patients in all hospitals which is the present feature; the number of long-stay patients being discharged is some two or three percent only,

although this represents some 3,000 individual patients. By contrast the figures for discharges from the units yield much higher percentages, particularly in the 2 - 5 year hospitalization group, although of course the absolute figures are low - and made lower because of the many gaps in our source data.

But it needs repeating that in this form comparison with the figures for Total Discharges and Lefts from all Hospitals is not really valid because more long-stay, elderly, patients are known to be placed in the units than short-stay ones.

Finally, disregarding for a moment the national figures, the data relating to the industrial units only are presented from a different viewpoint altogether.

The three tables set out below consist of calculations of the number of patients who succeeded in leaving both industrial unit and hospital, taken as a percentage of all those who left the unit, including patients transferred elsewhere within the hospital. These calculations use the now familiar breakdowns of age, length of stay and diagnosis, and since the tables refer throughout to the same group of patients, it follows that the percentage totals should coincide. In Tables XXII and XXIII they do so: the reason for the lower percentage in Table XXIV is to be found in the much smaller 'unknown' group here than in the preceding two tables.

The interesting feature to emerge is the lower percentage rate for female patients than male patients in all three tables. When all the qualifications are made, and possible other explanations are considered, it is hard to see that this means anything else than that industrial work is less successful for the rehabilitation of women than it is for men.

Table XXII

Patients Discharged from Unit and Hospital expressed as a percentage of all patients who left the Unit, by Age

	Male			Female		
Age Group	Col. 1 Total Left	Col. 2 Left Hosp.	Col. 3 Col. 2 as % of Col. 1.	Col. 4 Total Left	Col. 5 Left Hosp.	Col. 6 Col. 5 as % of Col. 4.
- 15	5	4	80	4	4	100
- 20	37	32	86	17	15	88
- 25	159	123	77	64	45	70

- continued -

Table XXII
(continued)

	Male			Female		
Age Group	Col. 1 Total Left	Col. 2 Left Hosp.	Col. 3 Col. 2 as % of Col. 1.	Col. 4 Total Left	Col. 5 Left Hosp.	Col. 6 Col. 5 as % of Col. 4.
- 35	267	202	75	106	72	68
- 45	318	229	72	166	103	62
- 55	248	184	74	144	93	65
- 65	172	124	72	90	53	59
Over 65	61	39	64	94	55	58
Total	1,267	937	74	685	440	64
Unknown Age	259	140		95	92	

Table XXIII

Patients Discharged from Unit and Hospital expressed as a percentage of all patients who left the Unit, by Length of Stay

	Male			Female		
Length of Stay (Known)	Col. 1 Total Left	Col. 2 Left Hosp.	Col. 3 Col. 2 as % of Col. 1.	Col. 4 Total Left	Col. 5 Left Hosp.	Col. 6 Col. 5 as % of Col. 4.
- 2 years	920	765	83	443	321	72
2 - 5 "	160	90	56	102	61	60
5 - 10 "	65	25	38	55	25	45
10 - 20 "	51	14	27	40	15	37
20 +	19	6	31	22	5	22
Total	1,215	900	74	662	427	64
Length of Stay Unknown	305	174		206	103	

Table XXIV

Patients Discharged from Unit and Hospital expressed as a percentage of all patients who left the Unit, by Diagnosis

	Male			Female		
Diagnosis (Known)	Col. 1 Total Left	Col. 2 Left Hosp.	Col. 3 Col. 2 as % of Col. 1.	Col. 4 Total Left	Col. 5 Left Hosp.	Col. 6 Col. 5 as % of Col. 4.
Schizophrenia	799	503	63	405	217	54
Depression	305	237	77	260	187	72
Neurosis	56	47	84	56	41	73
Other	261	194	74	119	73	61
Total	1,421	981	69	840	518	62
Diagnosis Unknown	102	92		32	14	

3 PATIENTS TRANSFERRED FROM UNIT AND REMAINING IN HOSPITAL 1966

As previously explained, hospitals with industrial units were asked to make detailed lists of patients who left the industrial units during 1966 but stayed on in the hospitals. These patients were transferred to other occupations within the hospital. In a sense they may be regarded as the 'non-success' of the industrial units: after working in them for a time it was considered better for them to work elsewhere. It was explained in the Report that the various industrial units have very differing policies with patients: some unit staff would persevere for a very long time with patients who do not respond and fit in the unit while the staff in others think it better to try other workplaces for these patients. Therefore the transferred patients do not collectively constitute a single category of 'non-success'. Furthermore, as the industrial units themselves are of a great variety (see the Report) it is quite possible that patients not fitting into their particular unit might have fitted into another type. Nevertheless, all of these transferred patients have one thing in common, that is that they were referred to the industrial unit of their hospital and having worked there were transferred. It seemed sufficiently interesting to examine some of their characteristics in order to see if any could be associated with not succeeding in the industrial units.

The details asked for were age, length of time spent in the hospital and diagnosis.

Table XXV

Age Groups of Patients who left the Industrial Unit but remained in the Hospital

Age Groups	Number of Patients			
	Male		Female	
	No.	%	No.	%
- 15	1	0	0	0
- 20	5	1	2	1
- 25	36	8	19	6
- 35	65	15	34	10
- 45	89	20	63	19
- 55	64	14	51	15
- 65	48	11	37	11
65 +	22	5	39	11
Unknown Age	119	26	95	28
Total	450	100	340	100

Table XXV shows the age distribution of patients who were transferred from the industrial units. The youngest age group is the smallest - this follows the pattern of age distribution of all patients working in the units (see Table II). The 20 - 45 age groups constitute larger proportions of the total number of transferred patients than the corresponding figures on Table II would warrant, while the over 45 age groups constitute smaller proportions of these patients. It seems as if, apart from the very young, younger rather than older patients are transferred from the units. The differences between the percentages on the two tables are relatively small; but it is known that some sections of units are established specially for the older patients, who work there regardless of 'success' and are not considered for transfer elsewhere. Nevertheless the figures indicate an association of younger patients with 'non-success' in the industrial units.

Table XXVI

Diagnoses of Patients who left the Industrial Unit but remained in the Hospital

Diagnosis	Number of Patients			
	Male		Female	
	No.	%	No.	%
Schizophrenia	296	66	188	55
Depression	68	15	75	22
Neurosis	9	2	15	4
Other	67	15	46	14
Unknown	10	2	18	5
Total	450	100	340	100

Table XXVI shows the diagnosis of the transferred patients. If the percentage figures on this table are examined in conjunction with those of Table VII it can be seen that the distribution of transferred patients according to diagnostic categories is very similar to the corresponding distribution of all patients working in the industrial units. It seems therefore that patients are transferred in approximately the same proportions whatever their diagnosis. Diagnostic category does not seem to influence 'non-success' in the industrial units.

Table XXVII

Length of Stay in the Hospital of Patients who left the Industrial Unit but remained in the Hospital

Length of Stay	Number of Patients Male No.	 %	 Female No.	 %
Under 2 years	155	34.7	122	36.1
2 - 5 years	70	15.7	41	12.1
5 - 10 years	40	9.0	30	8.9
10 - 20 years	37	8.3	25	7.4
Over 20 years	13	2.9	17	5.0
Unknown	131	29.4	103	30.5
Total	446	100	338	100

Table XXVIII

Length of Stay in the Hospitals of Patients who left the Industrial Units but remained in the Hospitals

Mean Figures

Hospital Regions	Male		Female
1	6.5	years	6.8
2	6.1		6.6
3	3.3		7.8
4	2.0		3.0
5	2.8		4.6
6	-		-
7	-		5.7
8	3.8		2.5
9	1.4		1.0
10	1.4		0.6
11	8.9		4.9
12	4.3		4.0
13	12.0		-
14	5.3		9.0
15	3.6		9.2
All Regions	4.7		5.0

This table shows the mean stay in the hospital of transferred patients by hospital regions. If it is compared to Table III on which the corresponding figures concerning patients who work in the units are shown, it can be seen that the tendency is for the transferred patients to have spent less time in the hospitals than all the patients working in the units. (The exceptions are the male patients in Region 13 and the female patients in Regions 1, 13 and 14.) It seems therefore as if patients who have stayed in the hospitals for a shorter length of time are more likely to be transferred from the units than longer staying patients.

Summary

This supplement to the report on Industrial Therapy in Psychiatric Hospitals has been concerned with detailed information about patients who have worked at the Industrial Units at a certain time or left the units during a certain year. Information was provided about each patient's diagnosis, age, length of stay in the hospital, working hours, pay and types of work; and, whether or no they were also discharged from hospital.

The data thus gained were compared with the latest available Ministry of Health figures concerning the patient population in all psychiatric hospitals and the discharges therefrom.

The analyses in this supplement have to be regarded with caution as they were based on information provided by a limited number of hospitals; they show tendencies rather than the whole factual position. However, we believe that these analyses are the only ones at present available on this subject and therefore are of considerable interest. In any case, it would be impossible to obtain complete information regarding each industrial unit patient because in many hospitals the necessary records do not exist.

The comparisons with the Ministry of Health figures also have to be regarded as tentative as part of the data refer to different years. Despite this we think that these comparisons have value, because they place the industrial units, and all the figures relating to them, in the wider context of the current psychiatric hospital situation.

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