Needs and Opportunities in Rehabilitation

Occupational rehabilitation and return to work: 2—Psychiatric disability

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Building a sheltered workshop for ex-psychiatric patients was unjustified, a local authority planner is said to have concluded, because it was cheaper to pay them to stay at home. Yet lack of work is at least as devastating for such people as for everyone else. Moreover, work has a "normalising" effect, and it gives companionship, activity, and structure to the day,[1] which they may be less able than the healthy to find for themselves,[2] while idleness will "confront them with themselves,"[3] often disastrously. According to Freud (quoted by Morgan[4]), work is the most powerful way of binding an individual more closely to reality. Delight at seeing ex-patients "blossom into real people again" was the reaction of one employer,[5] and a personnel manager I met quoted the words of a father: "I didn't know what a nice son I had until he started work." Having a job, rather than having somewhere to live or having no symptoms, was found to be the factor most strongly associated with staying out of hospital[5]; for long term inpatients, the study of institutionalism by Wing and Brown showed that doing work and occupational therapy was the chief factor distinguishing those who did and did not improve clinically.[6]

In one survey little more than a third of employers questioned said that they would as soon take on someone who had been in a mental hospital as anyone else.[4] Few appear to do so knowingly,[4 5 7] and some people who hide a psychiatric history are fired on its discovery, however satisfactory they are. But other firms make more positive efforts.[5] Some fears of employers are justified statistically—risk of relapse, above average sickness absence, social difficulties, for example (but not violence)[5]; "We have to think of our customers," as more than one said to me. But different types of disorder cannot be lumped together any more than different types of job. In many cases the problem is stigma rather than disability. Leaflets addressed to employers, such as that of the Manpower Services Commission, need wide distribution.

Rehabilitation facilities and preparation for work

Common criticisms of the services for work rehabilitation and resettlement are that they were not designed for the conditions and work milieu of the present day or for those with psychiatric disabilities, who have often different needs from other disabled people—in particular a longer rehabilitation process, which is often overlooked.[4 5 8] Services are also thought to be too fragmented, with not enough links between the different agencies, and above all too scanty. Some of the elements[5 8] were described last week (13 April, p 1135)—for example, sheltered work, job rehearsal and job introduction schemes, the disablement resettlement officer service, and employment rehabilitation centres (ERCs).

Rehabilitation for work should start in hospital, if only "to create or recreate the work habit," as Netherne Hospital's handout puts it. Work is also therapy in its own right.[4 9] Even for a course in an industrial rehabilitation unit (now ERC), adequate preparation in hospital seemed to be important for success in the pioneer study by Wing *et al* of chronic schizophrenics.[10] Lack of confidence and fear of failure obviously are deep problems for many and successes must if necessary be engineered. A graded series of workshops and offices for work with increasing demands[9] makes a useful start. More opportunity is now given for clerical work. There are many good discussions of principles and problems.[4 9 11]

Pioneering work in industrial therapy was done in the hospital setting by Morgan[9] at St Wulstan's Hospital, Malvern, and outside hospital in an independent industrial therapy organisation by Early[12] in Bristol. A recent innovation is the placing of a Manpower Services Commission instructional officer in Fulbourn Hospital, Cambridge, to work with long term patients. But some industrial therapy units in hospitals have been closing down and industrial therapy,[4 5 8 9] which developed fast in the 1960s, may have lost its momentum; many psychiatrists, it has been said, are not sufficiently committed to it. Even so, this may not be the chief problem. There are many workshop and other facilities for work in hospitals and day centres, and therapeutic needs as well as commercial viability are recognised in privately sponsored industrial therapy organisations. Individual assessment and planning of work programmes are accepted. But with a precise analysis of each person's handicaps, it is argued,[13] and a more active remedial approach with closely defined targets, more could be achieved than is usual in most centres—specific if perhaps small improvements in a person's work functioning and perhaps social behaviour that may make all the difference to his employability. Much is known about how to do this with techniques of behaviour modification and social skills training[13] and a lot of interest is being shown in this approach, but there is a long way to go. For example, concentration may be improved by a "graded training" approach; work effort increased by incentives, including staff attention and encouragement; and excessive anxiety reduced by "desensitisation"[13] or by constructive "self talk."[14] Recovery from depression may even be speeded up by the use of specific cognitive techniques directed at the lack of concentration and slowness.[4] "Task competence" has tended to emerge as a much less important factor than an acceptable "work personality" in research studies, which have been mostly on people with schizophrenia (Watts[4]).

A programme[15] for a work social skills group started by Netherne Hospital in 1980 has attracted much interest. This gives attention to verbal expression, non-verbal behaviour (appearance, eye contact, and so on), and assertive behaviour in general as well as to application for jobs and interview technique. Even before a course ends one or two people get jobs despite their poor initial prospects. Social skills training is given during the working day in the Ulster Industrial Therapy Organisation.[8] The project in Surrey to which I refer below had social skills training as an important element; and the second hand bookshop recently established by the National Schizophrenia Fellowship in Godalming, Surrey, will it is hoped

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become also a rehabilitation resource offering experience in various types of work plus social skills training.

Are work instructions always given in the best way in a rehabilitation programme? Different strategies of instruction have been worked out for different types of person—for example, non-competitive learning with continuous favourable comments from the instructor for the over anxious, but mild reprimands for those scoring low on anxiety.[16]

Two employment rehabilitation centres, in Egham (Surrey) and Leicester, have special courses—much longer than usual—for psychiatric ex-patients.[17] I met a biology graduate who seemed to enjoy gaining experience in gardening and was looking forward to a course to give him further experience. The Leicester ERC has a powerfully supportive setting for its six psychiatric clients; each has his own "rehabilitation instructional officer" (one of the section supervisors), who can relate to him with empathy and be available for informal conversation and counselling as the client needs them. The success of this venture is attributed in part to the "charismatic, entrepreneurial management."[17]

"It's heartbreaking if you aim too high," someone said; and thorough assessment helps to prevent this. In Netherne Hospital's day hospital rehabilitation unit the weekly monitoring of the many aspects of a person's functioning has become increasingly refined. This probably explains why rates for job placement have risen despite the recession. But on the other hand, said the work development officer of the Kensington and Chelsea Association for Mental Health, expectations are often too low and even for people long handicapped by mental illness repetitive work may be counter-productive. Her researches had suggested that much of what passes for work rehabilitation is merely occupation; the association's new work project (see box) is designed to provide expert training in skilled work, with the back up of a supportive organisation.

The many elements needed by a good rehabilitation workshop or work unit may be put together in small projects run by voluntary organisations with perhaps support from statutory services. Portugal Prints (figure) is an imaginative venture of the Westminster Association for Mental Health, giving an introduction to various types of work—office jobs, for instance, as well as the printing and production processes—and the chance of some creative work, with beautiful (and commercial) end products. At the same time there is a supportive milieu, with individual counselling and a creative writing group—and the important elements of reassurance, approval, and respect.

Support and special work

A cartoon of a man operating an electric drill, with the caption "He's holding down a job but he's shaking all over," was presented by an ex-patient to her psychiatrist on her return to nursing. Intensive support, often for months, may be needed after someone gets a job, sheltered or otherwise. At Netherne, for example, ex-patients may have a hospital appointment or a home visit in the evening; some hospitals arrange visits by staff to ex-patients (and their employers) at their places of work. The general practitioner with a good knowledge of a patient's personality and background may be well placed to give advice and support—or organise sources of help—and keep an eye on him or her after the return to work; a summary of needs and problems is given by Lucas.[18]

With those who return to their old place of work some firms go to a lot of trouble in providing support and counselling,[5] and offering if necessary less stressful or exposed work; inquiries I made suggested that this may be important in bigger firms. Remploy managers, I was told, are selected among other things for their ability to be "father confessors." Sheltered placement schemes (formerly "sheltered industrial groups"—see 13 April, p 1135) often have a supervisor such as a psychiatric nurse, perhaps on a peripatetic basis, which appears to make employers as well as workers happier.[5] A research project in Westminster found that the few employers prepared to recruit people who had suffered from mental illness were unsure how best to support them and knew little about the mental health resources available.[7]

A scheme for "lasting employment with open ended opportunities"

To create real and lasting employment is the aim of a scheme being set up by Kensington and Chelsea Association for Mental Health, with the help of revenue funding from industry for the first three years and capital from statutory services. There will be five training courses in specialised technical skills starting at six monthly intervals, each for six to eight people who have had recurring mental illness. Outside tutors with temporary contracts will be used. The first course will be painting, decorating, and "special finishes." Assertion courses, driving lessons, and training in book keeping and other skills will be provided for those who need them. After six months teams will start part time work (with further training), remaining on invalidity benefit and qualifying to keep "therapeutic earnings" of £23·50 a week (this earnings limit applies to those who have in the past worked for at least a year and are thus entitled to invalidity benefit, and who are doing work said to be of therapeutic value). Two KCAMH staff, an administrator and a peripatetic technical adviser, will form the "agency." Individual members of the teams will start full time work when they are ready and when there are sufficient contracts ensuring regular work—with the possibility of returning to part time work should they become too stressed.

In West Surrey as in many parts of the country medical and employment rehabilitation services are grossly overstretched, there is little sheltered work, and most discharged patients have to fend for themselves. A special ERC course is available for people severely handicapped with psychiatric conditions, but it was felt that many could not be helped by it; so a group of doctors, employers, psychologists, and the local branch of the National Schizophrenia Fellowship devised a scheme whereby people were to be placed in sympathetic local firms for work experience or sheltered work, with a back up of support and intensive training in social skills. But the hoped for funding for the scheme failed to materialise. "A lack of commitment on the part of central government to support this kind of project" was how a doctor summed it all up. Now the National Schizophrenia Fellowship's second hand bookshop referred to above is providing some work experience and will help to finance the work rehabilitation base that is planned.

Open employment, sheltered work, or. . . ?

Finding ordinary jobs is bound to be difficult. At Netherne Hospital an employment liaison officer paid by the National Schizophrenia Fellowship negotiates with firms on behalf of patients. In Oxford a nursing officer has done this, but in the past five years the task has become almost impossible where patients have chronic conditions. But in Surrey a general practitioner concerned about the position has managed to find jobs for some of his own patients with psychiatric disabilities by going himself to firms where he has friends.

There is said to be no shortage of sympathetic employers, but there may be missing links—namely, liaison and support. Someone who knows the patient or ex-patient may need to negotiate over jobs (whether the old job or a prospective one), with the same or a different person subsequently giving the needed supervision or support. Disablement resettlement officers (13 April, p 1135) cannot necessarily tackle these time consuming and all but intractable problems. If special posts cannot be funded for such tasks, is there not scope here for various professionals, from primary care, community, and hospital services, to give at least some help on an ad hoc basis? The crucial step then is to find the right professional in each case.

Portugal Prints, a rehabilitation workshop producing high quality greetings cards, set up in 1979 by the Westminster Association for Mental Health in a restored church house basement, with funding from Urban Aid (which is being superseded by local authority funding) and support from the business community and elsewhere. The staff of three include an occupational therapist and an art therapist, and a supportive environment is created—see text. About 24 people attend in a week, some nearly full time, for varying periods up to two years usually; in the first five years 119 people attended. Production bonuses as well as allowances are paid. A long term sheltered employment team works for half a day a week at printing on metal.

Clearly more special projects are needed for short term and long term work (such as the project described in the box), which must reflect the changing nature and patterns of job opportunities, with funding also for more sheltered placement schemes within open employment. This last (see 13 April, p 1135) was developed by Early in Bristol for people with chronic mental illness, for whom such schemes may be very suitable.[5 8] For the very disabled, sheltered work may be preferable anyway, at least for a time. Of the 15 people leaving Portugal Prints who were assessed as functioning at the highest level, all got jobs but none kept them; the only ones still working would be classed as neurotic (G Reynolds, personal communication). For those with severe afflictions therefore the Westminster Association for Mental Health is trying to start sheltered work projects. Many imaginative schemes are to be found, though on a small scale; one example is RESTORE in Oxford, an independent charity with groups doing high quality woodwork, silkscreen printing of fabrics and cards, and horticulture. The problem now is that these people are no longer able to move on to open employment.

The most severely handicapped people, of course, cannot do this kind of work, but the traditional repetitive jobs of industrial therapy may not be the answer for the young. They are not willing, said one psychiatrist, to pack cotton wool balls all day for £4 a week, seeing such work not as giving meaning to their life but as a form of exploitation. They need some satisfying alternative. I touched on activities two weeks ago (6 April, p 1059), and there is a great need for interesting activity centres wherever these do not exist. In some places clients divide the day between workshop and centre. The Mill, run by the Oxford Mental Health Association in partnership with professionals for the "new" chronically mentally ill, provides somewhere to go, with the chance of participation and creative activities.[19] Moreover, it has young unemployed volunteers who offer a role model: the possibility of finding purpose and status unrelated to a job.

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Portugal Prints Parish House, Portugal Street, London WC2
(See also last article—13 April, p 1135—for some other relevant addresses)

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What investigations and treatment do you advise for an air stewardess in her 30s who developed sonnei dysentery on returning from Spain and who seven weeks later is still excreting bacilli in her stools?

It is most unusual for someone who has had shigelli dysentery to continue excreting bacilli for more than a few months. With good hygiene, especially after defecation, the chance of person to person spread is minimal but does occur, especially, for example, in schools and potentially also, as in this case, in food handling. A week's course of an antibiotic to which the organism is sensitive can shorten the time during which organisms are excreted, and probably the most successfully used antibiotic is cotrimoxazole in ordinary doses for one week. If this fails a further course may be given, but regardless of its success the patient can be reassured that she is likely to be able to return to work soon.—E WALKER, lecturer in infectious diseases, Glasgow.