ORGANIZATION OF A HOSPITAL WORKSHOP FOR CHRONIC PSYCHOTIC PATIENTS

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INTRODUCTION

The part that regular and useful work can play in preventing deterioration in patients who are obliged to spend long years in mental hospitals has long been recognized. Nevertheless, it has required the exertions of a succession of outstanding clinical psychiatrists—such as Pinel (1801), Conolly (1856), Esquirol (1838), Browne (1837), Kirkbride (Bond, 1947), Hill (1839), Charlesworth and Ellis (Granville, 1877), in the 19th century, and Bleuler (1911), Simon (1927), Schneider (1939), and Barahona Fernandes (1954), in more recent years—to remind us of the importance of this concept.

There is also reason to believe that an inactive régime can contribute to the deterioration of chronic patients, by fostering “institutionalization”, as described by Martin (1955). This phenomenon has often been discussed in psychiatric literature, but the process has never been studied systematically in mental hospital patients. Studies carried out with inmates of prisons have suggested ways in which to counteract the demoralizing effects of prolonged incarceration. For example, Horsch and Davis (1938) and Driscoll (1952) have shown that a high degree of conformity to the institutional régime is related to social and personal maladjustment, rather than to good mental health. Fenton (1952) noted that the majority of short-term prisoners and a significant proportion of “old lags” were potentially responsive to measures of re-socialization. In describing how these are to be applied, he emphasized the need for prison workshops incorporating features which have been shown to raise morale in industry. His conclusions—“The prison as a whole, not merely particular shops, must develop the atmosphere of adjustment” and “It is unfair, until in the walled prison the prerequisite atmosphere of adjustment is present, to attribute to defects or limitations in the personalities of the inmates any deficiencies in their willingness to accept treatment”—are very relevant to current experiments in the rehabilitation of chronic psychotic patients.

One reason for the periodic neglect of work therapy in hospital may be that it was never clearly established whether the therapeutic gains were due to specific measures or to the personality and drive of the doctors concerned. Vigour and enthusiasm on the part of the doctor are likely to enhance the success of any therapy, and it is essential to attempt an objective examination of the techniques involved. The present paper reports the preliminary stages of such a study carried out in Banstead Hospital, Sutton, Surrey.

MATERIAL

The patients were twelve men, aged between 26 and 46. All were diagnosed as schizophrenics, but examination of the records showed that in three cases there was evidence of other pathological factors in the history, viz., post-encephalitic personality disorder, cerebral syphilis, and epilepsy. Duration of stay in hospital since admission varied from 4 to 22 years, (mean 7·5 years, but if one individual is excluded, 6·2 years). All except one were certified patients.

THE WORK AND ITS SETTING

In June, 1955, an industrial workshop for these twelve male chronic psychotic patients was opened in a large well-lit room in a disused corridor of the main hospital building. The only furniture required was a table and two chairs for each pair of men. An empty adjoining room served as a store for raw materials and for the finished product, and another as the supervisor’s office. The supervisor, an elderly man recruited from the local labour exchange, was selected after interview because he showed a ready grasp of the aims of the rehabilitation process, firm but good-natured disciplinary leadership, and a minumum of preconceived ideas about the capabilities or handicaps of psychotic patients. He had never before been inside a mental hospital.

The work consisted in folding, glueing, and packing cardboard containers (egg-boxes, cake-boxes, etc.). The
"raw materials" consisted of stamped and printed flat cardboard sheets; the "finished products" were parcels of from 250 to 1,000 containers packaged and labelled for dispatch to their several purchasers. This work is usually carried out in factories, or by out-workers. It is done by hand (for the most part by female labour) only where short runs of up to 200,000 of each article are demanded; in the case of larger orders it becomes more economical to tool up for machine production.

Box-folding is a repetitive, relatively unskilled task, which calls for application and dexterity rather than for any special training. It is not lucrative work; on the existing rates, agreed by the relevant wages council, an average worker earns only a little more than 2 shillings an hour. For the purposes of the present study, however, it had several advantages:

(i) it required no equipment other than spring clamps to hold the folded containers, and these were provided by the factory;
(ii) it provided individual work, in units which could be counted, to provide a measure of each patient's daily output;
(iii) it was available in sufficient quantity from a firm which has already had several years' experience of dealing with a sheltered workshop in a mental deficiency hospital.

**Observations**

**Level of Work.**—Before the workshop was instituted, an experiment was carried out with eight male long-stay patients, diagnosed as paranoid schizophrenics, and aged 40 to 44 yrs.

They were given a simple repetitive task (sorting buttons of three sizes) and their rate of work was measured at 2-minute intervals. One of these patients protested at the interruption of his accustomed daily routine and refused to attend after the first week. The rest showed certain features in common. Their initial rate of work was much below that of a control group of normal men of the same age and similar intelligence level, and improved more slowly—but it continued to improve. Whereas the controls had "levelled off" at a fast rate of work after 7 days' practice, the patients levelled off only after 28 day's practice; by this time four of the patients had achieved the same rate as the controls, and the remaining three patients were working at 85 per cent. of that rate (O'Connor, Heron, and Carstairs, 1956).

It was concluded that long-stay patients could be expected to start much below the normal level of industrial output, but that given time they would slowly approximate towards that level. An important factor in sustaining this slow improvement was believed to be the offering of an incentive; and the simplest incentive is money. Accordingly, from the outset of the workshop trial, it was made clear to the patients that the money earned by their efforts would be distributed among them according to their output.

**Response to Money as an Incentive.**—It was soon clear that the opportunity to earn a few shillings a week was a potent incentive for long-stay patients. The patients remarked upon the amount of their earnings and took note of differences in the rewards of various members of the group. It was noted that on pay-day even the most autistic patients would talk relevantly and sensibly about their money and would discuss among themselves the resources of the hospital shop. For a time, their delusional pre-occupations ceased to dominate their attention.

As the previous experiment had suggested, the patients began work at a slow pace, and earnings were correspondingly low. During the first 3-week period the total earnings of the group averaged £5 each week, during the next 3-week period it was £7 17s., during the third £9 5s. 6d., and during the fifth £11 14s. After this the weekly earnings remained at between £9 and £10, although one of the best workers was absent for much of the time. These are extremely low earnings for a task at which twelve normal young women, working for a comparable number of hours, could expect to earn at least £24 per week.

This result might be due to incapacity, or to lack of incentive; but the former is an unlikely explanation in view of the experiment previously reported. An inspection of the individual pay-sheets showed that, during the last 3 weeks, seven of the twelve men earned £1 each. Four of them had previously frequently exceeded this figure; the other three had laboriously climbed towards it. The arrest of their earnings at this figure of £1 per week was not due to chance, but to the National Insurance Acts. A patient in hospital is permitted to earn sums up to £1 per week, while carrying out "work which is undertaken under medical supervision as part of his treatment". As soon as he exceeds this limit he forfeits his residual Sickness Benefit (7/6 per week, for most of our patients) and becomes liable to pay a weekly contribution of 8/5 as a self-employed person.

These regulations had been explained to the patients. It was pointed out that if they could increase their output to earn over £1 16s. 0d. per week, they could become self-employed persons and continue to earn more pocket-money. In effect, however, the prospect of working harder in order to pay taxes and forfeit benefits did not appeal to them.
In this situation, the existing regulations (intended no doubt to safeguard against abuses of social benefits) are an effective deterrent. This obstacle will only be overcome if patients can be offered a more remunerative form of work, or if the “permitted earnings” limit is raised.

**Individual Variations in Work Level.**—Four patients early revealed themselves as the most productive members of the group. The best of them was soon entrusted with the task of packaging the finished work for the entire workshop. The remaining three, in 23 consecutive weeks in which individual totals were noted, scored the highest weekly output of the group on 7, 6, and 10 weeks respectively. Three others were consistent in their output, but at a slightly lower level. The remaining five patients showed very considerable fluctuations; with one exception, each man in the last group showed that when working at his best he could exceed the average output of those in the previous group, but that he could not sustain this level. The one exception also showed fluctuations in work level, but with a lower best performance; this individual differed from the rest in two other respects: he had had the longest period of hospitalization, and he had a history of epilepsy.

It was anticipated that schizophrenic symptoms might interfere with the performance of some patients, since a psychiatric examination carried out at the beginning of the trial period showed that ten of them currently exhibited delusions, hallucinations, or misinterpretations, and the two others gave evidence of similar experiences in the past. However, a day-by-day record of events in the workshop indicated that, provided that the patients came to the workshop (one patient’s attendance was interrupted for a period of 6 weeks, and three others were absent for a total of 5 single days for reasons attributable to their mental illness), the continuance of their symptoms appeared to interfere only to a minor extent with their application to work.

Occasionally, disturbed behaviour on the part of one or other of the patient-workers was sufficiently disruptive to be recorded in the diary of events. Such incidents were rare and concerned only three of the twelve patients. A total of eight incidents was noted for the 6-month period: five were associated with one patient, two with a second, and one with a third man.

In one instance an hallucinated schizophrenic suddenly struck a nearby worker. In a subsequent interview this patient pointed out that the man he had assaulted kept talking aloud and that on this particular occasion he was simultaneously moving his foot, thereby seeming to kick what he was saying into the patient’s head. This had made the patient very angry and he had therefore retaliated. At a later date, the same patient began swearing loudly for no apparent external reason in a manner which upset nearby workmates. Interview disclosed that this was a reaction to intrusive hallucinations and passivity phenomena. An attempt was made to convey a sympathetic understanding of these abnormal experiences, but the patient was nevertheless informed that behaviour of this kind could not be permitted in the workshop because of its effect on other patients. He was advised to take a walk in the grounds whenever he felt impelled to respond in this fashion. From this time the patient seemed able to contain himself despite continuing provocation, and he never did retire to the grounds.

The greatest number of incidents was associated with an irascible paranoid schizophrenic who was disposed to react promptly and vehemently to real or imagined injury or injustice. His aggression was mainly verbal, though on one occasion he angrily hurled a piece of cheese through an open window. Another time he threatened to hit a patient who was responding to his own hallucinatory experiences by continual swearing. This man’s outbursts were treated in the same manner as those of the hallucinated patient mentioned above; he was taken aside, and given an opportunity to express his current grievance, which he did vehemently. Any well-founded complaints were acted upon, but on the other hand the doctor made it plain that he did not accept all the patient’s misinterpretations and could not permit violent behaviour. These interviews appeared to dissipate much of the patient’s resentment and helped him to resume his place as the most industrious worker in the shop.

Another patient showed a tendency at times to idly drawing and smoking, occasionally laughing foolishly or shouting obscene abuse directed at no particular object.

At no time was the tenor of work in the factory substantially affected for more than a minute or two by such incidents.

**Improvement in Social Behaviour.**—At the start of this experiment four of the patients were under constant surveillance, requiring to be escorted to and from the locked wards in which they lived. Two of these patients had histories of repeated attempts to escape; the two others were regarded as liable to wander off in a disoriented manner. After 2 months’ attendance at the workshop it was noted that none of these patients was now escorted to and from work. The two “escapers” had both been transferred to
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open wards, and the two others had shown themselves able to proceed to and from work on their own.

Seven patients were lodged in locked wards at the beginning of the experiment, although three of them had limited “corridor parole” privileges at certain hours. After 6 months, four of the seven had been transferred to open wards. No patient was downgraded in respect of parole status during this time. These changes in status were effected by the ward doctors, purely on the evidence of the patients’ generally improved level of behaviour: they were not instigated by those in charge of the workshop.

During the 6 months following the period under review, the twelve subjects were joined by twenty more men and thirty women patients, in an expansion of the workshop programme. One year after the commencement of the first experimental group the position of the twelve was as follows: three had been discharged (including the man with 22 years’ stay in a succession of hospitals), one had absconded and remained at large for the period necessary for his certification to lapse, seven were in open wards and working regularly, and one remained in a closed ward although still attending the workshop.

Changes in Patients’ Social Environment.—It should be noted that this experiment was carried out in a hospital which was in a process of change. A vigorous treatment policy was being combined with a drive to improve the amenities and wherever possible to increase the amount of freedom accorded to patients. Against the background of these general changes in the hospital environment must be set the particular changes in the social field of each participating patient. Not only did he attend the workshop and associate with the others in productive work: he also became recognized by the staff and other patients in his ward as one of those gainfully employed in the “box factory”, so that their attitudes towards him were correspondingly modified.

Many of these wider social influences defied precise observation. One was aware of a widespread interest among the nursing staff in the progress of the workshop; and also of not a little hostility towards this innovation, some of which found expression in teasing the working patients, making fun of their allegedly high earnings, etc.

Two studies were carried out to obtain more detailed observations upon the patients’ wider social environment. The first (Carstairs and Heron, 1956) completed during the early weeks of the 6-months’ pilot experiment, consisted of an opinion survey carried out with 210 male members of the hospital staff (including staff of all ranks and occupations, from the Medical Superintendent to the scullery hands) in order to ascertain their attitudes toward mental patients, evaluated in terms of “custodialism versus humane treatment” and degrees of authoritarianism. It was apparent that the most “custodial”, and to a less extent, the more “authoritarian” attitudes were to be found among older men in the lower ranks of hospital employment: among those, in fact, with whom patients most often come into contact.

The second study (O’Connor, Carstairs, Rawlsley, 1956) carried out at the conclusion of the 6 months’ period, consisted of an inquiry into the extent to which information about the workshop, and interest in it, had permeated the entire population of male long-stay patients in the hospital. 560 patients were given a brief interview in which they were asked whether they had heard of the “box factory” (as the workshop is known in the hospital), and if so whether they had heard of it from a staff member or from a fellow-patient. Questions were also put to elicit their attitude to the workshop project, and finally they were asked whether they would like to take part in it.

Analysis of the responses showed that 37 per cent. of these patients had heard of the workshop. The proportion who had done so was higher in the open wards (49 per cent.) than in the closed wards (29 per cent.). On the other hand, the number of patients who expressed a desire to enter the workshop exceeded the number who claimed to have heard about it, and in this case a higher proportion of volunteers came from the closed than from the open wards (55 per cent. and 33 per cent. respectively).

Summary

During the initial trial of an industrial workshop in which mental hospital patients were paid for their work, some problems were answered and others raised. It was shown that many long-stay patients are capable of reaching normal levels of rate of work at comparatively unskilled tasks. That normal output is not achieved is due to lack of incentive rather than to lack of capacity, and patients showed ready acceptance of money as an incentive. Regular attendance at the workshop was accompanied in many cases by an appreciable improvement in patients’ social behaviour: this was most marked in those whose previous behaviour had been least satisfactory. It was recognized that attendance at the workshop was only one among a number of social interactions in which patients were involved.

Attempts were accordingly made to obtain measures of two accessory social influences, namely the attitude of staff towards patients, and the degree of
intercommunication between long-stay patients in the hospital. It is suggested that, if industrial work is to be further developed as an instrument for the social rehabilitation of chronic psychotic patients, planned social incentives will be required to supplement the financial one. This will especially be the case if patients who are initially negativistic or indifferent are to be successfully involved in such a programme.

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REFERENCES


