For almost two years now my colleague Anne Aldrich has been engaged on 'action research' to devise ways of assessing the abilities and potential of our workers and of managing the transition to outside employment. This project has been part funded by the MSC as the first Pilot Employment Initiatives for Disabled People.

The task has been in two parts; firstly to devise questionnaires and records which enable the workers to participate in their own assessment over the period of time they are in the workshop. The assessments invite the workers to compare their perceptions of themselves and their skills and abilities with the observations of the supervisors. Thus a dialogue is begun which, if successful, will lead to a more realistic perception by the workers of their employment ambitions, and will also enable staff to understand the sorts of work which the worker finds satisfying and self confirming rather than self negating.

The second part of the task has been to develop a network of local firms who are prepared to take people on work experience placements during which both the worker and the employer receive support in making the placement a success. The time limited nature of these placements minimises the risk of failure and the worker begins to build a pattern of small successes which it is hoped will lead to them acquiring the ability to sustain long-term employment.

During 1987 three firms offered placements and six workers have been able to take advantage of these. One worker has in fact now been taken on as a regular employee of the firm in which she was placed.

Concluding remarks

Whatever term is used to describe industrial therapy, the employment of people with mental handicap and mental ill health is an essential part of Community Care. If a person does not have the opportunity to make a productive contribution to society within the limits of their capabilities then they are being denied a basic component of human dignity.

A partnership between social welfare agencies and the world of commerce need not herald a return to the workhouse, as long as the cardinal principle is understood that the main purpose of any initiative is to enhance the quality of people's lives.

Work at Netherne – A service responding to change

MOUNIR EKDAWI, Consultant Psychiatrist, Netherne Rehabilitation Service, Coulsdon, Surrey

Work activities were systematically introduced by R. K. Freudenberg at Netherne Hospital, in the 1950s, as a component of a rehabilitation programme for severely disabled in-patients. At about the same time, Douglas Bennett utilised the psychological, vocational and economic benefits of work in preparing long-stay Netherne patients for resettlement in the community. The value of work as a principal rehabilitative medium in a wide spectrum of disability was periodically reported.[1,2,3,4]

Although work rehabilitation is essential to equip some patients for future employment, the view that employment is its ultimate aim is unrealistic, and it can only result in disillusioned patients and demoralised staff. When employment was plentiful in the 1960s and 1970s, a follow-up study of 367 carefully selected and intensively trained long-stay Netherne patients showed that only about a third could sustain competitive employment.[5] This ratio has thereafter fluctuated, but it has remained below 50%. Work rehabilitation should therefore not be seen as relevant only to employment problems; the performance of a work role is in itself an indicator of social adjustment, and it is so perceived by those in close contact with the patients.[6]

The number of patients for whom the Netherne Rehabilitation Service are responsible has remained fairly constant at about 300; however, while in 1961 all were long-term in-patients, less than 50 are now in hospital accommodation. During the last 25 years, the impact of social and organisational changes, including the gradual shift to community rehabilitation, the changing scene of the MSC provisions for disabled people and the NHS management reorganisation, have led to various modifications in the

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Netherne Service. Its resources have become largely community based.

The rehabilitation day hospital

This specialised 30-place facility was moved from the Netherne site to a building in one of the local towns in 1976. Its functions include occupational, social and clinical assessment and rehabilitation, organised in three departments for industrial work, office work and printing. It is also a base for long-term treatment and support for 150 patients and their families and it provides back-up services for other community work facilities.

Industrial therapy workshops

Although their image has changed over time, industrial therapy workshops still provide a valuable environment, particularly for severely disabled patients. Two 30-place community workshops suitable for two levels of disability have now largely replaced the hospital workshops. They evidently satisfy the users, since the attendance rates have not fallen below 85%.

The clerical training office

Before the 1970s, Employment Rehabilitation Centres (previously known as IRVs) were, for many patients, a stepping stone from hospital workshops to employment. These units were of undoubted benefit, but they also had major limitations, so far as psychiatric patients were concerned. They were mainly of use to people with moderate disability, the duration of their courses was too short and the rates of their subsequent job placements were low. This led to the emergence of Industrial Therapy Organisations (ITOs), pioneered by Donal Early in Bristol, as more suitable alternatives, by offering prolonged rehabilitation in more protected environments.

The district served by Netherne is predominantly white collar, with open and sheltered employment opportunities in office work. It was therefore thought appropriate that the recently established small local ITO should provide training in typing, word processing, book keeping, computer operating and reception work.

Sheltered employment

The Sheltered Placement Scheme, supported by the MSC, has many advantages over the Remploy-style workshops. It does not require a large capital investment, it avoids the segregation of disabled people and it offers a diversity of work opportunities, rather than just factory work. The need for Netherne's district was calculated to be for eight to eleven places at any one time. It is a worthwhile scheme, although it involves much red tape to start with.

The employment coordinator

Placement in open, sheltered or voluntary employment is often dependent on the efforts of an intermediary, and, traditionally, this has been the Disablement Resettlement Officer; some DROs have, in the past, worked effectively as members of the rehabilitation team. Others made little contribution to the field, being reluctant to face the problems of the psychiatrically disabled. They often wrote them off as risks, or, at best, thought them only capable of routine, 'unstressful' work.[7] Moreover, they tended to hold the view that the psychiatrically disabled (unlike the physically disabled) should not expect any adaptations to the work environments to accommodate their disabilities. This view was challenged by Floyd *et al*,[8] who maintained that some mutual adjustments could be profitably achieved, given prior careful preparation and subsequent ongoing support to both employer and employee. The skill and time commitment required to find suitable jobs, prepare the patient, negotiate changes with the employer and maintain regular contact are considerable, and neither is now available from the DRO service. It was for this reason that the post of Employment Coordinator was developed.[9]

Long-term care and support

No work rehabilitation system can survive for long without a network of support. This includes a calendar of regular reviews in each of the work settings, a competent back-up service and individual and group counselling and support for patients and carers.

Some problem areas

Evaluation of community services is notoriously difficult, not least because of the long duration of time it requires; early successes are often the product of the flush of enthusiasm. Meanwhile, the development of work projects is never problem-free. Many of the projects described were started on a shoe-string, with funding from grants and contributions from joint finance, industry and charities. These resources are both finite and time-limited, and work rehabilitation can hardly ever be self-supporting. In the long term, financial difficulties may well occur.

Since it has been necessary to involve a variety of statutory and voluntary organisations, there have been problems of coordination as well as occasional conflicts of interest. The scatter of facilities in different locations, as compared with the relatively compact hospital provisions, can cause delays in patient movement, if only to correct the occasional mismatch between patient and work environment.

Finally, there are two notable organisational problems. Netherne is scheduled for closure; planning alternative residential provisions has taken

precedence over other services, including work provisions, and thus the current plans have ignored the fact that there are still some day patients who work on the hospital site. The management has also yet to be convinced that rehabilitation is not a time-limited course, ending in discharge and effecting economies; community rehabilitation projects are, in fact, labour intensive and they need a perpetual input of expensive professional time.

References

[1] BENNETT, D. H., FOLKARD, S. & NICHOLSON, A. K. (1961) Resettlement unit in a mental hospital. *Lancet*, **ii**, 539–541.

[2] WING, J. K. & FREUDENBERG, R. K. (1961) The response of severely ill chronic schizophrenic patients to social stimulation. *American Journal of Psychiatry*, **118**, 311–322.

[3] ——, BENNETT, D. H. & DENHAM, J. (1964) *The Industrial Rehabilitation of Longstay Schizophrenic Patients*. MRC Memo. No. 42. London: HMSO.

[4] —— & BROWN, G. W. (1970) *Institutionalism and Schizophrenia*. London: Cambridge University Press.

[5] EKDAWI, M. Y. (1972) The Netherne Resettlement Unit: results of ten years. *British Journal of Psychiatry*, **121**, 417–424.

[6] COLLIS, M. & EKDAWI, M. Y. (1984) Social adjustment in rehabilitation. *International Journal of Rehabilitation Research*, **7**, 259–272.

[7] STUBBINS, J. (1985) Resettlement services of the employment services, Manpower Services Commission. In *Handicap in a Social World* (eds. A. Brechin., P. Lilliard and J. Swain). Sevenoaks: Hodder & Stoughton.

[8] FLOYD, M., GREGORY, E., MURRAY, H. & WELCHMAN, R. (1983) *Schizophrenia and Employment*. The Tavistock Institute of Human Relations. Occasional Papers No. 5.

[9] GLOAG, D (1985) Occupational rehabilitation and return to work: 2 – Psychiatric disability. *British Medical Journal*, **290**, 1201–1203.

Consultant manpower in child psychiatry

North East Thames Region

This paper has been prepared by the North East Thames Child and Adolescent Psychiatric Advisory Sub-Committee (NETCAP) in order to draw the attention of the Region to deficiencies in consultant child psychiatric services in the Region. It sets out below the population of each district and the current consultant manpower. These figures have been obtained from the district general managers and in some cases corrected by the local consultants.

In 1973 the Royal College of Psychiatrists[1] recommended that the realistic minimum requirement for child psychiatrists was 1.5 per 200,000 population with a further 1:500,000 for adolescence. Even by these now outdated standards the NET Region is three consultants short (see Table I). In 1978 it was recommended that these figures be increased by a factor of 1.6 for teaching districts to take account of the extra manpower requirements for teaching medical students and research.[2] In 1983 the College revised its recommendations, taking into account the expanded role of child psychiatry because of effective treatments such as family therapy which "now enables psychiatrists to tackle problems of childhood and adolescence which were previously insoluble" and other factors. It recommended an "irreducible minimum" of two consultant child and adolescent psychiatrists per 200,000. We are five consultants short of that standard. However, the College 1983 "realistically desirable" standard was 3:200,000 population with an extra loading for teaching districts.[3] By these standards we are 29.5 consultants short. We have not included in the district figures the Tavistock Clinic, the Hospital for Sick Children and the regional adolescent units consultants in these calculations as they serve as tertiary referral clinics. They add another 17 consultants to the total for the region. If they are included we are still over 12 consultants short on 1983 recommendations. These recommendations were made five years ago. Since then there have been many developments which have increased the demand on child psychiatric services, outlined below.

Increase in marital breakdown

In the past 15 years, the divorce rate has more than doubled, and many of these divorced parents remarry. Children of divorce more likely to become disturbed than children from intact families, and more likely to be referred to child psychiatric services.

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