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Employability of the Mentally Disabled in the 1970s

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Summary: Of 156 discharged patients, the forty who succeeded in open employment had shown before they left hospital a combination of significantly less clinical disability, less abnormal behaviour, better work performance and better relationships with other people. We specify the approximate levels of these variables that were required to get and hold a job in the 1970s.

There is no formal way of assessing and predicting the employability of people who are ready to leave hospital and are candidates for open employment. The fallibility of intuitive selection methods has concerned the Manpower Services Commission and its predecessors for many years and has recently been deplored by Wansbrough and Cooper (1980). Each time that a job placement ends in failure, there is damage to the patient's fragile morale, disappointment for the staff (whose resilience is not endless) and destruction of another precious fragment of sympathetic employer's goodwill.

Attempts to unravel the problem by researchers based outside hospital have not been entirely successful. A large, hitherto unpublished study by Paul Cornes in Birmingham produced findings that were inconclusive. An elaborate study by Floyd *et al* (1981) of schizophrenia and employment focussed exclusively on the specifications of the jobs into which their sample of patients were placed, but provided no quantified information about the clinical state of the patients themselves.

In the present retrospective study, begun in 1980, we focus more on the specifications of the patients to see if there is an association between the degree of their residual disability and their success or failure in open employment. Having documented early warning signs of it years ago (Morgan and Cheadle, 1975), we recognise only too well that nationwide unemployment has put an almost complete stop to the resettlement of the mentally disabled into open employment in the 1980s. We submit, however, that experience gained in more prosperous bygone times is worth preserving, in case better times return sooner than anybody dares to expect.

Method

Our sample consists of 156 patients (received from other hospitals after selection for a course of rehabilitation), who were discharged from this hospital in the 1970s and whose case-note records were sufficiently complete for our purpose. We have deliberately included patients with the whole range of outcomes from the most to the least successful, in the hope that the characteristics of those who proved their employability may thereby be highlighted against the rest. Success in open employment was defined as starting a job within four weeks of discharge and being still at work six months later (not necessarily in the same job), with no more than a fortnight of unemployment in the interval. We compare those who met these criteria with those who did not.

The features recorded at the time of discharge and available for comparison included sex, age on first-ever admission to mental hospital, age on discharge, marital status, social class, years of illness, years in hospital, diagnosis, I.Q., physical state, Wing Group, social withdrawal and socially embarrassing behaviour scores (Wing, 1961), Cheadle behaviour score (Cheadle, 1975) social assessment score (Morgan and Cheadle, 1981, p. 106) work score in hospital (Cheadle and Morgan, 1972), prognosis index (Morgan and Cheadle, 1974; Morgan and Gray, 1982) the nature and place of the job into which the patient was resettled, and the drug treatment on discharge. From the last work score in hospital, four ratings were derived, described by Griffiths (1973, 1977) and denoting what he called task competence, response to authority and supervision, relationships with others, and work motivation and enthusiasm. We did not have the data to measure Griffith's fifth factor—confidence-initiative—which both he and Watts (1978) have found less satisfactory.

Results

The sample contained 86 men and 70 women. Their ages ranged from 21 to 61 (mean = 43 ± SD 11), and they had been ill for an average of 24 years, more than half of which had been spent in hospital. All except eleven were working class, both in family background

and previous occupation, six having been skilled, 50 semi-skilled, and 89 unskilled. Out of the total of 156, 125 had never been married, and the remainder no longer were. Seventy-eight suffered from chronic schizophrenia, 38 were mentally retarded, 16 showed signs of mental retardation and schizophrenia, and the remaining 24 were neurotic or chronically depressed or brain damaged. Thirty nine patients were discharged on maintenance treatment with parental antipsychotic medication, 87 were on oral antipsychotic drugs, and 30 were on no such drugs.

The patients may be divided into five sub-groups according to their placement on discharge. Sub-group A contains 40 patients, who succeeded in open employment by the criteria stated above. Sub-group B consists of 22 patients, who failed after being placed in open employment. Sub-groups C D and E are respectively 26 patients who were discharged home but never got a job, 34 patients who became day-patients in sheltered employment, and another 34 patients who were returned to their hospitals of origin, being too intractably disabled for resettlement at any level.

We first compared Sub-groups A and B on every available variable, but only two served to discriminate, and then only at the 5 per cent level. The successes (Sub-group A) had been significantly *longer* in hospital and had better relationships with other people, the latter confirming a finding by Watts (1978). Apart from these two variables, which discriminated too poorly to be of practical use, Sub-groups A and B were indistinguishable, from the data at our disposal.

Of the 22 members of Sub-group B, only one failed through not taking his tablets; he was manic-depressive and became manic without regular lithium. Two patients became physically ill. Four patients with poor personality, three being temporal lobe epileptics, were too moody, irritable, argumentative or aggressive to be kept on by their employers. Three patients, who had worked excellently under the shelter of hospital, soon went to pieces outside (as opposed to relapsing with their original symptoms) and must be labelled inadequate. Eleven patients were just not adaptable enough to meet the demands of their new jobs; they were variously described as too slow, unreliable, lacking initiative, unable to grasp instructions, and needing constant supervision.

We could not find that the nature of the job affected the outcome in any way. The members of our sample differed from those of Wansborough and Cooper (1980) and Floyd *et al* (1981) in having all been severely ill and out of work for many years, and most of them had been in lowly jobs or no job at all before that. Their long lay-off and residual disabilities left them no choice but to rejoin the employment ladder on its bottom rung. Vacancies in accessible areas dictated that half went into hotel work, a quarter found domestic jobs, and the remainder did factory labouring. The proportions of failures in each of these situations were almost exactly equal.

We proceeded next to compare the Sub-group A with the rest of the sample (Subgroups B C D E); as there was little difference in outcome between the sexes, they have been considered together. Detailed tables of association between outcome and each of the variables listed in the Methods section are available from the authors. For some variables, there was no significant association, while for others there was, but these merely confirmed the verdict of the key variables, without adding any discrimination; they have therefore not been used.

There turned out to be five key variables, chosen because they are based on well validated and widely used scales, and because they produced highly significant differences with the chi-squared test. (On each of these scales, the higher the score the greater the disability). Of the 40 patients who succeeded in open employment, none was in Wing Group 2, 3, 4 or 5, only one had a social withdrawal score (possible range 0–16) of more than 2 ($P < 0.001$), only one showed any socially embarrassing behaviour ($P < 0.01$), none had a work score of more than 39 (out of a possible 64) ($P < 0.001$), and only three patients scored more than 3 (out of a possible 8) for relationships with others ($P < 0.001$).

We were surprised by the lack of predictive validity in some of the other variables that were tested. The patients who fell ill and entered hospital at an early age did no worse than those who became ill later in life. A poor social assessment score did not necessarily prevent patients from coping with a job. Schizophrenic patients on parenteral maintenance treatment fared no better than those on oral treatment. Higher intelligence gave a slight advantage, but never outweighed the key variables.

Concurrent physical disability was present in 20 per cent of sub-group A and 32 per cent of the rest, but the difference was not significant. Obesity was the commonest disability, affecting one and 13 members of the sub-groups respectively, but this too failed to reach significance.

We would have liked to examine what bearing the patients' previous work history had on their employability after rehabilitation (Watts and Bennett, 1977), but unfortunately, the considerable information that was available in the patients' case notes was not detailed enough for this purpose.

Discussion

Community-based studies, lacking any measurement of patients' residual disabilities on placement in

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open employment, have concluded that the outcome depends on the specifications of the job. By contrast we have found that the outcome depends largely on the extent of the patient's disability. We have specified the levels of performance on five key variables, below which success in open employment occurred seldom or never in our sample.

We can predict that success in a job requires membership of Wing Group 1, a social withdrawal score of less than 3, a work score of less than 40, a score of less than 4 for relationships with other people at work, and freedom from socially embarrassing behaviour. When this formula was applied to our sample, it correctly identified 37 of our 40 successes and 72 of our 116 failures. Its sensitivity (92.5 per cent) is satisfactory, but specificity (62 per cent) and predictive value (46 per cent) are low. The latter can be improved slightly with other formulae that we have tried, but only at the price of lowering sensitivity, which seems undesirable.

Since the prevailing level of local unemployment plays such an important part in determining the disabled person's relative prospects of re-employment (Morgan and Cheadle, 1975), there is no point in trying to be any more precise about absolute levels of accomplishment required. The data have shown clearly enough that a patient's psychiatric condition, behaviour, work standard, and relationships with others are clinical factors that determine in large part the outcome of his resettlement. Any hospital which omits to measure them is working in the dark, and any study of employability which ignores them is incomplete.

References

CHEADLE, J. (1975) Statistical ratings for psychiatric patients. *Nursing Times*, 24 July, 1182–5.

—— & MORGAN, R. (1972) The measurement of work performance of psychiatric patients: a reappraisal. *British Journal of Psychiatry*, **120**, 437–41.

FLOYD, M., GREGORY, E., MURRAY, H. & WELCHMAN, R. (1981) *Schizophrenia and Employment: Summary of Final Report*. London: Tavistock Institute of Human Relations.

GRIFFITHS, R. D. P. (1973) A standardised assessment of the work behaviour of psychiatric patients. *British Journal of Psychiatry*, **123**, 403–8.

—— (1977) The prediction of psychiatric patient's work adjustment in the community. *British Journal of Social and Clinical Psychology*, **16**, 165–73.

MORGAN, R. & CHEADLE, J. (1974) A scale of disability and prognosis in long-term mental illness. *British Journal of Psychiatry*, **125**, 475–8.

—— —— (1975) Unemployment impedes resettlement. *Social Psychiatry*, **10**, 63–7.

—— —— (1981) *Psychiatric Rehabilitation*. Surbiton: National Schizophrenia Fellowship.

—— & GRAY, S. (1982) Prognosis in chronic mental disability. *British Journal of Psychiatry*, **141**, 178–80.

WANSBROUGH, N. & COOPER, P. (1980) *Open Employment after Mental Illness*. London: Tavistock.

WATTS, F. N. (1978) A study of work behaviour in a psychiatric rehabilitation unit. *British Journal of Social and Clinical Psychology*, **17**, 85–92.

—— & BENNETT, D. H. (1977) Previous occupational stability as a predictor of employment after psychiatric rehabilitation. *Psychological Medicine*, **7**, 709–12.

WING, J. K. (1961) A simple and reliable sub-classification of chronic schizophrenia. *Journal of Mental Science*, **107**, 862–75.

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