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The Psychiatric Rehabilitee

By N. L. GITTLESON

Introduction

The Disabled Persons (Employment) Act of 1944 set up a national register of disabled persons and facilities for their industrial rehabilitation. The Industrial Rehabilitation Units of the Ministry of Labour which were provided for by this Act were described and their functions evaluated in the Piercy Report (1956). The broad scope of present concepts of rehabilitation is fully reviewed by Vaughan Jones (1961) and will not be discussed here.

Persons suffering from organic or functional psychoses, subnormality, epilepsy or personality disorders are eligible for rehabilitation—i.e. the so-called "psychiatric case". The advantages of an I.R.U. Course have been discussed by Wing and Giddens (1959). In brief they are: First, the demonstration of working ability to the doctor, the I.R.U. staff, the Disablement Resettlement Officers, the employer, and to the rehabilitee himself. Secondly, the more realistic near-industrial conditions of the Unit. Thirdly, the inculcation of work habits and the minimizing of the protective atmosphere of a hospital.

The Ministry of Labour Industrial Rehabilitation Unit at Handsworth, Sheffield is typical. It serves an industrial area biased towards heavy steel, engineering and coal-mining. The non-medical staff consists of a Rehabilitation Officer (Manager), a Disablement Resettlement Officer, a Vocational Officer (in this unit an industrial psychologist), a Social Worker and a Remedial Gymnast. In addition, there are Shop Supervisors (fully skilled tradesmen) in charge of each section of the Unit. Practical work is provided in educational and clerical subjects, machine operation, bench engineering, woodwork and miscellaneous light work. There is also a general section for unskilled manual tasks such as gardening and heavy work. All entrants commence their first week in the intake section where general tasks are assigned in an attempt to assess overall efficiency in general and tool skills in particular early in the course. All female entrants commence on light miscellaneous and bench assembly tasks. Sections are all working to fulfil contracts for local firms and individual private customers. The rehabilitees are told this, and know that the tasks they are doing are the "real thing" and must attain the standards of finish of open industry in quality, if not in quantity.

Referrals to the I.R.U. are by doctors, Ministry of Health Regional Medical Service, local Employment Exchanges, Youth Employment Bureaux, Trade Unions, employers and the National Assistance Board. A condition for a course at the I.R.U. is reasonable prospects of employability on completion of a course.

It is important to state that an I.R.U. course, besides giving rehabilitation to those who have never worked or who have had to change their jobs, has two further functions. The first is "toning-up" or accelerating convalescence. The second is the assessment function, which is of great importance in the "psychiatric case" but is understressed in the literature.

The assessment of working potential at interview of the psychiatric case is so difficult in the present state of our knowledge (or lack of it) that practically all "psychiatric" referrals which are supported by a psychiatrist or other doctor are accepted for entry to the I.R.U. Wing (1960), referring to schizophrenics, states that selection procedures have not been worked out—it is still true of the psychiatric case in general. Wing also comments on the dearth of published information in regard to I.R.U.s.

All rehabilitees on entry are given an introductory talk explaining the objects of the course, etc. They are then seen individually by the Unit Medical Officer, the Social Worker, the Chief Occupational Supervisor, the Disablement Resettlement Officer, the Vocational

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Officer and the Rehabilitation Officer. The Vocational Officer gives tests of intelligence and aptitudes. A psychiatrist (N.L.G.) visits weekly.

The rehabilitee's progress is discussed periodically at case conferences, at which all the reports available are considered, and changes of type of work decided or vocational training may be recommended. The maximum length of a course is fixed at twelve weeks. Throughout the course great emphasis is laid on producing an "industrial" atmosphere. Rehabilitees clock-in and receive their allowances in pay packets. Supervision, though friendly and sympathetic, is designed to avoid the slower tempo and protected atmosphere of hospital occupational therapy units. Whilst the Rehabilitation Officer and other non-medical staff have access to psychiatric advice, all recommendations are the responsibility of the case conference which takes as its criterion the standards of open industry.

The dominance of non-medical control is undoubtedly seen by the rehabilitee as an expression of his advance towards true independence. Lewis *et al.* (1945) wrote: "Psychiatric advice is not the same thing as advice by psychiatrists, it is wider than that and covers all advice which has as its aim the furtherance of mental health." The authors went on to say: "Valuable as diagnosis may be in certain instances, or for other purposes, it cannot by itself be as important from the industrial point of view as the personality and the morbid anomalies of behaviour which the worker exhibits. Judgment of the latter is sometimes said to be beyond the competence of the non-psychiatrist—I do not think it should be." With the above statements the author entirely agrees.

Object of Investigation

The object of this investigation is the ascertainment of those factors which appear to determine success or failure in rehabilitation (at an I.R.U.) of rehabilitees who have suffered or are suffering from Mental Disorder. The criterion used is the rehabilitees' performance during the I.R.U. course.

It might appear that the ultimate criterion for an I.R.U. course is the number of rehabilitees who later on are fully employed in the open labour market. The reliability of this criterion, however, is affected by the overall economic situation to which certain industries may be selectively vulnerable. The viewpoint which takes account only of the numbers ultimately in open employment ignores the assessment function of an I.R.U. and ignores the fact that an I.R.U. has a duty to give a chance to the "poor risk" or "borderline" case.

There is little published information on the correlation between performance during an I.R.U. course and ultimate employment status, but it is reasonable to assume that those rehabilitees who do badly in an I.R.U. will be less likely to find open employment than those who do well. Rehabilitees who do badly during their I.R.U. course can hardly be strongly recommended by the local Employment Exchange to prospective employers.

Method

Period of Study

Thirty-six consecutive weekly intakes to the I.R.U. were studied. The study commenced on 28 May, 1962 and ended on 28 January, 1963. There was no intake during the Christmas week, commencing 24 December, 1962.

Referral

Four classes of rehabilitees were studied.

1. Those whose entry documents bore a diagnosis of any type of mental disorder, as primary, secondary, subsidiary or sole disability. This included, besides the technical terms, such labels as "nervous debility", "neurasthenia", "effects of head injury", "concussion". The diagnosis "epilepsy (all types)" was considered as mental disorder. The labels "educationally subnormal", "poor learning ability", "defective intelligence", etc. were accepted as "mental disorder—subnormality".
2. Those whose entry documents bore the label "no disability", "nil", or "able bodied" in the space for disability.
3. Those who were thought to be mentally

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disordered by the Unit Medical Officer at the initial or any subsequent medical examination by him.

4. Those who were thought by the Rehabilitation Officer to be mentally disturbed, and thought by him to need psychiatric assessment. The Rehabilitation Officer acted on the information given to him by his non-medical staff.

Groups 3 and 4 were defined in an attempt to unmask the hidden "psychiatric case", and at the same time avoid criticism that psychiatrists see mental disorder where none exists. The line between the normal and abnormal personality is hard to draw. Schneider (1958) views the question of personality disorder as the extremes of a standard distribution curve. In statistical terms, the cut-off point is arbitrary. It was considered desirable to allow the non-medical staff to be the arbiters of the cut-off point for "abnormal personality". For Group 3, the Unit Medical Officer was the arbiter.

Diagnostic Categories

Diagnosis was based on the clinical interview. In some cases the disorder had receded (e.g. depressive psychosis), or remitted (e.g. schizophrenia) by the time the rehabilitee had entered the Unit, but the diagnostic label was retained.

The criteria for a diagnosis of personality disorder were those of Schneider (1958). Schneider's anancasts include the "sensitives" of Kretschmer (1952) and the obsessionals. His asthenics correspond closely to the classical "inadequate psychopath" of Henderson (1939), and the "neurasthenic psychopath" noted by Tonge (1955). This group are characterized by lack of drive. Hysterical personalities were delineated, using the criteria of Mayer-Gross *et al.* (1954), and coincide with the "attention-seeking personality disorder" group of Schneider (1958).

The diagnosis of "brain damage" was made clinically.

The diagnosis of "clinical subnormality" was made on the basis of the interview, and by noting and testing the literacy, ability to do simple calculations, and social demeanour. There are two reasons for this approach. First the diagnosis of subnormality is not purely and solely a question of test scores. It is predominantly a social definition. Second, employment is usually preceded by an interview, and interview performance is a major criterion used by potential employers.

Criteria of Employability

The Disablement Resettlement Officer was responsible, at the end of each rehabilitee's course, for entering on the data sheet the final coding *re* employability, allotted by the final case conference. The final coding was, therefore, the responsibility of the non-medical staff, using the standards of open industry as their criterion. For the purposes of this study four categories were used.

1. Suitable for employment. Rehabilitees with this coding were thought to be suitable for open work, and likely to succeed in finding and holding work.
2. Capable of employment. These were rehabilitees thought capable of open work but unlikely, in fact, to do so because of social or marital pressures, lack of financial incentive, or poor motivation.
3. Sheltered. These were so disabled that they were incapable of competing in the open labour market, but suitable for a sheltered workshop—e.g. Remploy. This excludes a Local Authority Occupation Centre.
4. Doubtful. Rehabilitees whose prospects of gaining or keeping work in the open market, or in a sheltered workshop, were very remote. Rehabilitees recommended for a Local Authority Occupation Centre were included in this group.

Premature Termination is the term applied when a rehabilitee leaves, or has to be discharged from the Unit before the full process of rehabilitation considered appropriate in his case has been completed. It may occur for medical or social reasons, and in a sense, represents a failure on the course.

Statistics

All the Chi-squared tests have been calculated using Yates's correction.

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Results

One hundred and eighty-nine rehabilitees were seen, consisting of 159 males and 30 females. Of these 189, 6 were considered to be cases where the psychiatric factors were not clearly the major disability (4 males, 2 females). This leaves 183 rehabilitees (155 (84·7 per cent.) males and 28 (15·3 per cent.) females) whose major disability was "psychiatric" in the sense previously defined.

A. Referral to the Psychiatrist

1. *Diagnostic Categories*

Table I below shows the diagnostic categories and mode of referral to the psychiatrist.

Several points emerge. All 14 rehabilitees whose entry documents stated that they were "able bodied" or were categorized as "no disability" proved to be mentally disordered. The referral figures amply confirm the statements of Lewis *et al.* (1945) that the identification of mental disorder is not beyond the competence of the non-psychiatrist.

The total intake into the I.R.U. was 461. One hundred and eleven cases (23·9 per cent.) were categorized on entry as being primarily psychiatrically disabled. In fact 183 (39·7 per cent.) were found to be so—a ratio of predicted (111) to found (183) of 1 : 1·65. If the highest possible estimate is made from the entry documents of the incidence of psychiatric disability by combining cases where the disability is given as solely, or primarily, or secondarily psychiatric, we obtain the figure of 132 (28·6 per cent. of the total intake of 461). These are the known cases of Table I, plus the 2 cases thought not to be primarily psychiatrically disabled by the psychiatrist. The ratio of predicted (132) to found (183) is 1 : 1·39, i.e. an extra 39 per cent. of the highest possible entry document estimate. The "new cases"—i.e. rehabilitees diagnosed for the first time as suffering from mental disorder were 53—11·5 per cent. of the total of 461. This is 16·1 per cent. of the cases in the entire intake categorized as "no disability", or as purely physical disability.

The above figures for the "new cases" are minimal estimates by reason of the nature of the referral. The 10 epileptics being counted as psychiatric cases, reduces the ratio of "new" to "known" cases.

Lewis (1935) examined 52 men referred by the local Public Assistance Committee, and found that hysteria was the dominant picture.

Table I

Diagnostic Categories and Mode of Referral to the Psychiatrist

Diagnosis	Mode of Referral to Psychiatrist: Rehabilitation Officer	Unit Medical Officer	"No Disability"	Total "New" Cases	Total "Known" Cases	Total No.	Cases %
Schizophrenia	0	3	1	4	20	24	13·1
Depressive psychosis ..	0	1	1	2	22	24	13·1
Epilepsy	0	0	0	0	10	10	5·5
Brain damage	1	1	0	2	5	7	3·8
Clinically subnormal ..	4	8	5	17	44	61	33·3
Anancasts	5	5	3	13	12	25	13·7
Asthenics	4	0	2	6	5	11	6·0
Hysterics	6	1	2	9	12	21	11·5
	20	19	14	53	130	183	
Psychiatric disorder not the major disability ..	2	2	0	4	2	6	

Known cases are those whose entry documents bear a psychiatric diagnosis as the sole, primary or secondary disability.

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As long ago as 1934, Cassidy concluded that 29·5 per cent. of patients seen in his consulting cardiological practice were neuropaths and showed no evidence of organic disease. In 1935 Halliday examined the causes of incapacity among insured persons. He noted that there was a tendency for the disability label to be altered from psychiatric to physical. Hewitt (1949) examined 50 unemployed disabled men and concurred.

Table II compares the method of referral to the psychiatrist for the group consisting of personality disorders, compared with other psychiatric diagnoses.

It can be seen that the "new cases" show a marked preponderance of diagnoses of personality disorder, when compared with the "known" cases. This is statistically highly significant, $\chi^2=14\cdot96$; $\cdot0005>P$. There is no significant difference between the "no disability" group and either the U.M.O. group, or the Managerial group. There is, however, a significant difference between the Managerial group and the U.M.O. group; $\chi^2=5\cdot75$; $\cdot02>P>\cdot01$.

The obvious interpretation of this difference is that rehabilitees suffering from a personality disorder are more likely to show evidence of it after a period of time in one of the workshops, and will not reveal themselves at routine medical examination, which makes much fewer demands on them.

2. *Premature Termination*

None of the six rehabilitees considered not to be primarily psychiatrically disabled were terminated prematurely, and they are counted as "non-psychiatric" cases. The "no disability" referrals had the highest premature termination rate of all—5 out of 14 (35·7 per cent.). In Table III they are included in the "new cases".

The above table shows analysis of Premature Terminations. None of the differences between the rates of premature termination are significant at the ·05 level.

TABLE II

Referral to the Psychiatrist of Personality Disorder Group Compared with Other Diagnoses

	Personality Disorder	Other Diagnosis	Total
Managerial referral	15 (75·0%)	5 (25·0%)	20
Unit Medical Officer referral	6 (31·6%)	13 (68·4%)	19
"No disability" referral	7 (50·0%)	7 (50·0%)	14
"New cases"	28 (52·8%)	25 (47·2%)	53 (29%)
"Known" cases	29 (22·3%)	101 (77·7%)	130 (71%)
Totals	57 (31·1%)	126 (68·9%)	183

TABLE III

Analysis of Premature Terminations

	Premature Termination	Completed Course	Total
"New" psychiatric cases	16 (30·2%)	37	53
"Known" psychiatric cases	32 (24·6%)	98	130
Psychiatric cases	48 (26·2%)	135	183
Non-psychiatric cases	53 (19·1%)	225	278
Total intake	101 (21·9%)	360	461

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Maxwell Jones (1956) in a series of 208 selected patients still under hospital treatment, found a premature termination rate of 23 per cent.

3. *Final Case Conference Employability Coding*

There is no significant difference between the "new" and "known" cases.

B. Referral to the Industrial Rehabilitation Unit

1. *Premature Termination*

There were no significant differences between the Premature Termination rates of cases referred to the Unit by psychiatrists (32·8 per cent. of 58), doctors who were not psychiatrists (15·8 per cent. of 38), medical agencies (26·0 per cent. of 96) or non-medical agencies (26·4 per cent. of 87).

2. *Final Case Conference Employability Coding*

Unit referrals by psychiatrists have a greater incidence of "doubtfuls" (40 per cent.) than referrals by non-psychiatrists (13 per cent.) as opposed to other codings; $\chi^2=6\cdot57$; $\cdot02>P>\cdot01$. This is hardly surprising, as referrals from a psychiatrist are more likely to have been admitted to a psychiatric hospital, and are therefore more likely to have been socially disturbed.

The referrals by psychiatrists, doctors who were not psychiatrists, and non-medical agencies were respectively 31·7 per cent., 20·8 per cent. and 47·5 per cent. of cases considered to be primarily psychiatrically disabled.

C. Previous Admission to an Industrial Rehabilitation Unit

1. *Diagnostic Groups*

There are no significant differences between the incidence of previous admissions (to the Unit) in the personality disorder group (anancasts, asthenics, hysterics)—6 (11 per cent.) out of 57, the "other diagnoses"—25 (20 per cent.) out of 126 and the functional psychosis group (depression and schizophrenia) which is 13 (27 per cent.) out of 48.

2. *Premature Termination*

The only significant difference in Table IV is between "previous" admissions who completed the course, and "previous" admissions which were prematurely terminated. $\chi^2=5\cdot21$; $\cdot05>P>\cdot02$.

3. *Final Case Conference Employability Coding*

Although the differences in Table V are not significant, one can say that there is no evidence that repeated admission to an I.R.U. improved the outlook as predicted from the employability codings; in fact the trend is the reverse.

D. Diagnostic Groups

1. *Premature Termination*

Of 57 cases of personality disorder, 20 (35 per cent.) were prematurely terminated. Of 126

Table IV

Influence of Previous Admissions to the I.R.U. on Premature Termination Rate
(Percentages are approximate)

	Terminated Prematurely	Completed the Course	Total
Previous admission to I.R.U. which was prematurely terminated	9 (64%)	5	14 (7·6%)
Previous admission to I.R.U. which was completed	3 (18%)	14	17 (9·3%)
Total previous admissions to I.R.U.	12 (39%)	19	31 (16·9%)
First admission to I.R.U.	36 (24%)	116	152 (83·1%)
All psychiatric cases	48 (26%)	135	183

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TABLE V

Effect of Previous Admission on Employability Coding
(Percentages approximate)

	Doubtful	Sheltered	Capable	Suitable	Total
Previous admission to I.R.U. ..	10 (32%)	3 (10%)	8 (26%)	10 (32%)	31
First admission to I.R.U.	43 (28%)	10 (7%)	21 (14%)	78 (51%)	152
Total admissions	53 (29%)	13 (7%)	29 (16%)	88 (48%)	183

patients with "other psychiatric diagnoses" 28 (22 per cent.) were prematurely terminated. This difference is not significant. The premature termination rate of the non-psychiatric cases is 19 per cent. (53 out of 278). This is significantly less than the rate for personality disorders (35 per cent.). $\chi^2=6{\cdot}2$; $\cdot 02>P>\cdot 01$, but not significantly less than the rate for other psychiatric diagnoses (22 per cent.).

It can be concluded therefore that personality disorder cases are more frequently prematurely terminated than non-psychiatric cases, and that these personality disorders are the factor which tends to increase the premature termination rate of the psychiatric group as a whole, compared to the non-psychiatric group, though this latter difference is just short of statistical significance—see Table III.

Markowe *et al.* (1955) (I and II) concluded that occupational adaptability is primarily determined by the subject's personality, and that the abnormal personality predominates in the chronically unemployed in times of full employment.

Maxwell Jones (1956) found premature termination rates for mental defectives, neurotics and psychotics of 14 per cent., 26 per cent., and 25 per cent. respectively. In this study the rate for clinical subnormals is 25 per cent. (15 out of 61).

Comparing the psychiatric and non-psychiatric groups, there are no significant differences between them for the incidences of medical reasons for premature termination (13 per cent. and 10 per cent. respectively) or non-medical reasons (13 per cent. and 9 per cent. respectively).

2. *Final Case Conference Employability Coding*

Comparing personality disorder with other psychiatric diagnoses, there are no significant differences between them for each individual coding compared separately. See Table VI.

E. COMPENSATION

I. S. Williams (1958) concluded that outstanding claims for compensation were not a significant factor. This series agrees.

1. *Premature Termination*

Three (21 per cent.) of the 14 "compensation" cases were terminated prematurely, as opposed to 45 (26·6 per cent.) of the 169 cases where there had been no question of compensation.

TABLE VI

Employability Codings of Personality Disorders and Other Psychiatric Diagnoses

	Doubtful		Sheltered		Capable		Suitable		Total
	No.	%	No.	%	No.	%	No.	%	
Personality disorder	12	21	2	4	13	23	30	53	57
Other psychiatric diagnoses ..	41	33	11	9	16	13	58	46	126
Total	53	29	13	7	29	16	88	48	183

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2. *Final Case Conference Employability Coding*

Nine (64 per cent.) of the 14 compensation cases were coded "suitable", as opposed to 79 (47 per cent.) of the 169 non-compensation cases.

F. Sex

There were 28 females (15·3 per cent.) and 155 males. There were no significant differences in:

1. *Diagnostic Categories*

Of the 155 males, 52 (34 per cent.) were categorized as personality disorder. The 28 females contained 5 (18 per cent.) so categorized.

2. *Premature Terminations*

Of 155 males, 44 (28 per cent.) were prematurely terminated, of 28 females, 4 (14 per cent.) were prematurely terminated.

3. *Final Case Conference Employability Coding*

For the categories "doubtful", "sheltered", "capable", and "suitable" the respective percentages for males were 29 per cent., 6 per cent., 17 per cent., and 47 per cent., and for females 29 per cent., 11 per cent., 7 per cent., and 54 per cent.

G. Marital Status

Two categories—"married" and "others" were used. Thirty-two per cent. (58) of the 183 psychiatric cases were married and living with their spouses.

1. *Diagnostic Categories*

Forty per cent. of the "marrieds" were categorized as personality disorder and 27 per cent. of the 125 "Others".

2. *Premature Terminations*

Thirty-six per cent. of the 58 "marrieds" were prematurely terminated as opposed to 22 per cent. of the "Others" (0·1>P).

If we take out the "worst" group, i.e. "married personality disorders" whose premature termination rate is 48 per cent. (11 out of 23) and compare it with the rest of the psychiatric group (i.e. all other diagnoses, plus "non-married personality disorders") whose rate is 23 per cent. (37 out of 160) we find a significant difference $\chi^2=5\cdot13$; $\cdot05>P>\cdot02$.

It will be noted that a rehabilitee was only categorized "married" if he was living with his or her spouse. This was an attempt to measure whether or not the rehabilitee was being supported socially, and although the criterion only measures the degree of social support crudely, it is easier to make than the assessment of how happy a marriage is, or how socially isolated a person is. It has the advantage that this kind of information is easily and freely given by rehabilitees to non-medical staff of the Ministry of Labour.

3. *Final Case Conference Employability Coding*

For the categories "doubtful", "sheltered", "capable" and "suitable" the respective percentages for the "marrieds" were 24 per cent., 3 per cent., 31 per cent., and 41 per cent. and for the "Others" 31 per cent., 9 per cent., 9 per cent., and 51 per cent. Comparing the two groups for "capable" versus "suitable" there is a highly significant difference. $\chi^2=10\cdot0$; $\cdot01>P>\cdot001$. Thus it can be seen that a married rehabilitee is much more likely to be coded "capable" than "suitable".

H. Age

1. *Premature Termination*

The "clinically subnormal" group had a significant "watershed" at age 25. Of 38 aged 25 or less, 5 (13 per cent.) were prematurely terminated, as opposed to 10 (43 per cent.) of the 23 aged 26 or more. $\chi^2=5\cdot5$; $\cdot02>P>\cdot01$. There was no age bias for schizophrenia or personality disorder.

2. *Final Case Conference Employability Coding*

Of 38 "clinical subnormals" aged 25 or less, 19 (50 per cent.) were coded "suitable", as opposed to 3 (13 per cent.) of the 23 aged 26 or more. This difference is significant. $\chi^2=6\cdot9$; $\cdot01>P$.

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I. Period of Unemployment

This was not a significant factor.

J. Duration of Illness

This was not a significant factor.

K. Previous Admission to a Psychiatric Hospital

Seventy-three (40 per cent.) of the 183 psychiatric cases had been treated as in-patients at a psychiatric hospital. The premature termination rate of those who had was 18 out of 73 (25 per cent.), as opposed to 30 (27 per cent.) out of 110 who had not been in a psychiatric hospital. Forty-nine per cent. (36) of those previously in a psychiatric hospital were coded "suitable" as opposed to 47 per cent. (52) of those not previously in a psychiatric hospital. This similarity of performance may well be due to good selection. For "personality disorders" and "clinical subnormals" there were no significant differences in premature termination rates and employability codings between those who had, and those who had not been in-patients in psychiatric units.

L. Relationship Between Premature Termination and Final Case Conference Employability Coding

The premature termination rate of the "suitables" is 6·8 per cent. (6 cases) and similar to that of the "sheltered" 7·7 per cent. (1 case). The rate for "capables" is 41·4 per cent. (12 cases) which is similar to that of the "doubtfuls" 54·7 per cent. (29 cases).

M. Co-operation of Rehabilitees

At no time was any resentment evinced by the rehabilitees as a result of the interview. Many were pleased to have the opportunity to discuss their work problems with a psychiatrist, even though it was made quite clear that the purpose of the interview was the relationship of their disability to working capacity, and that medical treatment of their disability was not being offered.

Conclusions

Of rehabilitees categorized on entry as being not disabled, or solely physically disabled, an important fraction (in this case 16·1 per cent.) will be likely to be primarily psychiatrically disabled. These "new" cases (in this study) are a minimal estimate and amount to an extra 39 per cent. of the highest possible estimate of psychiatric cases that could have been made from the entry documentation. This "new" or hidden group contains twice as many cases of personality disorder as the "known" psychiatric cases. Rehabilitees categorized as being "able bodied", or as "no disability" are particularly likely to be primarily psychiatrically disabled.

The most well-defined criterion of performance on course is the premature termination rate. Using this criterion, the following conclusions may be drawn:

Psychiatric cases as a whole do not fare significantly worse than the non-psychiatric case. There are no differences in the reasons for premature termination. Personality disorders do, however, fare significantly worse than non-psychiatric cases.

Within the psychiatric group, cohabitation with the spouse, though not quite a statistically significant factor on its own, when combined with personality disorder isolates a group who fare significantly worse than the rest of the psychiatric cases.

The source of referral to the I.R.U., a previous course at the I.R.U., duration of illness, compensation, sex, period of unemployment and previous admission to a psychiatric hospital, were factors which appeared to have no significance. Age seemed unimportant, except that in the "clinically subnormal" group those aged 25 or less fared better than those aged 26 or more.

The second criterion, that of the final employability coding, showed fewer significant differences. This was partly due to the reduction in numbers of each group associated with a four-category split. The trends were similar. By this criterion, the married group living with their wives were significantly more likely to be coded "capable" rather than "suitable". The subnormals aged 25 or less were also significantly more likely to be coded "suitable"

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than those aged 26 or more. The negative findings were as for the premature termination criterion.

Summary

Thirty-six consecutive weekly intakes to a Ministry of Labour Industrial Rehabilitation Unit were studied. The criteria of performance on course were premature termination of the course and the final employability assessment —both applied by the non-medical staff.

It was found that 16 per cent. of those documented on entry as not disabled, or solely physically disabled were primarily psychiatrically disabled. This previously unknown "new" group are diagnostically loaded with personality disorders. The psychiatric cases did not fare significantly worse compared with non-psychiatric cases. The rehabilitee suffering from a Personality Disorder and living with the spouse fared significantly worse than the other psychiatric rehabilitees.

The following factors were unrelated to performance on course: a previous I.R.U. course, sex, age (except for the "clinically subnormal"), the period of unemployment, previous admission to a psychiatric hospital, compensation claims, or whether referral to the I.R.U. was via medical or non-medical channels.

The "clinically subnormal" rehabilitees aged 25 or less fared better than those aged 26 or more.

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