

# Recovering Ordinary Lives

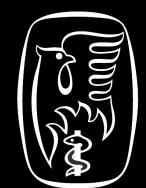
*The strategy for occupational therapy  
in mental health services 2007–2017*

*Literature review*

College of Occupational Therapists

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**Core**



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Therapists**

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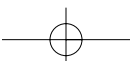
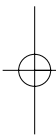
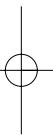
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## 1 Introduction

This literature review refers to occupational therapy in the field of mental health and is intended to apply to all areas of mental health occupational therapy practice. Where the content relates to policy, theory or professional philosophy, the literature may refer to occupational therapy in general. Where occupational therapy literature relating to practice is cited, the content is specific to mental health occupational therapy and does not apply to other areas of practice.

The review is intended to cover the four nations of the United Kingdom (UK). The importance of taking into account the social, cultural, geographical and policy differences between the four nations was emphasised by occupational therapists responding to a questionnaire from the College of Occupational Therapists (COT) which can be found in *Recovering Ordinary Lives: the strategy for occupational therapy in mental health services 2007–2017*, a vision for the next ten years (College of Occupational Therapists 2006a).

The review was completed in September 2005.

## 2 Method

The subject of occupational therapy in mental health is very broad, so the literature search was limited in order to complete the review within the time available. The areas to be included were identified as:

- policy framework in England and Wales;
- policy framework in Scotland;
- policy framework in Northern Ireland;
- COT/BAOT statements, guidelines etc.;
- occupational therapy principles and values;
- occupational therapy skills;
- generic skills for work in the field of mental health;
- the purpose and goals of occupational therapy for mental health;
- the relationships between occupation, mental health and wellbeing;
- traditional areas of occupational therapy practice;
- emerging areas of occupational therapy practice.

A list of policy documents was compiled and circulated to a small number of occupational therapists in the four UK nations, asking if there were any key papers missing. The final list was too long to be fully included in the review so, in order to sharpen the focus, four experienced mental health occupational therapy practitioners were asked what they thought were the essential issues to be included in a mental health strategy for occupational therapy. This literature review follows the format that they suggested.

At a later stage in the process, the responses of a sample of occupational therapists to a questionnaire about *The strategy for occupational therapy in mental health services, a vision for the next ten years* (College of Occupational Therapists 2006a) were checked to see if they raised any issues that had not been covered in the review. The themes emerging from these responses were also incorporated into the review.

The review begins by defining key terms in order to clarify how they are used within the strategy. This is necessary because there is no universal agreement among occupational therapists on the meaning of such terms as *occupation* or *occupational therapy*. The policy context of occupational therapy services is then described. Two directions are identified, each of which has the potential to influence the way that the occupational therapy profession develops in the future. The section of the review describing occupational therapy for mental health takes a historical perspective, looking at how the profession has developed within health and social services in the United Kingdom (UK) and how this has contributed to the development of a weak professional identity and role confusion. The review finishes with a brief description of occupational therapy in the field of mental health in the UK today.

### 3 Definitions of key terms

#### 3.1 Occupation

Occupation is a social construct, not a particular action or type of action. It is a complex concept that does not allow for easy definition. Some of the elements that have been used in definitions of occupation from different countries include:

- activity/ activities (Canadian Association of Occupational Therapists 1997, College of Occupational Therapists 2005, European Network of Occupational Therapists in Higher Education 2004, Law et al 2002, Townsend 1997);
- tasks (Canadian Association of Occupational Therapists 1997, Christiansen & Baum 1997, Townsend 1997);
- organises action (Creek 2003);
- personal meaning (Canadian Association of Occupational Therapists 1997, College of Occupational Therapists 2005, Christiansen & Baum 1997, European Network of Occupational Therapists in Higher Education 2004, Law et al 2002);
- personal value (Canadian Association of Occupational Therapists 1997, Law et al 2002, Townsend 1997);
- cultural meaning (Law et al 2002, Townsend 1997);
- cultural value (Law et al 2002, Townsend 1997);
- named within a culture (European Network of Occupational Therapists in Higher Education 2004, Law et al 2002, Townsend 1997)
- supports participation in society/community (European Network of Occupational Therapists in Higher Education 2004, Law et al 2002, Townsend 1997);
- over time (Christiansen & Baum 1997, College of Occupational Therapists 2005, Creek 2003);
- directs effort/ goal directed (Christiansen & Baum 1997, Creek 2003);
- part of personal and social identity (Creek 2003).

An occupation incorporates these and many other elements, which interact with each other in unpredictable ways to influence how a person feels, thinks and acts in particular situations and over time. Occupations are enacted through activity, so that a single occupation may incorporate many different activities. For example, mothering involves such activities as communicating, feeding and teaching, but the nature and balance of those activities change over time as the child grows and develops.

People's occupations enable them to:

- survive (eg. feed themselves, earn money, keep the domestic environment clean, manage personal hygiene);
- interact with others in ways that give them a satisfactory role, contribute to social identity, self validation etc. (eg. be a good student, look after the children, do a good job at work, be a good grandparent);
- find pleasure and meaning in activity for its own sake (eg. surfing, gardening, drinking, playing computer games).

None of these is mutually exclusive and the range of activities engaged in by an individual will be different according to such factors as age, responsibilities and interests. In the eyes of the world, and in our own eyes, we are largely what we do. If an individual is unable to do any of these activities in a way that is satisfactory and appropriate to her/his time of life, then that person will suffer decreased self-confidence, feelings of isolation, uselessness, depression and anxiety.

For children, the important activities are those that increase their abilities for self-management, provide a vehicle for socialisation and make pleasurable the stretching of the body and mind to higher levels of achievement.

For adults of working age, work – in its broad sense of doing things for others that are rewarding and rewarded – is at the centre of what it is to be an adult. For people between the ages of 18 and 65, most occupational imperatives come from fulfilling responsibilities at home and at work. These include being economically self-sufficient, looking after the family and being perceived as a good worker and/or parent. The entitlement to take part in pleasurable leisure activities is earned through work. For adults of working age, a large part of what makes life meaningful is being able to discharge responsibilities through work.

For older people, the important activities are those that enable retention of the ability to look after oneself, maintain a social life, create a role that keeps at bay the sense of loss that may come from no longer having childcare responsibilities or a job and keep alive a sense of continuing learning and development.

### 3.2 Health and mental health

Wilcock (1998, p110) defined health from an occupational perspective as:

- the absence of illness but not necessarily of disability;
- a balance of physical, mental, and social wellbeing attained through socially valued and individually meaningful occupation;
- enhancement of capacities and opportunity to strive for individual potential;
- community cohesion and opportunity;
- social integration, support and justice, all within and as part of a sustainable ecology.

The World Health Organization (1999) defined mental health as 'a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community.' Mental health has been defined for occupational therapists as 'more than the absence of mental illness; how the individual thinks and feels about her/himself and others; interprets events, communicates and learns; copes with change, stress and conflict; forms and sustains relationships, and participates in her/his social and

physical environment' (Creek 2003, p55). All these definitions emphasise that the ability to do things and to participate in community life are aspects of good health and positive mental health.

### 3.3 Wellbeing

The word *wellbeing* is often used in conjunction with *mental health* to indicate that quality of life depends on more than being free of disease or illness. Wellbeing is 'a general term encompassing the total universe of human life domains, including physical, mental and social aspects, that make up what can be called a "good life"; a sense of physical and mental comfort' (Creek 2003, p61).

### 3.4 Occupational therapy

The description given here is taken from the occupational therapy literature and supported by the views of respondents to the COT questionnaire.

The purpose of occupational therapy is to assist people to fulfil their occupational nature. The main aim of the profession is to maintain or improve the client's functional status and access to opportunities for occupation and participation. The process by which this is achieved is through the maintenance, restoration or creation of a match between the abilities of the person, the demands of her or his occupations and the demands of the environment. Activity is the main medium of intervention and agent of change in occupational therapy.

Occupational therapists have a range of skills that include *profession-specific skills*, sometimes called *discrete skills*, and *generic skills*, which are those shared by other health care professionals. *Core skills* are the expert knowledge and abilities that are shared by all occupational therapists, irrespective of their field or level of practice (College of Occupational Therapists 2004). The *core skills* of the occupational therapist include both *profession-specific* and *generic skills*. In addition, a therapist may have *specialist skills* relevant to a particular field of practice, which may also be *profession-specific* or *generic*.

Occupational therapy is essentially client-centred in that it helps people to find or create opportunities for action and increases their ability to make choices.

### 3.5 Patient, service user and client

The terms used to indicate the people who receive the services of occupational therapists can be confusing and the subject of dispute. The preferred term used by a therapist tends to be influenced by the work setting, such as community mental health team or social services, and what is generally considered to be acceptable by society at large. So, the terms *patient*, *client*, *service user*, *person who uses occupational therapy services* and *individual* are all widely used by occupational therapists in the UK. The term chiefly used in this document is *client*, but the reader may prefer to substitute another term.

## 4 Policy context

Policies are intended to give a positive steer to services but an absence of clear guidance can also influence the approach taken. For example, the Department of Health Expert Briefing on *Employment for people with mental health problems* gives no guidance on good practice with people who have a job (National Institute for Mental Health in England 2003). Staff may therefore assume that everyone admitted to hospital with a mental illness is unemployed or should be treated as though they are unemployed.

In the UK, at the beginning of the 21st century, government policy and guidance on mental health services can be seen to take two different approaches to mental health and illness. The terms used to describe these two approaches are taken from a Rethink press release welcoming the publication of *Mental health in the mainstream* (Rankin 2005):

- crisis and compulsion;
- recovery and hope.

### 4.1 Crisis and compulsion

Crisis and compulsion describe policies and guidance that lead to mental health problems being treated as episodes of illness or as chronic illnesses that have to be controlled or managed. Policies have tended to apply, or be interpreted as applying, to people who are already in contact with secondary services rather than addressing the mental health needs of populations and communities. There is a danger that this approach can result in services that are reactive, risk averse, segregated and coercive. Some examples are given here of publications from the four UK nations that illustrate this approach to mental health care.

The *Draft mental health bill* (Department of Health 2004) makes provision for various types of compulsion to be applied to people who are considered to require assessment of, or treatment for, mental disorder. For example, a person who has been registered as liable for assessment under chapter 3 of the Bill 'may be taken into custody and conveyed to the relevant hospital or place by the patient's clinical supervisor' (Department of Health 2004, p68).

*A Review of literature relating to mental health legislation* (Atkinson et al 2005) in Scotland found that from 1985 to 2003 there was a rise of between 47% and 233% in cases of detention under all four sections of the Mental Health (Scotland) Act 1984 allowing for civil detention: Section 24 (Emergency admission), Section 25 (Emergency detention), Section 26 (Short-term detention) and Section 18 (Full detention). The authors felt that this rise may in part be due to changing attitudes to detention by psychiatrists and others.

A review of mental health and learning disability provision in Northern Ireland (Review of Mental Health and Learning Disability (Northern Ireland) 2005), commissioned by the Department of Health, Social Services and Public Safety,

found that up to one third of inpatients could have been provided with therapeutic interventions and care in more appropriate settings but community mental health teams were currently unable to respond adequately to the needs of people with severe mental health problems at times of urgent need. The report highlighted 'significant under-investment' (p3) in mental health services in Northern Ireland.

When resources are directed towards services for managing crisis and containing risk, there is less possibility of adequate funding flowing into services that have a wider remit to promote health and wellbeing for the whole population.

#### 4.2 Recovery and hope

Recovery and hope describe policies and guidance that direct resources across a range of government departments and services towards promoting positive mental health for the whole population and, as far as possible, preventing the development of mental illness or working towards recovery. Until recently, this agenda has tended to be driven by the voluntary sector rather than by statutory services. However, recent major policy themes across the four nations include:

- recovery (National Institute for Mental Health in England 2005);
- employment (Department for Work and Pensions 2004);
- social inclusion (Office of the Deputy Prime Minister 2004);
- equality (Department of Health 2005);
- health improvement (Scottish Executive 2003, Wanless 2004).

Some examples are given here of publications from the four UK nations that illustrate this approach to mental health care.

The first standard in the *National service framework for mental health* (Department of Health 1999) for England has an element of mental health promotion for all, through interventions both to strengthen individuals and to tackle local community factors that undermine mental health. Performance will be assessed at a national level by a long-term improvement in the psychological health of the population.

The Scottish Executive published an action plan for 2003 to 2006 for improving mental health and wellbeing for all age groups, from infants through to later life (Scottish Executive 2003). A key priority area in the plan is developing communities through the provision of good-quality housing, quality built environments, a good transport infrastructure, safe recreational facilities, cultural activities, clean streets, responsive policing and the encouragement of greater involvement of local communities in all these areas.

The *Strategic framework for adult mental health services in Northern Ireland* (Review of Mental Health and Learning Disability (Northern Ireland) 2005) is underpinned by a set of principles that include the promotion of

independence, self-esteem, social interaction and social inclusion through choice of services, facilitation of self-management, opportunities for employment and social activities.

#### **4.3 Impact on occupational therapy**

These two approaches speak to occupational therapists in different ways. Crisis and compulsion offer occupational therapists opportunities to extend their role to include such activities as prescribing and taking patients into compulsory detention. Scarce resources may be targeted at those with serious mental illness who are thought to pose a risk to themselves or others. Such people may be treated in hospital or in community settings, using interventions that have been shown to be clinically and cost effective, such as cognitive behavioural therapy and medication. Occupational therapists may undertake additional training to be able to deliver these treatments. Additionally, they will have the option to take on the roles of case manager, approved clinician and/or clinical supervisor. Responses to the COT questionnaire suggest that some occupational therapists feel that this would be a positive direction for their own professional development.

Recovery and hope offer occupational therapists opportunities to work with individual clients and carers, organisations and communities, helping them to develop their skills and resources. The values of the occupational therapy profession match the ideals of equality, integration, social inclusion and participation that underpin this approach. Core professional skills can be used to achieve the goals of health promotion, disease prevention, community development, rehabilitation, return to employment and enhanced occupational opportunity. Responses to the COT questionnaire suggest that some occupational therapists are excited by the possibilities that this approach offers to the profession.

There is the potential for the profession to split, as occupational therapists working in the field of mental health choose to follow one or other of these two directions. This review will focus on the second option, recovery and hope, because this is the approach that will lead to a strengthening of profession-specific skills and roles for occupational therapists. First, there will be a brief review of the historical development of occupational therapy in the United Kingdom, showing how the profession has so far failed to identify a clear role for itself within statutory services.

## 5 Role confusion

For over thirty years, it has been recognised that the profession of occupational therapy, in the United Kingdom and elsewhere, lacks a clear, professional role and purpose. For example, in 1969, a study of five of the professions supplementary to medicine in the United Kingdom (dietetics, orthoptics, radiography, physiotherapy and occupational therapy) concluded that 'there appears to be a lack of clarity concerning their role in the hospital service. There seems to be no effective consensus on the contributions to be made at present, and more particularly in the future, by these professions' (Martin 1969, in Alaszewski 1979, p431).

In the 1980s, an American occupational therapist, Barris (1984), wrote that occupational therapy did not have a logical and coherent system of ideas that described its goals and the means for reaching these goals. She surveyed occupational therapists in psychosocial practice across the United States and concluded that 'occupational therapists lack a coherent image of what practice should be – an image that is derived from a base of systematic knowledge, theory, and tradition, that is, from a professional ideology' (p19). Barris felt that this lack of a clear professional ideology led to diffusion of occupational therapy roles and confusion about pre-registration educational curricula.

In the 1990s, Mountain (1997, p433) carried out a content analysis of the *British Journal of Occupational Therapy* from 1989 to 1996 and found concern over a perceived lack of clarity about the role of occupational therapy in various fields of practice. She concluded that 'Occupational therapy is currently being subjected to enormous policy-driven changes. It is therefore imperative for the profession to be able to articulate its role and core activities within that policy framework clearly.'

In 2005, occupational therapists in the United Kingdom wrote of 'professional insecurity and role uncertainty experienced by occupational therapists throughout mental health' (Wright & Rowe 2005, p45), 'lack of role definition' (Harrison & Forsyth 2005, p182) and a 'downward spiral in confidence and motivation' linked to lack of clarity about professional role (Mountain 2005, p295).

The occupational therapists who responded to the COT questionnaire also identified the need for increased awareness of the role of occupational therapists and a raised profile for the profession.

### 5.1 Reasons for role confusion

Several reasons have been identified for this lack of clarity about the role of occupational therapy. For example, Alaszewski (1979), a sociologist, suggested that occupational therapy has not developed a body of techniques with which it is identified and that this lack makes it difficult to draw a clear boundary between occupational therapy and other professional groups. Alaszewski proposed that specialisms within health care are sometimes organised on

conflicting principles. At one extreme are patient-oriented specialisms that define their area of practice and competence in terms of a group of patients and emphasise the areas of knowledge and the techniques that are relevant to these patients. 'These specialisms can also be characterised as "holistic" because they emphasise the treatment of the whole patient, not just a part' (p432). At the other extreme are the technique-oriented specialisms that define their area of practice and competence in terms of a technique, 'and are concerned only with those patients who require or fit that technique' (p432).

Alaszewski (1979) identified the profession of occupational therapy as a person-oriented specialism, 'placing more emphasis on the patient than on the specific technique utilised' (p438), and pointed out that 'technique oriented professions dominate in both size and status within health care services and that their practitioners are accorded a higher status than holistic practitioners' (p432).

Creek (1998) argued that occupational therapists are doubly disadvantaged within health care services: because the profession is predominantly female and because occupational therapy knowledge is practical and contextual rather than rational and abstract. 'In order to make their voices heard within the multidisciplinary health care team, occupational therapists find themselves having to avoid describing patients in non-scientific terms such as "She can't make a cup of tea independently." They may either apply standardised tests to obtain a numerical score for what they have observed or dress up the patient's functional level in "scientific" language' (p132).

Mountain (2005) hypothesised that occupational therapists tend to look for external approval and recognition for their work because of low professional self-esteem and lack of confidence. This leads them to undertake activities that they hope will improve professional credibility rather than rooting activities in local and individual needs. A negative cycle is set up as these activities are less likely to have satisfactory outcomes for service users and carers, which will reduce recognition from stakeholders, further lower professional self-esteem and decrease motivation to develop the knowledge base of occupational therapy. Mountain felt that the solution was to be clear about the role of the occupational therapist as a prerequisite for sound professional judgement and the delivery of appropriate clinical activity based on assessed needs.

A management study of the British Association of Occupational Therapists and the College of Occupational Therapists, carried out in the 1980s, also identified a client-centred role for occupational therapy, 'helping people to achieve the maximum degree of independent living within the context of their communities of which the individual is capable' (Faulkner & Scarfe 1986, p44). However, the authors felt that the profession at that time was 'quite a long way from directing its efforts to this goal and does so in a rather confused and fragmentary way' (p39). The report concluded that 'unless [the College] is able to unify the membership behind a set of broadly supported strategic goals and secure the active participation of very many members in achieving those goals,

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the long term consequences for the profession and its members are likely to be extremely adverse' (p6).

For most of the past three decades, higher pay and higher status for occupational therapists have been achieved by moving away from practical work and into management or educational roles. Linking practical work with lower pay devalues the contribution that occupational therapy can make to the wellbeing and quality of life of the people who use our services. However, there is limited evidence to support the value of that contribution, as research into occupational therapy interventions has been sparse, small-scale and, often, not of the highest quality.

## 6 Weak evidence base

In 1986, the report of a management study of the British Association of Occupational Therapists and the College of Occupational Therapists (Faulkner & Scarfe 1986, p44) concluded that 'it is . . . essential that the profession build up a much sounder research basis to support its claims, its activities and its goals.' Two of the priority areas for research recommended in the report were the efficacy of particular therapeutic interventions and the mechanisms by which proven therapeutic interventions achieve the outcomes.

A Commission of Inquiry into occupational therapy, in the late 1980s, suggested that 'the virtual absence of experimental research designed to evaluate the effectiveness of occupational therapy practices and procedures. . . is a weakness which leaves the profession unnecessarily vulnerable to challenge. . . those professions which seek successfully to evaluate their practices are likely to gain the advantage over those which do not' (Blom-Cooper 1989, p46). The report of the Commission recommended that the profession should devise 'ways of measuring and monitoring the effectiveness and efficiency of practices, procedures and organisational arrangements' (p88).

In 1997, Mountain reviewed the contents of the *British Journal of Occupational Therapy* from 1989 to 1996 to find out: the nature and extent of the body of research concerning occupational therapy; evidence of awareness of, and responses to, changes in health and social care, and the extent to which the clinical effectiveness of occupational therapy has been demonstrated. She found that physical disability was the most frequently reported clinical topic but that 'a substantial proportion of papers. . . might be considered peripheral to the core activities of occupational therapists' (Mountain 1997, p433). She did not find a strong research base for occupational therapy and concluded that it is necessary for occupational therapists to develop one.

Randomised controlled trials of the effectiveness of other interventions within the field of mental health care have sometimes used occupational therapy as a control, demonstrating that occupational therapy is less effective than the intervention being studied (Mairs 2003). This may be for two reasons: because the measures of effectiveness are set by the discipline carrying out the study and are designed to validate the intervention being studied, and because occupational therapy has been poorly defined for the purposes of the study. These spurious demonstrations of occupational therapy as an inferior mode of intervention have the effect of increasing professional anxiety and further reducing the status of practitioners.

In 2001, the College of Occupational Therapists reviewed the 1997 *Research and development strategy* (Eakin et al 1997) and published a *Strategic vision and action plan* for research and development (Ilott & White 2001). This review affirmed research and development as essential activities that should underpin and enhance professional practice, but noted a 'modest research

capacity' (p271) and a 'need for national, coordinated investment in allied health professions' research' (p272). The document set out six objectives, with constituent action points, that would make all occupational therapists into informed consumers of research, some into participants in research and a few into proactive researchers by 2005.

The target figure for research leaders was one per cent of occupational therapists, or 210 people. This figure has not been reached, if the College of Occupational Therapists' research register reflects accurately the number of research active therapists in the United Kingdom. There is no clearly defined career pathway for health service research occupational therapists and the majority of researchers, if they are not self-funded, 'live from one short-term project grant to another' (Walker 2003, p342).

There is little evidence for the effectiveness of specific occupational therapy interventions for people with mental health problems, either common or severe mental illness (Mairs 2003, Lloyd et al 2004). Much of the evidence for effective interventions relates to drugs and cognitive behavioural therapy (CBT). This means that policies and guidelines emphasise the importance of increasing access to medication, preferably via a psychiatrist, and CBT. Nowhere is occupational therapy described as the treatment of choice for any mental disorders: in fact, occupational therapists are encouraged to retrain in order to be able to deliver CBT (Layard 2004). Funding flows towards those interventions that have been demonstrated to be effective in randomised controlled trials (RCTs), and even a poor quality RCT is considered to provide stronger evidence of efficacy than well-designed research projects using other methods, such as a pre-test/post-test design (Mairs 2003).

It is therefore essential for its survival that the profession builds research capacity and starts to carry out high-quality research into the effectiveness of occupational therapy interventions for people with mental health problems. Several of the therapists who responded to the COT questionnaire felt that there is a need for more research in occupational therapy and that practice should be based on the best research evidence.

White (2003) identified that not only occupational therapy but all allied health professions in the UK suffer from underfunding for research, paucity of research infrastructure and limited research capacity. She claimed that 'We no longer have to defend the need for occupational therapy research. It has been established that this is essential to further knowledge, develop capacity and provide the evidence that will enable students, clinicians, managers and educators to deliver the best quality services' (p 226).

If we fail to demonstrate that occupational therapy can help people with mental illness to live more fulfilling lives, then the profession will not survive in its present form. Occupational therapists will increasingly be expected to undertake generic functions within the multidisciplinary team and to carry out CBT rather than occupational therapy interventions.

## 7 Generic versus profession-specific working

Occupational therapists express concern about perceived pressure to abandon their specialised professional role in order to carry out generic interventions, that is, 'those interventions that any mental health professional who has been suitably trained to work in a community mental health team can carry out' (Cook 2003, p19). This concern was echoed by several respondents to the COT questionnaire. With a national shortage of psychiatrists and increased demand for psychologists within the NHS, there is a drive to retrain other staff in 'extended roles' to make up the shortfall in desired skills (Layard 2004). Professions that are not able to demonstrate that they have their own specialist skills, or that those skills are effective, are most at risk of losing a specific professional role and becoming generic workers.

The greatest pressure towards generic working seems to be experienced within community mental health teams, where there is often a single occupational therapist working in isolation from professional colleagues or professional line management (Harries & Gilhooly 2003). Three patterns of working within these teams have been identified (Harries & Gilhooly 2003, p101): 'generic casework, specialist occupational therapy casework and a mixture of the two.'

Occupational therapists may be informed consumers of research evidence (Ilott & White 2001) but there is no strong evidence base for occupational therapy. This poses the risk that practitioners will move away from using occupational therapy interventions and either adopt those interventions that have been demonstrated to be effective, such as cognitive behavioural therapy, or spend increasing amounts of time in generic working. These strategies are likely to lead to further role confusion and loss of professional identity for occupational therapists through 'both restricting and undermining [their] traditional professional role and work' (Reeves & Mann 2004, p268).

If occupational therapists are to defend their professional role, it is necessary to:

- be clear about what that role is;
- provide evidence for the effectiveness of occupational therapy interventions;
- demonstrate that profession-specific services benefit the service user.

Unfortunately, occupational therapists are often unclear about their profession-specific role and function (Mountain 2005, Wright & Rowe 2005) or lack the confidence to justify giving priority to functional problems and using activity as their treatment medium (Cook 2003). Three possible sources of professional confidence and clarity of purpose are:

- close working relationships with occupational therapy colleagues;
- professional line management;
- effective professional education.

Occupational therapists often work within multidisciplinary teams where they are the only occupational therapist and their line manager may belong to a different profession (Harries & Gilhooly 2003), therefore, there is an onus on pre-registration education courses to produce graduates who are professionally competent and confident. Several therapists who responded to the COT questionnaire felt the need for continuing education and training.

The trend in recent policy developments is towards providing services that meet perceived or service user-identified needs rather than providing profession-specific services (Department of Health 1997). Several responses to the COT questionnaire stressed the importance of being client-centred and providing needs-based services. However, it is unrealistic to think that needs can be assessed independently of a prior theoretical framework: the needs that are identified will be influenced by the frame of reference of the assessor. For example, a psychologist is more likely to perceive cognitive-behavioural needs while an occupational therapist will identify occupational needs. Service users themselves may be influenced in what they identify as their needs by the services that they have heard of or that they think are available.

Within the multidisciplinary team, in which each member of staff takes a generic case management role, it is theoretically possible for each professional to refer to the other team members for their specialist input, since individual team members do not necessarily feel skilled in meeting all the needs of the client. However, owing to workload pressures, this does not always occur and staff may find themselves having to work outside their area of expertise. (Harries & Gilhooly 2003)

Four tools have been identified for tackling the problems of role confusion and loss of professional identity:

- a clear statement of the core skills, function and unique approach of occupational therapy;
- guidance on the proportion of time that should be spent on occupational therapy rather than generic tasks;
- a statement of the tasks that are within and outside the scope of occupational therapy practice;
- research into occupational therapy interventions and outcomes (Cook 2003).

The first and third of these tools have been produced. In 2001, the South London and Maudsley NHS Trust and the College of Occupational Therapists jointly commissioned the development of a definition of occupational therapy in order to clarify what is and is not occupational therapy, for the purposes of research (Creek 2003). This definition is based on the idea that occupational therapy is a complex intervention which is comprised of 'a number of separate elements which seem essential to the proper functioning of the intervention although the "active ingredient" of the intervention that is effective is difficult to specify' (Medical Research Council 2000, p1). The definition seeks to

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identify and describe the components of intervention, the defining features of occupational therapy and the limits of occupational therapy. It is suggested that the definition is 'a description of what occupational therapy ought logically to be [that] can be tested against the reality of occupational therapy practice' (p9).

## 8 What is occupational therapy for mental health?

Since Barris (1984) described occupational therapy as lacking a coherent image of what practice should be, based on systematic knowledge, theory and tradition, there has been an expansion in the knowledge-base of the profession, particularly in our understanding of the nature of occupation. However, occupational therapists appear to have been more interested in developing models for practice than in building theories to explain the relationships between occupation, activity and health. Consequently, while the profession has several coherent models to direct therapeutic intervention in different fields of practice, there are many gaps in our knowledge base, which still cannot be described as systematic. Key basic concepts are often poorly defined and the mechanisms by which activity can influence health and wellbeing are not fully understood. There is a need for more basic research to build the knowledge base of the profession, in addition to applied research into the effectiveness of occupational therapy interventions.

The publication of the UK definition of occupational therapy as a complex intervention (Creek 2003) marked a critical shift in theorising, from using general systems theory as an organising framework (Reilly 1974) to acknowledging the complex, multifaceted and contextual nature of occupational therapy. 'Occupational therapy is complex because it incorporates many active ingredients that interact in dynamic and unpredictable ways' (Creek et al 2005, p282). The definition highlights that, while occupational therapy has a clearly articulated domain of concern (occupation) and goals (occupational performance and social participation) that appear to be recognised by occupational therapists everywhere, practice is always shaped by local, social, political, cultural, economic, ethnic and gender circumstances and values.

Occupational therapy is concerned with what is most important occupationally to the individual. For example, if an adult of working age is not working then it is the role of the occupational therapist to help her or him to overcome physical, psychological and environmental barriers to work. If someone is at risk of losing a job through ill health, it is the role of the occupational therapist to help her or him to retain functional capacity and work towards recovery.

The individualised, localised, context-specific nature of occupational therapy intervention means that there can be no universally applicable techniques, theories, models or approaches to practice. 'Occupational therapy intervention is not standard but, for each client, a package of care and therapy is designed to meet her/his individual needs' (Creek 2003, p30). Occupational therapists responding to the COT questionnaire emphasised that service user involvement is essential in planning, monitoring and evaluating services as well as in planning and delivering interventions for individuals. This involvement will ensure that services remain responsive to local and individual needs and circumstances.

Effective occupational therapy intervention depends on the ability of the therapist to be aware of and to process a range of information in order to select the most appropriate course of action with a client, within a specific context, to achieve the best possible outcome (Creek et al 2005). The thinking skills and thought processes of the therapist are, therefore, crucial in occupational therapy practice.

In thinking about how to proceed in any particular intervention, the therapist takes account of (Creek 2003):

- his or her own capabilities and limitations;
- the client's needs, wishes, history and current situation;
- the wider social, cultural, political and economic environments;
- national and local policies and standards;
- guidelines and care pathways;
- local norms and procedures;
- the immediate working environment;
- the evidence base for effective practice.

Occupational therapists are concerned with 'the nature, balance, pattern and context of occupations in individuals' lives, [with] the meaning and purpose that clients place on activities and occupations and with the impact of illness or disability on their ability to carry them out' (Creek 2003, p31). An American anthropologist, Mattingly, described occupational therapy as a 'two-body practice':

One of the most interesting features of occupational therapy practice is that it tends to deal with functional problems that fall nicely within biomedicine [treating physical injuries with specific treatment techniques], as well as problems going far beyond the physical body, encompassing social, cultural, and psychological issues that concern the meaning of illness or injury to a person's life.

(Mattingly 1994, p37.)

### 8.1 Developing roles for occupational therapists

Occupational therapists in the United Kingdom have always worked mainly within health and social services, and most still work in these settings, adapting their practice to the constraints of institutional structures and systems. In recent years, more services have become integrated. Occupational therapists responding to the COT questionnaire expressed positive feelings about these changes and about cross-agency and partnership working in order to provide seamless services. Working in partnership with other agencies that provide facilities for education, work and leisure is seen as essential for achieving participation and social integration for clients.

Changes in the social and political environments in the UK in recent years have led to the possibility of two alternative ways of working outside traditional health and social care services: public health and community development.

Mental health promotion was identified by respondents to the COT questionnaire as an emerging area of practice for occupational therapists, and greater involvement in community working is also seen as desirable. The view was expressed that occupational therapists need to develop a profession-specific role within these new roles and environments.

Public health is concerned with health promotion and the prevention of disease. In 2004, the Treasury published the report of a review of the wider determinants of health in England, and of the cost-effectiveness of action to improve the health of the whole population and reduce health inequalities (Wanless 2004). The report concluded that 'Our health services must evolve from dealing with acute problems through more effective control of chronic conditions to promoting the maintenance of good health' (p10). This shift of emphasis may offer opportunities for occupational therapists to use their professional skills to the full in developing and delivering strategies to engage people in monitoring and maintaining their own health through what they do.

Community development is a population approach to improving people's lives and health that involves building capacity within communities rather than bringing in expertise from outside (Watson 2004). Community development focuses on raising people's awareness and understanding of the possibilities for change, alongside providing training and assistance with the process. Any agent of change from outside the community must work in partnership with the community, demonstrating respect for local customs and power dynamics. 'Community development is a slow process and one that. . . can be ultimately sustainable only if it is owned, undertaken and nurtured by the people whose concerns it addresses' (Watson 2004, p57). This approach is congruent with much current government policy in the UK and also fits comfortably with occupational therapy's client-centred, flexible way of working. However, to date, most examples of effective community development work by occupational therapists have come from South Africa and South America (see, for example, Watson & Swartz 2004 and Kronenberg, Algado & Pollard 2005).

## 9 Summary

The profession of occupational therapy in the UK started in the field of mental health. Occupational therapists work with individuals, groups, organisations and communities to improve people's mental health and wellbeing. They assist people to fulfil their occupational nature by maintaining or improving functional abilities and facilitating access to opportunities for occupation and participation.

Since 1997, the modernisation agenda of the UK government has brought about radical and extensive changes in the way that health and social care services are delivered, and in the goals of those services. Occupational therapists working in the field of mental health are facing a range of threats to their professional role, for example, the demand that interventions be based on research evidence and the pressure to take on generic responsibilities.

However, there are also opportunities to move into new areas of practice where the values and skills of the occupational therapist could make an effective contribution. Occupational therapists have the knowledge, skills and attitudes that will enable them to work effectively in three main areas of practice:

- institutional services and settings (including community-based work), providing individualised care for people receiving primary, secondary and tertiary services;
- public health, including the primary promotion and maintenance of health and disease prevention;
- community development, working with communities to build capacity and resources to support health and quality of life.

This consolidation and expansion of the occupational therapist's role requires a clear vision of what the profession can and should achieve and a big investment in research to provide evidence for the effectiveness of occupational therapy interventions.

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