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Occupational therapy – the forgotten speciality within the community mental health team?

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From the plethora of articles examining the role of individual disciplines within the community mental health team, one discipline appears almost conspicious by its absence. How has occupational therapy become the forgotten speciality?

As a discipline it has much to offer. Historically a young profession, despite the fact that improving health through occupation has been recorded since 600 BC (Hippocrates), it is only in the post-war era that there has been a rapid expansion of occupational therapy services. Initially within the mental health field the profession identified itself as an aide to psychiatrists. However as occupational therapy was by prescription, its development and treatment processes were limited to craftwork. In the 1950s the psychodynamic principles of activity as a therapy were explored and Fidler (1948) introduced a more scientific method for activity analysis. In addition, the Burg *et al* (1976) critical performance approach was the single most appropriate method found to identify the range of skills required by occupational therapists in treating patients. This allowed them to define their contribution to psychiatry; so by the 1970s occupational therapy had moved away from being an aide to the psychiatrist to being a co-professional, co-operating in the treatment and rehabilitation of the mentally ill. As we move services for the mentally ill increasingly into the community, what can occupational therapy offer within the community team?

One of its main advantages is that occupational therapy philosophy goes beyond treatment of the symptoms or the disease process in encouraging individuals through the use of activity to work towards an improved quality of life, despite their disability (Yerxa, 1983). Such a philosophy adds a broader dimension and widens the functioning ability of the team, especially in its interface with the community and primary care services. Secondly, occupational therapists are in a unique position within the team, in that there are no statutory requirements regarding practice made of them as a profession. This allows greater flexibility in applying skills and setting priorities for work, enabling therapists to respond to perceived need rather than to statutory mandates. Thirdly, several 'core' skills of occupational therapists have been identified as advantageous within the community mental health team. These skills include assessment and treatment of activities of daily living (ADL), activity analysis and the use of activity as a treatment medium. Such skills can be of great benefit to patients living and requiring rehabilitation within the community, helping them to maintain their independence. Lastly, a major advantage may be that occupational therapists are trained to work both in community and hospital settings and can adapt easily to working between the two, requiring no further training. It is interesting to note that occupational therapists are the only profession employed in both Health and Social Services Departments. Pressure of work, however, means the remit of occupational therapists within social services is limited to the assessment and provision of aids, despite their considerable psychiatric training. Considering present initiatives to move the care of the mentally ill from hospital into the community, would it not be more profitable to utilise these professionals, who have suitable training and are already ideally situated, in planning joint initiatives to meet the needs of the mentally ill?

Why has occupational therapy not played a more prominent role within community teams? One of the major reasons would appear to be that despite the origins of occupational therapy being firmly rooted in psychiatry, the profession still lacks confidence in itself and in its relationship to psychiatrists. The lack of confidence in itself appears related in part to the sad lack of evaluative research examining occupational therapy skills and capabilities. Evaluation is an integral part of occupational therapy training and treatment processes; despite this, little is formalised or published in the UK. More evaluative research would directly affect and improve clinical practice, the utilisation of occupational therapy services and increase the confidence of the speciality in offering a wide ranging service to psychiatry. In addition to its own lack of confidence, psychiatrists appear to be unaware of the full range of skills and training within occupational therapy, which include: a knowledge of psychopathology, interviewing, counselling, group treatment and management skills in sufficient detail to more than fulfil the criteria for the five classes of skills Ouvretveit (1986) lists as required by each discipline within a multidisciplinary team. Often these

skills have been overlooked and there has been stereotyping of attitudes within the ward team towards occupational therapy as the provider of a basket making 'Butlin's' approach of keeping everyone happy and busy. It would be a great pity if the same were to happen in the community and such skills already available were not fully utilised.

Within the present drive to create a more effective and efficient NHS, more and more professionals are being asked to determine their value and state their 'core skills'. This accounting for oneself can produce anxiety, frustration and uncertainty in all professions, who feel their role is being eroded and perhaps others will be identified as more effective or cheaper alternatives. It is essential to the effective functioning of the multidisciplinary team that there exists a respect for each profession and the skills they have to offer. It is hoped that such a respect may develop for occupational therapists who have a useful range of skills to offer in the provision of a wide ranging comprehensive community mental health service and that it may no longer be the forgotten speciality in psychiatry.

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Psychiatric intensive care after two years

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The following is a descriptive study of Willoughby Ward, a psychiatric intensive care unit, opened in Parkside Hospital, Macclesfield, in July 1986. It provides a moderately secure facility for the treatment of psychiatric patients within both Crewe and Macclesfield Health Authorities. The unit has 15 beds, of which two are funded and used by Crewe area, where, unlike Macclesfield, the psychiatric unit is located in the district general hospital. Managed as a locked ward, the patients are admitted under the provisions of the Mental Health Act 1983. As well as being mentally ill as defined in the Act, the patients were disturbed to a degree as to be unmanageable in open conditions.

The unit has a high nursing staff to patient ratio, with at least one nurse to every 2.5 to 3 patients, there being always at least four nursing staff present during the day, and three at night. Treatment programmes were tailored to the individual needs of the patients, and their progress regularly monitored.

The unit was funded by the Regional Health Authority, the total ward budget being £202,386 per annum, including funds from Crewe area for two beds. This budget covered all ward expenditure.

In the two years studied, there were 40 admissions, of which 80% were single, almost 70% male, and 90% unemployed. The mean age was 37.5 years, with a range from 18 to 61 years. Forty-five per cent were admitted under Section 3 of the Mental Health Act, 22% under Section 2, 16% under Section 37, 8% under Section 35, and 6% informally. There were none admitted with a restriction on discharge, unlike those admitted to the Interim Secure Unit at Rainhill Hospital, which reflects their differing functions (Higgins, 1979). Willoughby Ward copes primarily with those who are difficult to manage, and the interim secure unit caters for patients who are a serious immediate danger to the public (Basson & Woodside, 1981; Higgins, 1981).

NHS hospitals accounted for 67% of referrals, with 22% from the penal system, 8% from special hospitals, and 3% from community agencies.

Of our patients, 57% were schizophrenic, 22% had organic psychosis, 16% were personality disordered and 5% had bipolar affective disorders. The high rate of organic psychosis was because the David Lewis Centre for Epileptics, a national centre for epileptics, was within the catchment area, and referred