Creek's Occupational Therapy and Mental Health

FIFTH EDITION

Edited by

Wendy Bryant
Jon Fieldhouse
Katrina Bannigan

Consulting Editors

Jennifer Creek & Lesley Lougher

Forewords by

Jennifer Creek & Peter Beresford

CHURCHILL
LIVINGSTONE
ELSEVIER

Creek's Occupational Therapy and Mental Health

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FOREWORD

Occupation has become an increasingly important issue in public policy for people with mental health problems. There has been growing pressure internationally to increase the numbers in paid employment of groups like lone parents, people with learning difficulties, people with physical and sensory impairments, as well as people with backgrounds in the psychiatric system. These are also all groups which face particular challenges to their mental health because of the problems of discrimination, exclusion and material disadvantage that they face. Efforts to direct people into employment have been encouraged through policies like 'activation' and 're-ablement', to challenge the low percentages of such groups identified as in employment and to reduce their reliance on welfare benefits.

This has frequently been a narrow, blunt and instrumental policy objective, which has taken little account of the barriers in the way of some groups and individuals, including mental health service users, entering, thriving in, and securing a career in the existing labour market. This policy approach has also often taken a very narrow view of occupation, disregarding the gains to be had from voluntary activity, peer support, user involvement, recreational and family and networking activities. All of these can bring major benefits and counter the isolation and exclusion frequently associated with being a mental health service user and increase people's skills and confidence. Sadly also, 'work' has often been constructed negatively as a 'responsibility' rather than positively as a 'right' which should be equally and accessibly available to all.

Given such a difficult context, this book is both remarkably timely and immensely helpful. Informed by key values like 'occupational justice', with a sensitivity to the active involvement of people as service users, notably through its use of service user commentaries, it opens up discussion about occupation and takes it in helpful and practical directions, just when this is particularly needed. This is a book that both brings together different perspectives – and its engagement with service user perspectives is invaluable – and which also draws on the knowledge and wisdom of occupational therapy, gained through practice, management, planning, research and evaluation.

This book brings together the practical and the theoretical, and highlights the importance of exploring the links between them. It builds an understanding of the importance of both individual and collective approaches to practice. It does not fall into the trap of offering the kind of technicist solutions that evaporate in real life, but instead builds on and offers a diverse range of experience and ideas for the reader to engage with and benefit from.

From within these covers, a liberatory approach to occupation and supporting occupational equality emerges. The ultimate beneficiaries will be service users, but those involved in the many roles of professional occupational therapy will also be greatly helped here in their efforts to develop a more participatory and helpful practice. As one service user says in his commentary, occupational therapy 'has helped me move forward, and built my confidence'. That is exactly what this book can do to help all involved in the project of occupational therapy, regardless of their role or standpoint.

PETER BERESFORD

November 2013

FOREWORD

In late 1984, I received a letter from the Edinburgh-based publisher, Churchill Livingstone, inviting me to edit a new textbook on occupational therapy and mental health. Annie Turner's recent book on occupational therapy in the physical field was a success and they were looking for someone to edit a companion volume. This was not a good time for me, as my daughter was still a baby, but I seized the opportunity. I had a clear idea of what a textbook should include but no experience of writing for publication or of editing. Initially, the publisher asked for an outline of my proposed contents, suggestions about contributors and a sample of my writing. After consulting various people, they decided to proceed with the project and the contract was signed in January 1986.

Personal computers had come onto the market not long before and I was strongly encouraged to buy one by a friend's father, Professor Max Hamilton, who told me that writing a book by hand would be no better than using a slab of rock and a chisel. So, I learned to type and became an early computer user, although most contributors to the first edition sent in handwritten or typed drafts of their chapters. I was very fortunate in the editorial team at Churchill Livingstone, including Mary Law, Ellen Green and Dinah Thom. Ellen patiently taught me how to edit my own and other people's work; a skill that I have used and valued now for nearly 30 years. Mary, Dinah and I developed a close working relationship that only ended when the company merged with Elsevier.

The first edition of *Occupational Therapy and Mental Health: Principles, Skills and Practice* was published in 1990. It proved difficult to find occupational therapists willing or able to contribute and I ended up writing seven chapters myself. The book fell so far short of my vision that I was embarrassed to be recognized as its editor. However, it sold well enough for Churchill Livingstone to request a second edition and I was determined that this one would be better. The second time around, it was easier to find occupational therapists willing to commit themselves to print: one of my ploys for finding authors was to invite the people who made constructive criticisms of the first edition to write chapters. The second edition was published in 1997.

I have always tried to ensure that the book will have relevance for occupational therapists working in the field of mental health in any sector and any country. Obviously, no book can explain and guide practice across all services and cultures but each of the editions included a wide range of theory and practice and avoided a bias towards any particular way of working. The book does not present instructions for doing occupational therapy but aims to provide practitioners with a range of tools and techniques, including tools to support their thinking, from which they can select those most appropriate to particular contexts. The second edition continued to find markets, both in the UK and overseas, and the publisher asked if I would like to produce a third edition, which came out in 2002.

By the time Elsevier expressed an interest in publishing a fourth edition, I was approaching the end of my career as an occupational therapist. I looked for a younger person to co-edit this edition with me and, perhaps, take over the book when I retired. No-one was willing to take on this huge task so, for a time, I continued editing the book myself. Then, my daughter died suddenly, in 2005, and I was unable to work. Rather than abandon the book, I asked Lesley Lougher if she could help, since she was an experienced editor in her own right and had been involved with *Occupational Therapy and Mental Health* from the beginning. She took over from me and the fourth edition was published in 2008.

This edition had a more explicitly international flavour and was the first to have a foreword, written by a distinguished Dutch occupational therapist, Hanneke van Bruggen. Another innovation was the inclusion of chapter commentaries by occupational therapy service users. We wanted to give the last word to people who had experienced occupational therapy services: three people accepted the invitation.

Since we were not able to find an individual willing to take over the role of editor, Lesley had the idea of putting together a small editorial team. To our delight, the three people we approached all agreed to take on the fifth edition. They had not worked together before but they brought a freshness and energy to the process that has produced an excellent volume. Not only have they included several new topics and found exciting new authors but they also persuaded 13 occupational therapy service users to read and comment on some of the chapters.

Over the years, many people have been involved in the book. The first three editions were all edited by me but the number of authors rose from 19 for the first edition, to 29 for the second, to 39 for the third. The fourth edition had two editors and 32 authors, plus three commentators. The fifth edition had three editors, 42 people wrote chapters and there were 13 commentators. In total, 177 people have written or co-written chapters or commentaries for the five editions.

Looking back over my long career, and at four editions of the book, I can see that much has changed, both within the profession of occupational therapy and in the contexts of our theorising and practice. When the first edition came out, most occupational therapists worked in hospitals or social services: we now work in a wide range of settings and the scope of our practice continues to expand. The profession has moved from a focus on in-patient care to a community orientation and from a biomedical approach to a human rights perspective. There has been a healthy development of theory in recent years, and the quality of writing in the book reflects a move from diploma to Bachelor or Masters degree-level entry to the profession.

Occupational Therapy and Mental Health has been a large part of my life for nearly 30 years. It opened up opportunities for me to meet and work with some of the great practitioners and scholars of occupational therapy. Most of all, it gave me the privilege of being able to contribute to the growth and development of our profession.

Jennifer Creek

November 2013

PREFACE

Promoting and maintaining mental health continues to be one of the biggest challenges in society today. We know that being active in our everyday occupations is key to promoting health and wellbeing so the need for a textbook like *Occupational Therapy and Mental Health* continues to be relevant. This edition, as with all previous editions, has captured contemporary practice in mental health settings but has also broadened its scope to speak to an international audience of occupational therapists and the people they work with.

CREATING THIS EDITION

The editors of the earlier editions, Jennifer Creek and Lesley Lougher, said they approached us to create a new editorial team because of our vision for occupational therapy and mental health, our particular capacity for networking and our attention to detail. The edition took shape over five years, involving much hard work and all the attributes we had been recognized for. Throughout we were guided by Jennifer and Lesley, meeting regularly at the British Library in London, UK; a central meeting point. At those meetings, we discussed every aspect of the book and agreed to remain faithful to what we perceived to be the 'Creek ethos' – espoused in a few key principles for the book:

1. It is a *practical* guide to theory and practice. The theory chapters may be written by academics but the applied chapters are written by cutting-edge practitioners.
2. It is epistemologically transparent. The book is clear about the meaning given to key terms and the philosophical and epistemological perspective being taken on each topic.
3. It is theoretically diverse. Different theories, models and approaches are incorporated into the relevant chapters but no chapter is devoted to a single theory, model, frame of reference or approach.
4. It presents difficult or complex topics in a way that makes them accessible without simplifying them to the point where they become something different.
5. It includes the most up-to-date evidence whilst appreciating that research-based evidence is but one component of professional reasoning.
6. It is inclusive. Where appropriate, material from outside occupational therapy is included, in both theory and applied chapters.
7. It anticipates future practice wherever possible.

As co-editors we have championed these principles and on this basis we are pleased that this new edition will be called *Creek's Occupational Therapy and Mental Health*. We feel it is a fitting tribute to Jennifer Creek's contribution to shaping this key text on occupational therapy and mental health over two decades.

AIMS

This book, like previous editions, has been written to inform those new to occupational therapy and mental health, as well as stimulating new ideas and supporting the practice of those with more experience. Authors have been encouraged to share their knowledge and experience in a clear and accessible way, recognizing that what is obvious to one person may not necessarily be obvious to another. However, simplicity can create problems if it results in an *over* simplification of issues, undermining the necessary (though sometimes challenging) engagement with the complex social and political contexts for mental health practice. Consequently, as co-editors we have debated terminology and agreed an approach that uses inclusive language and acknowledges that people using services should be central in the therapeutic process.

USE OF LANGUAGE

The words used to describe the people that occupational therapists work with reveal the practice context, conveying underlying assumptions about how power is used. The success of occupational therapy is dependent on an appreciation of people as occupational beings, so in this book the word *people* or *person* has been preferred. However, occupational therapy is usually provided within health and social care services where terms such as *patient* and *client* are often used. There is flexibility in the use of terminology in this book and the reader is encouraged to consider the implications of this. *Service user* is particularly prevalent in the UK so this term has been widely used in this book also.

WHAT'S NEW AND WHAT'S NOT

All chapters have been updated, new chapters have been included, and some existing chapters have new authors to bring a fresh perspective to well-established features of *Creek's Occupational Therapy and Mental Health*. The book has been written in an evolving context, with shifting dynamics around the dominance of medicine, new 'voices' in research generating debates about what constitutes mental health, applications of new research methodologies and changing models of service delivery. As well as a number of chapters being updated, new ground is covered. For example, we explore trust in relation to accountability, service user involvement in research, intersectionality and green care.

We have avoided chapters focused on diagnostic categories because we regard occupational therapy as being fundamentally about engaging with the person in their wider context, and enabling them to respond positively to the challenges of living. To encourage diverse perspectives, we have involved more service users as commentators for the chapters in this book.

SERVICE USER COMMENTARIES

Our desire to expand the range of service user commentaries in this edition reflects our experiences as practitioners, researchers and educators. We had a very positive response to our call for commentators, with so many people offering to write we could not take up all the offers. Contributors were given a wide brief. Some wrote a critique of the chapter, others addressed particular issues raised, whilst others gave their personal response to the topic. All these approaches are valid and, we hope, will encourage readers to see occupational therapy and mental health from new perspectives.

We also hope the commentaries will encourage readers to explore how they can involve service users to develop practice

JENNIFER CREEK AND LESLEY LOUGHER

Jennifer is undoubtedly a doyenne of the occupational therapy profession who has had a far-reaching impact on its thinking and its practice. She has been a mentor to many practitioners; not only ensuring that their voice was paramount in a textbook about practice but also providing many with their first opportunity to write. She has now provided us with our first opportunity to edit a book and we are very grateful for this experience. It has been an honour to take on the editorship of this textbook. It was a great privilege to oversee the contribution of so many innovative practitioners, theoreticians and researchers, continuing Jennifer's practice of supporting new writers. Throughout the creation of this new edition, Jennifer has been generous with her time, forthright in her views in the debates that inevitably unfolded, and supportive in her consulting editor role.

Lesley Lougher, who co-edited the fourth edition of the text, brought her considerable organizational skills to the creation of the fifth edition. She admirably steered us through the practicalities of book editing and we are indebted to her for her steady hand and wise words.

ABOUT US

Wendy is a Senior Lecturer at the University of Essex, having recently moved from Brunel University in West London, UK. In 2014 she will celebrate 30 years of being an occupational therapist including 10 years as an academic. Her practice included a wide range of mental health and other health settings in hospitals and the community. She has also worked in social care. Her research is focused on collaborating with service users and providers, using participatory and creative

methods. She is very interested in developing understanding of occupational justice and human rights.

Jon is a Senior Lecturer in Occupational Therapy at the University of the West of England, Bristol, UK. He worked in community mental health practice from 1989 – including specialist occupational therapist, generic case manager, and service manager roles – until moving into education in 2006. Since then, he has continued as an active researcher and writer with particular interests in the ongoing evolution of community-based care, occupational justice, social inclusion and citizenship for mental health service users, and the application of participatory action research and action inquiry methodology.

Katrina is a Reader in Occupational Therapy and Director of the Research Centre for Occupation & Mental Health (www.yorksj.ac.uk/RCOMH) at York St John University, UK. Working with others, including practice-based researchers and undergraduate and postgraduate students, she is developing occupation-focused research programmes about mental health; with an emphasis on investigating participation and boredom. She is also the co-author of the Model of Professional Thinking (www.yorksj.ac.uk/MPT) which grew out of her passion for making evidence-based practice central to clinical reasoning. An interest in increasing the evidence base for practice was the catalyst for her moving from working in practice in mental health settings to becoming an academic.

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Section 1 INFORMING PHILOSOPHY AND THEORY

1 A SHORT HISTORY OF OCCUPATIONAL THERAPY IN MENTAL HEALTH

CATHERINE F. PATERSON

CHAPTER CONTENTS

INTRODUCTION

History is interesting for its own sake, but it also facilitates our understanding of contemporary roles and relationships. Just as our sense of personal identity is rooted in family history, our professional identity and understanding of the contexts in which we work are enhanced by knowledge of their development. This chapter outlines the history of occupational therapy in the field of mental health within the wider context of the social and medical history of psychiatry and the development of the profession as a whole.

Throughout history, the care of the mentally ill has been dependent on prevailing attitudes and beliefs. What constitutes 'normal' and 'abnormal' behaviour, and what is considered 'mad' or 'bad' has varied throughout the ages. Beliefs about the causes of mental illness have had a significant influence on the way sufferers have been treated. Ideas of causation have included imbalance of the humours, possession by evil spirits, psychological trauma, genetic inheritance, faulty biochemistry and vulnerability to stress. Finally, the national economy and society's willingness to pay have dictated limitations to the provision of services. Consequently, the therapeutic use of occupation has fluctuated in relation to medical, social, political and economic factors.

Although the concept of the therapeutic use of occupation dates back to antiquity, the term 'occupational therapy' was not coined until early in the 20th century, and the first training course in the UK was not started until 1930. This chapter briefly surveys some of the earliest references to occupation as treatment; explores the moral movement in psychiatry and other philosophical influences in the late 18th and early 19th centuries; discusses the contribution of psychiatrists Adolf Meyer, David Henderson and Elizabeth Casson to the founding of the profession and identifies some of the major developments in

Creek's Occupational Therapy and Mental Health

psychiatry and occupational therapy in the 20th century. Finally, there is a brief discussion of the professional organizations, training and regulation which are important to the professionalization of occupational therapy.

MENTAL HEALTH AND THERAPEUTIC OCCUPATION PRE-19TH CENTURY

From the very earliest surviving manuscripts, reference was made to the belief that occupation in the form of exercise, work, recreation and amusements, can be used to improve mental and physical health. The Greek physician Hippocrates, in the 4th century BC, taught that the brain was the seat of the mind and described how mental health depended on a balance of four bodily humours: blood, choler, phlegm and bile (Digby 1985). Galen, the most influential of the Roman physicians, in the 2nd century AD, followed the methods of Hippocrates. Seigel (1973, p. 276) records that Galen, 'advised good nursing care; demanded kindness with the emotionally ill; employed as physical methods hydrotherapy, showers, sweating, local application of heat and sunbathing …. In milder cases he recommended travel, occupational therapy and, for the educated, an increasing participation in lectures, discussions, reading and in pastime creative activities'.

While the idea that madness was caused by evil spirits, witchcraft, sin or divine intervention, dominated popular thinking throughout the Dark and Middle Ages, physicians in Europe continued to accept Hippocrates' and Galen's explanation of the humoral basis of madness well into the 18th century (Porter 1999). In Britain, a rich person with a mental illness would likely be attended at home by a physician or placed in a private 'madhouse'. On the other hand, the 'mad' poor were mainly treated as social deviants, classed with destitutes, vagrants and criminals. Some were incarcerated in prisons or workhouses, or in one of the few hospitals for pauper patients, such as Bethlem Hospital in London. The conditions in which the mentally ill were kept, whether at home or in an institution, were appalling. They usually included the use of physical restraint (often by manacles and chains), no heat or lighting, little food, clothing, bedding or sanitation, no segregation of the violent from the quiet and withdrawn, and no meaningful occupation. There was even wrongful confinement of people who were not in fact mentally ill. Traditional medical remedies were aimed at re-establishing humoral balance and included special diets, bleeding, purging, emetics and blistering, often on a seasonal basis (Jones 1972).

MENTAL HEALTH AND THERAPEUTIC OCCUPATION IN THE 19TH CENTURY

Eventually, scandals, changes in public opinion and the example of a few asylums run on humanitarian principles led to a period of reform. At the beginning of the 19th century, the two asylums most celebrated for introducing reforms were the Bicêtre in Paris, under Dr Philippe Pinel (1745–1826), and the York Retreat, founded by layman William Tuke (1732–1822). Pinel and Tuke became internationally acclaimed for their introduction of moral treatment for the mentally ill, that is, psychological rather than physical treatment (Paterson 1997).

Pinel was appointed to the Bicêtre in 1794, during the French Revolution, when the institution housed upwards of 200 male patients who were regarded not only as incurable but also as extremely dangerous. Instead of blows and chains, he introduced light and fresh air, cleanliness, workshops and areas for walking, but above all, kindliness and understanding (Batchelor 1975). Pinel wrote in his famous 1806 treatise on insanity: 'It is no longer a problem to be solved … I am convinced that no useful and durable establishments … can be founded excepting on the basis of interesting and laborious employment' (Pinel, reprinted 1962, p. 216).

Tuke and the Society of Friends founded the Retreat in 1796 on the Quaker principles of compassion and humanity. The central emphasis was on trying to help the patient gain enough self-discipline to master his illness. To this end, it was thought important to create a comfortable, domestic environment in which the patient could experience normal civilized daily living conditions, which would help the process of self-control. Ann Digby (1985, p. 57) summarized the regime:

> *The need to balance the emotions and distract the patient from painful thoughts and associations led to the central feature of the Retreat's moral therapy: the creation of varied employment and amusements … the key to moral treatment lay in the quality of personal relationships between staff and patients. This is what makes the term moral treatment so elusive, and also made the treatment so difficult to translate successfully from the Retreat to other institutions in the mid-nineteenth century.*

Although Pinel and Tuke are most frequently credited with the introduction of moral treatment, there were other asylum superintendents at the beginning of the 19th century who were particularly interested in the therapeutic use of occupation as part of a humane regime of care. These included William Hallaran (1765–1825), the first physician of the Cork Asylum; Sir William C. Ellis (1780–1839), medical superintendent of the Hanwell Hospital and William A. F. Brown (1805–1885), the first medical superintendent of the Crichton Institution at Dumfries (Paterson 1997).

Hallaran published a book in 1810 called, *On the Cure of Insanity*, which advocated the use of suitable occupation for 'the convalescent maniac', combining 'corporeal action, with the regular employment of the mind'. He was the first physician to recognize the danger of institutional neurosis and gave the first account of the benefit derived from being allowed to paint (Hallaran 1810, cited by Hunter and MacAlpine 1963, p. 650).

Ellis was appointed to the newly opened Wakefield Asylum in 1818, with his wife as matron. Samuel Tuke (1784–1857) credited Ellis with: 'the first extensive and successful experiment to introduce labour systematically into our public asylums. He carried it out … with a skill, vigour, and kindliness towards the patients which were alike creditable to his understanding and his heart' (Tuke 1841, cited by Hunter and MacAlpine 1963, p. 871). While the men at Hanwell were encouraged either to follow their own trade or to learn a new one, Lady Ellis organized the female patients under a 'workwoman' to make 'useful and fancy articles', which were then sold (Ellis 1838, reprinted in Hunter and MacAlpine 1963, p. 876).

The foremost of the moral physicians in Scotland was Browne. His first position was as medical superintendent at the Montrose Asylum, where in 1837, he wrote an influential treatise entitled *What asylums were, are and aught to be*. He wrote:

> *It is not enough to have the insane playing the part of busy automatons …. There must be an active, and, if possible, intelligent and willing participation on the part of the labourer, and such a portion of interest, amusement, and mental exertion associated with the labour, that neither lassitude not fatigue may follow. The more elevated, the more useful the description of the occupation provided then, the better.*
>
> ***(Browne 1837, p. 94).***

From the 1840s, the Victorian era in Britain was characterized by the building of large public asylums on the outskirts of every large town for the 'better care and maintenance of lunatics'. Many of these asylums became the mental hospitals which were later closed in response to the care in the community policies dating from the 1960s. Nonetheless, these institutions were, themselves, the product of social reforms, at a time when the urban industrialized working class in Britain lived in conditions of squalor and grinding poverty (Jones 1972).

However, the optimism that cures could be effected through treatment in an asylum could not be sustained. Patients became quieter and more manageable but most were still unable to return to their former lives. The success of the asylums led to the admission of more inmates, so that their very size – many containing 2000 or more patients – made them the antithesis of the domestic surroundings necessary for treatment on moral principles. Many asylums found it impossible to attract the number and calibre of attendants required to manage disturbed patients without resorting to measures of restraint. Thus, during the latter half of the 19th century and well into the 20th, the individualized prescription of occupation gave way to the widespread use of the physically fit patients for work in the kitchens, laundry, farms and gardens of the asylums, as much for economic as for therapeutic reasons (Jones 1972).

MENTAL HEALTH AND SOCIAL POLICY IN THE 20TH CENTURY

During the early part of the 20th century, the most important influences on psychiatry were the theories of Sigmund Freud (1856–1939) and his associates Alfred Adler (1870–1937) and Carl Jung (1875–1961), who developed psychoanalysis and psychotherapy. Although these new disciplines had a significant influence on the way people thought about mental processes and on private practice, they had little effect on regimes within British asylums (Shorter 1997).

The move beyond the asylum can be traced back to the changes in practice during the First World War, when the problem of shell-shock required a new response to mental distress (Stone 1985). The Mental Treatment Act of 1930 blurred the distinction between mental and physical illness, so that medical terminology was adopted; asylums becoming hospitals, for example. The Act also further stimulated the development of outpatient clinics and after-care services, as well as admission of non-fee-paying patients on a voluntary basis (Jones 1993). Of particular note, was the founding of the Marlborough Day Hospital in 1946 by Joshua Bierer (1901–1984), a pioneer in social psychiatry, whose treatments included occupational therapy (Bierer 1951). The Second World War resulted in many problems for mental hospitals – some had been taken over to accommodate the war-wounded and there was an acute shortage of trained staff, which severely set back progress, and although most were taken over by the newly founded National Health Service in 1948, lack of finance continued to be a major problem (Jones 1993).

Denis Martin (1968) described mental hospitals during the first half of the 20th century as benignly authoritarian, in that the satisfactory running of the hospital depended on the submission of the patients to authority with the minimum of resistance. Methods of dealing with those who were unable to submit included locked doors, various forms of mechanical restraint, segregation of the sexes, heavy sedation, electroconvulsive therapy, prolonged sleep and prefrontal leucotomy, which were administered as treatment but which could be perceived or even used as punishment. However, the same authority was, arguably, benevolent, since the hospital provided security and met the patients' physical needs, so that the net result was: 'institutionalization'.

Although the Mental Health Act of 1959 greatly reduced stigmatizing procedures of admission and discharge, the planned measures to improve care outside mental hospitals were not uniformly achieved (Jones 1993). The 1960s saw the beginning of a sustained debate about the legitimacy of custodial care. The criticisms were led by psychiatrists Ronald Laing, David Cooper and Thomas Szasz – collectively dubbed 'anti-psychiatrists' – and by Erving Goffman, whose seminal work *Asylums*, published in 1961, drew attention to the dangers of the 'total institution' (Pilgrim and Rogers 1993).

However, the move from hospital to the community was greatly facilitated by the pharmacological revolution. It began in the 1950s with chlorpromazine (a phenothiazine) for the management of schizophrenia, and continued with lithium for manic-depressive psychosis (bipolar disorder), and the tricyclic antidepressants (Shorter 1997). With the new confidence in medication, the *1962 Hospital Plan for England and Wales* stated that large psychiatric hospitals should be closed and local authorities should develop community services (Ministry of Health 1962). The White Paper of 1975 further stated that the mental hospitals should be replaced by psychiatric units within district general hospitals (DHSS 1975). The development of depot neuroleptic drugs also facilitated the rehabilitation of patients with chronic schizophrenia who had difficulty with complying with oral medication (David et al. 2009).

The ideological and financial pressures on the psychiatric hospitals, together with the continuing development of effective medication, expedited the deinstitutionalization movement, which began slowly in the 1960s and gained momentum with each subsequent piece of legislation. By the 1990s, a wide range of supported accommodation had been set up, often by voluntary bodies. Nevertheless, there continued to be a need for provision for the 'new long-stay' patients, many of whom were detained under the Mental Health Act (1983), and after the closure of the psychiatric hospitals this need was largely met by the private sector (Killaspy 2007).

By the end of the 20th century, the widespread reliance on drugs to control symptoms had re-established

the somatic basis of mental health problems as the dominant view, alongside precipitating psychological and social factors (Shorter 1997). However, medication does not cure mental health problems, but helps to control symptoms and facilitate psychosocial forms of treatment. Consequently, there continues to be a need for adequate community services to maximize the effectiveness of interventions (Hirsch et al. 1973, cited by David et al. 2009).

OCCUPATIONAL THERAPY PIONEERS

The Beginning of the Profession of Occupational Therapy in the USA

At the end of the 19th century in the USA, as in Britain, the asylums were suffering from overcrowding and economic pressures. However, there was a resurgence of interest in reform and in structuring the patient's day in a more productive manner, stimulated by various antecedents. These included pragmatism, the mental hygiene movement and the arts and crafts movement, as well as the legacy of the use of occupation as an integral aspect of moral treatment (Paterson 2010). This led to the introduction of an experimental 6-week course in occupations for asylum attendants at the Chicago School of Civics and Philanthropy (Quirago 1995). By 1915, the course lasted 2 years, and is considered the first professional course in occupational therapy (Loomis 1992).

A major influence on this development, as on psychiatry on both sides of the Atlantic, was Dr Adolf Meyer (1866–1950), who emigrated from Switzerland to America in 1892. According to Rowe and Mink (1993), Meyer viewed mental illness as the outcome of a person's maladaptive interaction with the environment. His emphasis on objective observation of patient behaviour and on habit was compatible with the psychology of learning that was being developed by American pragmatists William James (1842–1910) and John Dewey (1859–1952), and his views anticipated the biopsychosocial model adopted by many psychiatrists in the late 20th century.

As early as 1892, Meyer observed that: 'The proper use of time in some helpful and gratifying activity appeared to me a fundamental issue in the treatment of any neuropsychiatric patient' (Meyer 1922, reprinted 1977, p. 639). In 1895, Meyer's wife, a social worker, introduced a systematic type of activity into the wards of the state institution in Worcester, Massachusetts, so that: 'A pleasure in achievement, a real pleasure in the use and activity of one's hands and muscles and a happy appreciation of time began to be used as incentives in the management of our patients' (Meyer 1922, reprinted 1977, p. 640).

Meyer is generally regarded as one of the founders of occupational therapy in the USA, along with other professionals who were developing the use of occupation quite independently. These included Susan E. Tracy (1878–1928) a nurse; Eleanor Clarke Slagle (1870–1942) a social worker; William Rush Dunton Jr (1868–1966) another psychiatrist and George Barton (1871–1923), who was an architect. Barton became an advocate after his own illness, when he experienced the beneficial effects of directed occupation. He founded an institution in Clifton Springs, where people with chronic ill-health could be retrained or could adjust to gainful living by means of occupation. It was at Clifton Springs in 1917 that the National Society for the Promotion of Occupational Therapy was formed, with Barton as its first president. In 1923, the name was changed to the American Occupational Therapy Association (Licht 1967).

The Beginning of the Profession of Occupational Therapy in Scotland

Professor Sir David K. Henderson (1884–1965) (Fig. 1-1), a prominent Scottish psychiatrist during the first half of the 20th century, was much influenced by Meyer, with whom he had worked in the USA. After returning to Scotland, Henderson became the Medical Superintendent of the Gartnavel Royal Hospital in Glasgow (Figs 1-2, 1-3), where he employed, in 1922, Dorothea Robertson (1892–1952), the first instructor in occupational therapy in Britain (Henderson 1925). Robertson, although a graduate of Cambridge University, did not have the benefit of any training, but within months, she had made sufficient impact that the Commissioners of the General Board of Control for Scotland reported that:

FIGURE 1-1 ■ Professor Sir David K. Henderson. *Reprinted with kind permission of NHS Greater Glasgow and Clyde Archives.*

> *For many years the advantages of farm and garden work for men and domestic work for women have been recognised from curative and ameliorative aspects and many patients have been so employed. There are, however, many patients not physically fitted for these strenuous labours or whose mental disorder such, for instance, as epilepsy, requires that they be under constant supervision. In all such cases the occupational therapy is being tried with excellent results. Patients were seen under a competent instructress making baskets, toys, rugs, etc. So successful has the treatment been that it is proposed to erect a special building within the grounds of the establishment where manifold light occupations can be carried out.*
>
> *(General Board of Control for Scotland 1923, p. xix).*

Henderson became an influential figure in the development of occupational therapy in Scotland, particularly in his encouragement of the founding of the Scottish Association of Occupational Therapy (SAOT) in 1932, and in the reconstitution of the Association after the war in 1946, when he became its president (Groundes Peace 1957).

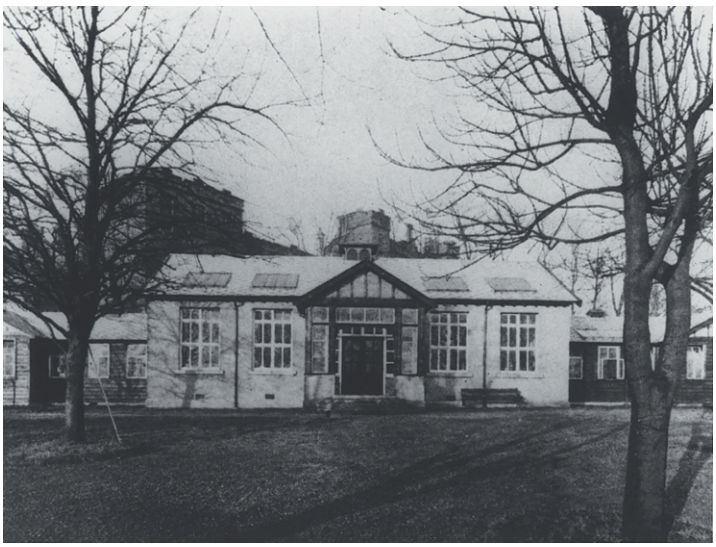

FIGURE 1-2 ■ The Occupational Therapy Pavilion, Gartnavel Royal Hospital, Glasgow, 1923. *Reprinted with kind permission of NHS Greater Glasgow and Clyde Archives.*

FIGURE 1-3 ■ The interior of the Occupational Therapy Pavilion, Gartnavel Royal Hospital, Glasgow. *Reprinted with kind permission of NHS Greater Glasgow and Clyde Archives.*

The first qualified occupational therapist to work in Britain was Margaret Barr Fulton (1900–1989) (Fig. 1-4), who became interested in occupational therapy during a holiday in the USA and who trained in Philadelphia. At first, Fulton found it difficult to find a position. However, she was eventually given an introduction to Henderson, who referred her to a former colleague, Dr R. Dods Brown, medical superintendent of the Royal Aberdeen Mental Hospital, who secured her services immediately (Paterson 1996).

In 1929, Dods Brown published an article entitled *Some observations on the treatment of mental diseases*, in which he gave a description of occupational therapy, which was based in an army hut erected in the grounds of his hospital. His article was illustrated with case material, including the reports in Box 1-1.

Following the appointment of Robertson and Fulton, it appears that many Scottish mental hospitals followed suit in appointing instructors, most of whom held art college diplomas. By 1932, there were 11 such ladies who, under the direction of Fulton, and with the encouragement of Henderson, formed themselves into the SAOT (Groundes Peace 1957).

Although Fulton continued to work at the Royal Aberdeen Mental Hospital until her retirement in 1963, her influence was considerable both throughout Scotland and worldwide in her capacity as one of the founders, in 1952, of the World Federation of Occupational Therapists and as its first president (Paterson 1996).

The Beginning of the Profession of Occupational Therapy in England

Among the delegates at the conference where Henderson described the occupational therapy department at the Gartnavel Royal Hospital in 1924 was Dr Elizabeth Casson (1881–1954) (Fig. 1-5),

FIGURE 1-4 ■ Miss Margaret Barr Fulton MBE.

FIGURE 1-5 ■ Dr Elizabeth Casson OBE. *Reprinted by kind permission of the College of Occupational Therapists and Elizabeth Casson's family.*

who was also destined to play an important role in the development of occupational therapy in Britain. Casson first trained as a housing estate manager with Octavia Hill (1838–1912), who greatly influenced her. Hill, a friend of the leaders of the arts and crafts movement, John Ruskin and William Morris, was a social reformer passionate about the development of social housing. The settlement movement, creating integrated mixed communities of rich and poor, grew directly out of Hill's work. Casson, appalled by

BOX 1-1

FROM DODS BROWN, *SOME OBSERVATIONS ON THE TREATMENT OF MENTAL DISEASES*

A man, aged 69, had been in hospital for several months, during which time he did not improve. He spoke to no-one, and would not employ himself in any way. He seemed to be deteriorating rapidly, and to be passing into dementia. He was sent to 'The Hut' every day, but for more than a week he showed not the slightest interest in anything he saw nor what was said to him. Later he was induced to do a little sandpapering, which he did in an entirely mechanical way. After a time he was given a fret saw to use, and this seemed to arouse some interest in him. As the days passed it was apparent that his interest was growing more and more, not only in the work, but also in his personal appearance, because one day he objected to the sawdust getting on his clothes. As time went on he was given more difficult work to do, and in this he became thoroughly interested and indeed enthusiastic, and when his discharge was being discussed, he was reluctant to leave the institution. He made a thoroughly good recovery.

A woman who had been in a depressed, and somewhat agitated condition, and who had maintained almost complete silence for about two years, and who, on account of delusions of unworthiness, had refused her food, and had been tube-fed for several months, was put to the occupational therapy department. From that time she began to converse, and to take an interest in things outside herself. She improved steadily and rapidly, and was discharged recovered.

Dods Brown 1929, p. 684–685)

the neglect of the poor, qualified as one of the first women doctors at Bristol in 1919, and chose to specialize in psychological medicine. In 1926, while on holiday in America, she visited an occupational therapy department at Bloomingdale Hospital, New York, and the Boston School of Occupational Therapy, where the idea of an English school on similar lines was conceived (Casson 1955).

At that time, Casson was employed at the Holloway Sanatorium, where there was a tradition of many forms of occupation, including games, entertainments and the annual sports day. One of the instructresses, Alice Constance Tebbit (1906–1976), later Mrs Glyn Owens, obtained a scholarship at the Philadelphia School of Occupational Therapy and qualified in 1929 (Casson 1955).

By this time, Casson had fulfilled her ambition of founding a residential clinic for women psychiatric patients at Dorset House in Bristol, to which was attached the first school of occupational therapy in the UK, which opened on 1 January 1930, with Tebbit as its first principal. The school later moved to Dorset House in Oxford, where it is now part of the Oxford Brookes University. At the Bristol clinic, Casson decided:

> *to establish a treatment centre where each patient's daily life would be so planned that it fitted the individual's need like a well tailored garment. She planned that each member of the household, whether patient or staff, should feel an integral part of the whole and each would contribute, according to capacity, to the welfare of the whole. There would be no sharp social or professional distinctions between members of staff …. In this community everyone would be essential and therefore would feel valued and valuable.*
>
> ***(Owens 1955, p. 96).***

This philosophy anticipated the concept of the therapeutic community developed after the Second World War by, among others, Maxwell Jones (1907–1990) and David Clark (1920–2010), who both had studied under Henderson (Clark 2005).

Dr Casson was a source of inspiration and encouragement to occupational therapists throughout her life, which is commemorated by the Casson Memorial Lecture delivered at the annual conference of the College of Occupational Therapists.

OCCUPATIONAL THERAPY IN THE 20TH CENTURY

Since the first occupational therapy departments were opened in the UK over 80 years ago, the places where occupational therapists work and the colleagues they work with have changed markedly. Occupational therapists have continually adapted in response to changes in healthcare, demography, social and political policy, and technology; and their own knowledge base and skills have developed considerably. The pioneering occupational therapists worked in mental hospitals, mainly treating acute admission patients and those long-term patients whose condition precluded them from working in one of the ancillary services of the hospital. They were based in departments where groups of patients attended classes centred mainly on the arts and crafts, and technicians, especially for woodwork and pottery, were often employed. Occupational therapists also participated in the wide range of social and recreational activities which characterized most mental hospitals (Paterson 2010).

By the late 1950s, home units had been introduced to prepare patients for discharge and a greater emphasis was placed on social, self-care and home-care skills (Thomlinson and Kerr 1959). By the 1960s, social psychiatry had stimulated the introduction of day hospitals and group psychotherapy to many hospitals. Hester Monteath recalled that with the introduction of the new drugs at that time: 'The impact of the phenothiazines on the long-stay hospital was to stimulate an unattractive backwater into a scene of great activity with patients, formerly doomed to a life sentence in hospital, receptive to treatment and rehabilitation' (Monteath 1980, p. 16).

At a time of low unemployment and a thriving manufacturing industry in the UK, one of the changes was the development of industrial units alongside the occupational therapy departments to replace hospital utility units as a focus of vocational rehabilitation (Davidson 1963). Payment to patients was often regulated by the application of behavioural psychology (Willson 1983).

As consumer goods became more available and craftwork less popular, creative therapies such as drama, art, creative writing, music, various forms of exercise, gardening and poetry became more prevalent (Willson 1983). Occupational therapists were becoming evermore specialist in distinct areas of practice such as learning disabilities, child, adolescent and forensic psychiatry, and care of the elderly. Techniques, such as relaxation, social skills training, anxiety management, desensitization, reality orientation, assertiveness training and counselling were also being increasingly applied (Willson 1983, 1984). By 1988, occupational therapists in the UK were basing their treatment on much more clearly defined theoretical frameworks – psychoanalytic theory, behaviourism, humanistic approaches and developmental theories – and were becoming interested in the emerging occupational therapy theories emanating from the USA, such as Gary Kielhofner's Model of Human Occupation (Finlay 1988). These theoretical frameworks stimulated a revival of interest in the concept of occupation, and Yerxa et al.'s proposal for a formalized academic discipline named 'occupational science' in 1989, has inspired a resurgence in pride in the term (Ilott and Mounter 2000).

By the 1990s, occupational therapists were working in a complex system of mental health provision provided by the NHS, local authority, non-statutory agencies and charities, and in a broad range of clinical and community environments. Despite the challenges, by the end of the century, Ormston (2002) considered that occupational therapists, with their training, were well placed to undertake the generic work necessary for a multidisciplinary team to be effective. However, this should not be at the expense of their specialist role in using occupation to enhance people's functioning and quality of life.

Regulation of Occupational Therapy

While the Scottish Association of Occupational Therapy (SAOT) had been formed in 1932, the Association of Occupational Therapists (AOT), covering the rest of the UK, had its inaugural meeting in 1935, when Owens (née Tebbit) was elected chairperson. In the few years leading up to the Second World War, the AOT organized the first national examinations in occupational therapy, which initially allowed students to qualify in either physical or psychiatric practice, and launched a journal (Anon 1955; Hume and Lock 1982). From 1939 to 1945 the Association was immersed in the war effort, including the organization of shortened courses for occupational therapy auxiliaries for the military hospitals (Macdonald 1957).

After the war, in 1948, the whole management of healthcare services was revolutionized by the formation of the National Health Service, whereby responsibility for all psychiatric services, except some small homes, became a national rather than a local authority responsibility, with services being free at the point of delivery. Most occupational therapists became employees of the NHS (Paterson 1998).

A commission was soon set-up to consider the staffing and training requirements of the new service, and representatives of the AOT and SAOT became involved in protracted negotiations on how occupational therapy should be regulated. The Professions Supplementary to Medicine Act (1960) provided for boards for each paramedical profession, regulated by the Council of Professions Supplementary to Medicine (CPSM) responsible to the Privy Council (Mendez 1978). The Act was significant, in that it recognized the need for properly qualified and registered occupational therapists to work in the NHS and the diplomas of the two associations were recognized as qualifications for entry to the register. The CPSM was replaced by the Health Professions Council in April 2002, which changed its name to the Health and Care Professions Council in August 2012. This body is now responsible for standards of education, continual professional development and conduct.

In 1952, Owens, the then Principal of the Liverpool School, hosted a meeting to form the World Federation of Occupational Therapists (WFOT). The constitution drawn up required that the AOT and SAOT should be jointly represented on the WFOT Council, which led to the Joint Council of the Associations of Occupational Therapy in the UK. Cooperation between the two associations inevitably led to amalgamation and to the formation of the British Association of Occupational Therapists in 1974 (Paterson 2007).

One of the outcomes of this amalgamation was revision of training, particularly the phasing out of the national diploma examinations, a system which had become unwieldy with increasing numbers of students. The new system of validation of courses paved

the way for the development of degree courses, the first being approved in Belfast and Edinburgh in 1986 (Jay et al. 1992). Since then, the profession has achieved all-graduate status and is increasingly focused on research and evidence-based practice.

SUMMARY

Historically, the use of occupation as an integral aspect of treatment has fluctuated in relation to prevailing ideas about the causes of mental illness and other social and political factors. Of particular importance was the moral treatment developed in small asylums in the early 19th century, where individualized programmes of work and leisure and good interpersonal relationships between staff and patients were paramount.

From the inspiration of three psychiatrists and a handful of remarkable pioneering occupational therapists, the profession has developed in the relatively short period of some 80 years, so that by 2011, there were over 32000 registered occupational therapists in the UK. Having been involved in the treatment of the most intractable problems within psychiatric hospitals before the introduction of effective drugs in the 1950s and the gradual deinstitutionalization of patients since then, the profession has an even greater challenge in the 21st century. Occupational therapists are now required to provide services to a wide range of service users, from the young to the very old, in diverse settings and fulfilling varying roles within teams. In the ever-changing organization and structure of the health, social and voluntary services, they need to be proactive in the provision of effective services for people with mental health problems, wherever they may be. Occupational therapists should continue to be mindful of the humanistic ideals on which the profession was founded: the belief in the therapeutic value of meaningful occupation, the importance of the environment and of satisfying interpersonal relationships, and balance in the daily routines of work, self-care and leisure.

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SERVICE USER COMMENTARY

In this commentary, I am going to talk about my experiences in the mental health system. I have been involved with mental health and criminal justice services since 1990. I have experienced both punitive approaches, and enabling and recovery-focused approaches. I have experienced ECT, various types of medication, and different kinds of therapy, some helpful and some unhelpful. I will talk about these and how they have impacted on my life, and my journey into recovery.

Approximately 13 years ago, as a result of my mother's death, I was suicidal. I started a serious fire in my accommodation. I piled up my furniture and set it alight and collapsed due to smoke inhalation and blacked out. My only vague memories are of briefly waking up on a stretcher outside my home, surrounded by emergency services.

I got charged for arson with intent to endanger lives and given a 4-year prison sentence. Whilst in prison, I was given psychotropic medication, which had little effect. I continued to feel suicidal and to experience feelings of hopelessness and desperation. This deterioration in my mental health resulted in me setting fire to my mattress and blanket, with the intent of ending my life. I was given solitary confinement, loss of privileges and could no longer attend the canteen but had to eat in my cell. I was also given a life sentence. It was clear that the medication regime was not helping to improve my mental health. This relates to the earlier approaches to psychiatry mentioned in this chapter, which appear to be about using force and medication to control or sedate patients, rather than engaging them in therapy to aid recovery.

I also received electroconvulsive therapy to attempt to improve my depression. I went to the ECT suite, and laid on the trolley. Electrodes were placed onto my head. I was given an injection (anaesthetic) and was asked to count to 10, but usually fell asleep by the time I had reached three. Once I came round, the nurse gave me a cup of tea and a biscuit. On waking up from the anaesthetic I always felt a very painful headache. Then I would be given paracetamol to ease the pain.

The ECT helped to some extent but not enough. My first experience of using work to support my mental health was when working in a prison. I worked 5 days a week cutting towels, sewing vests and packing items in boxes. This provided some structure and purpose to my week.

However, I still needed support with my mental health. I was moved to a secure setting for assessment, and have since moved down to medium secure services, and am currently in low secure services, with a view to discharge in the near future.

I have engaged in occupational therapy throughout my time in mental health hospitals. This has been varied, but involved me looking at what is important to me. I have completed timelines looking at my patterns of behaviour; what has worked and what has not. I have engaged in courses, such as English, Maths and Food Hygiene skills. I have attended pottery, relapse prevention work and psychology work. I engage in paid work, as I am currently the service user representative for the ward, and I also have engaged in voluntary work in the community. I have spent 2 months in an independent living flat attached to the ward, where I got used to budgeting for a week's worth of groceries, preparing my own meals, completing my own household chores, managing my own time and getting used to my own company again. These are things most people take for granted, but they are not things I have done for a long time, whilst in prison or hospital.

Occupational therapy can work for people who want to help themselves progress through the mental health system. It has helped me move forward, and built my confidence and my routine back up, so I will know what to do when discharged. My hopes for the future are to be discharged into my own accommodation and return to work. Hopefully some of the skills I have learnt whilst in hospital should help me achieve this.

Matthew Pickles

2 MENTAL HEALTH AND WELLBEING

JON FIELDHOUSE ■ KATRINA BANNIGAN

CHAPTER CONTENTS

INTRODUCTION

This chapter explores the usefulness, within occupational therapy, of the concept of wellbeing. First, the association between health and wellbeing is considered, and the relationship between wellbeing and *mental* health is then examined in greater detail. This includes reflection on how wellbeing relates to occupational justice, social inclusion, citizenship, and recovery. Wellbeing is presented as a contested social construct with no fixed meaning. Within this context an occupational perspective of wellbeing is presented, emphasizing the role of occupation in the human drive to survive and flourish, and the relevance of this to broader political agendas concerning wellbeing is explored. Finally, some methods of measuring wellbeing are highlighted.

HEALTH AND WELLBEING

Wellbeing and health have been bound together conceptually since the World Health Organization (WHO) defined health as 'a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity' (WHO 1948). This definition ambitiously proposed a holistic concept of health and wellbeing, established wide parameters for considering what constitutes human health, and recognized socioeconomic factors as the legitimate concern of health services (Barry and Yuill 2012). However, the WHO definition has been criticized for its impracticality and for appearing to correspond more to happiness than health. Huber et al. (2011) suggest it is no longer fit for purpose because it does not accommodate the fact that ageing with chronic illness is increasing worldwide. They propose shifting the emphasis towards seeing health as a person's capacity to adapt and self-manage in the face of social, physical, and emotional challenges, with fulfilment and a sense of wellbeing. This offers a dynamic view of health that has much in common with resilience, which is the capacity to maintain and restore one's equilibrium through coping and

social connectedness. (Resilience is also discussed in the context of the emotional health and wellbeing of children and young people, in Ch. 25.) Huber et al. (2011) describe a person's sense of coherence as a crucial factor in their health; seeing this as a capacity for coping, recovering from stress, and ultimately for experiencing wellbeing.

The word 'complete' in the WHO definition also attracts criticism, on several counts. Not only is it deemed impracticable because it is not measurable, but also because it would result in much of the world's population being classified as unhealthy most of the time. Furthermore, it is suggested that the WHO definition has unintentionally contributed to the medicalization of society by supporting the tendencies of the medical profession and pharmaceutical industry to diagnose and treat conditions not previously defined as health problems (Huber et al. 2011). While the WHO's definition of health highlighted the *importance* of wellbeing, it also instigated the entanglement of health with wellbeing. One unfortunate outcome of this has been the tradition that health is the exclusive preserve of biomedicine, and is objective; while wellbeing is about subjective emotional and psychological states (McNaught 2011). This has caused confusion. For example, Spiegel (1998) noted how health is often mistakenly assumed to be the necessary precondition for wellbeing;

> *Thus, although good health is more than the absence of disease, disease does not imply the absence of happiness.*
>
> ***(p. 87)***

Making a similar point, Lawton-Smith (Head of Policy for the UK's Mental Health Foundation) ponders the relationship between wellbeing and *mental* health;

> *… of course, it is possible to have a mental health problem while being generally happy with life, and to be generally unhappy with life without a mental health problem.*
>
> ***(Lawton-Smith 2011, p. 4)***

So, while the term *wellbeing* is widely used in health and social care, it remains largely unexamined in its own right and poorly understood as a consequence. Significantly, perhaps, there is no consensus on how to write it: *wellbeing*, *well-being* and *well being* are all used. What follows is an exploration of wellbeing in relation to contemporary mental health practice, with an emphasis on social perspectives and an awareness of the increasing inclusion of wellbeing in mental health and social policy.

Defining Wellbeing

The coupling of wellbeing and health is now a feature of everyday language (McNaught 2011). The *Oxford English Dictionary* (2013) defines wellbeing as 'the state of being or doing well in life; happy, healthy, or prosperous condition; moral or physical welfare (of a person or community)'. It is interesting, from an occupational perspective, to note the conjunction of 'being' and 'doing' and the fact that wellbeing is considered to be both a personal and societal phenomenon. However, attempts to define and explore wellbeing more deeply – so it can be used more reliably within health and social care practice – reveal wellbeing to be a complex, confusing and contested topic. The search for a generally accepted definition of such an elastic concept has been described as 'frustrating and fruitless' (McNaught 2011, p. 10).

The International Classification of Functioning, Disability and Health has defined wellbeing as 'a general term encompassing the total universe of life domains including physical, mental and social aspects (education, employment, environment, etc.) that make up what can be called a 'good life'' (WHO 2001a). While this definition highlights wellbeing's complex nature, it also reinforces its elasticity.

In her review and critique of the use of wellbeing in the professional discourse across occupational therapy and occupational science, Aldrich (2011) noted a large discrepancy between the number of sources that used *wellbeing* (or *well being* or *wellbeing*), as a keyword and the number of sources that also provided a definition of the term. She concluded that wellbeing was widely seen as a standardized concept that needed no definition because it was universal. However, she saw no evidence to support this claim of universality. Instead, the diversity of definitions suggested that the term is used inconsistently and uncritically (Aldrich 2011). Indeed, it sometimes seems to be used as a 'linguistic flourish' (McNaught 2011, p. 8). For example, in various

contexts it has been used as a concrete noun (where wellbeing is a distinct entity that can be improved or threatened), or as an adjective or qualifier for another noun (as in 'wellbeing outcomes'). It may be seen as something specific to particular groups (as in 'children's wellbeing' or 'employees' wellbeing') or as an 'extender' to a set of other qualities, somehow bringing them together, (as in 'x, y, and wellbeing') (Ereaut and Wright 2008).

It is possible that our intuitive sense of what wellbeing *might* mean confounds our attempts to clearly articulate what it is. Ereaut and Wright (2008) argue that, as a *social construct*, wellbeing cannot have a fixed meaning;

> *It is a primary cultural judgement: just like 'what makes a good life?' it is the stuff of fundamental philosophical debate.*
>
> ***(p. 7)***

They also note that wellbeing is 'up for grabs'; being hotly contested, and accorded particular significance. For example, the UK government's mental health outcomes strategy states that 'more people of all ages and backgrounds will have better wellbeing and good mental health' (DH 2011, p. 6). Like the previous government (DH 2009), it defines wellbeing as:

> *A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment*
>
> ***(DH 2011, p. 90)***

Agreeing how to define wellbeing may create problems when, as Aldrich (2011) notes, our use of the term implies judgements and assumptions about what it *ought to be*. For occupational therapists, whose person-centredness arguably has wellbeing as the ultimate goal of intervention (Hammell 2008; Pentland and MacColl 2009), these value judgements must be consciously acknowledged if occupational therapy is to be truly person-centred, culturally sensitive and inclusive. It would therefore be advantageous for occupational therapists to be able to describe more clearly what wellbeing means *to them*. There are two strategies for stabilising meaning; overt definition, and discursive usage aiming to give a term greater currency and hence understanding (Ereaut and Wright 2008). This chapter adopts the latter approach.

WELLBEING AND MENTAL HEALTH

The WHO (2001b) has defined mental health as 'a state of wellbeing in which the individual realizes 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'. In order to appreciate the resonance of wellbeing as a concept within mental health practice, this chapter now presents a variety of perspectives of wellbeing, concluding with specifically *occupational* perspective of it. This encompasses the different viewpoints through its holism, and offers a basis for incorporating wellbeing into occupational therapists' professional reasoning and practice. Wellbeing has historically been explored from two distinct, yet complementary traditions; a sociological viewpoint, focusing on *social* capital, and a psychological one, focusing on *mental* capital (Pilgrim 2009).

Wellbeing and Social Capital

The sociological viewpoint conceptualizes wellbeing as a relational, not a solitary, experience; one that reflects our interdependence within our family, friends and neighbourhood networks. The importance to a person's mental health of their social connectedness has long been recognized within mental health practice but it has proved to be challenging for service providers to reliably incorporate it as a resource in their care planning with individuals (Morgan and Swann 2004).

McKenzie and Harpham (2006) suggest it is difficult to draw a clear distinction between the comparatively well-researched concepts of social support and social networks, and the concept of social capital. Wilcock (2006, citing Nutbeam 1998) offers the following definitions: *social support* is the assistance available to individuals and groups from within communities that can provide a buffer against adverse life events and living conditions, and be a positive resource for enhancing quality of life; *social networks* are the relations between individuals that may provide access to, or mobilization of, social support; and *social*

capital is the degree of social cohesion which exists in communities. Putnam (1993) defines social capital as participation in community networks, the sense of belonging, solidarity and equality derived from that participation, and the norms of reciprocity and trust that emerge between co-participants. Social capital is, therefore, about people and populations 'having opportunities to participate in society and enact their rights of citizenship in everyday life' (Whiteford and Pereira 2012, p. 188). It can be seen as a process *and* an outcome; the means by which people are enabled to participate, as well as the fact of participation (Whiteford and Pereira 2012). Putnam (1993) suggests that social capital can not only strengthen the ties of people who know each other but makes for a more receptive or inclusive society, capable of bringing together people who previously did not know each other. Social capital is, therefore, a property of groups rather than of individuals, whereas social networks are a more discrete feature of individuals' day-to-day lives. Social inclusion is discussed further in Chs. 23 and 24, which focus on community settings and older people, respectively.

This sociological perspective is a broad one. Participation and inclusion are viewed against the backdrop of factors, such as social class, gender, ethnicity, place of living, health-related behaviours, and the degree of choice an individual or family has regarding education, work and play (Barry and Yuill 2012). People's innate drive to connect with others is acknowledged along with the importance of equal access to shared resources to enable people to do this. This relates to occupational justice (see Chs. 3, 13 and 29), which raises 'concerns about the unfairness of some people flourishing in what they do, whereas other people are leading unhealthy, empty, marginalized, or dangerous lives' (Stadnyk et al. 2010, p. 330). It also reflects Hammell's (2008) view that, because it is often unattainable in conditions of oppression and poverty, wellbeing is a political notion tied to human rights.

Wellbeing and Mental Capital

Mental capital refers to those elements of a person's psychological make-up that indicate how well an individual is able to contribute to society and experience a high quality of life through doing so. It is defined as:

> *the totality of an individual's cognitive and emotional resources, including their cognitive capability, flexibility and efficiency of learning, emotional intelligence (e.g. empathy and social cognition), and resilience in the face of stress.*
>
> ***(Kirkwood et al. 2008, p. 19).***

The term *mental wellbeing* describes how mental capital contributes to society. It is defined as;

> *a dynamic state in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society.*
>
> ***(Kirkwood et al. 2008, p. 19)***

This definition echoes Huber et al.'s (2011) perspective on health described earlier. The emphasis on wellbeing as something derived from doing is also significant. The psychological perspective of wellbeing places less emphasis on relationships, focusing on what is personally derived and internalized by the individual (Pilgrim 2009). Individualization and internalization finds expression in contemporary notions of positive psychology or 'happiness science' (Seligman & Csikszentmihalyi 2000). This perspective views the personal search for meaning as the impulse for self-actualization, echoing the Aristotelian principle of *eudaimonia*, or human flourishing (Carson and Gordon 2010). This is often described in terms such as belonging, resilience, hope, spirituality, self-efficacy, self-esteem, self-acceptance, flow, happiness, autonomy, purpose and meaning (see Glossary for all terms; Chs. 17 and 20 for discussion about flow; Ch. 16 for explanations of self-efficacy and self-esteem). These concepts highlight the connection between wellbeing and personal recovery (Slade and Davidson 2011). Recovery-oriented practice (discussed further in Chs. 6, 11 and 23) emphasizes these personal values. They are important because pursuing personal life goals without excessive frustration may be essential to self-efficacy, identity and wellbeing. Living within a wider society, therefore,

BOX 2-1

A SUMMARY OF SOME OF THE FACTORS THAT PROMOTE A SENSE OF WELLBEING

Contribution. An old Native American proverb states that the smile you send out returns to you. A sense of being able to give to others is an essentially healthful phenomenon.

Comfort with change in life. Self-regard and 'acceptance of one's lot' leads to being at ease in one's surroundings. Parallel with this is the ability to change and adapt so that the individual does not sink into stagnation.

Contact/companionship. Involvement and social networks are essential for human survival and the degree of support which a person perceives he or she is receiving from others is a crucial factor in the ability to cope. Empathy with others is an aspect of this.

Choice. Also significant is the degree to which the person feels in control, having a sense of empowerment and choice.

Competency. The ability to cope builds a positive self-concept, which reinforces a sense of competency. Carrying out activities proficiently promotes self-esteem.

Commitment. This brings a sense of purpose and belonging and direction in life.

(Blair et al. 2008, p. 27)

means it is the *mutual* respect for personal identity that makes these goals achievable for individuals. In this sense, wellbeing is still dependent on reciprocal, or two-way, relationships (see also Box 2-1).

From this brief overview of social capital and mental capital, it can be seen that an understanding of wellbeing requires an appreciation of human life as it is lived *in relationship* to others. It is not determined simply by factors within the intra-personal domain.

Pilgrim (2009) suggests that somewhere between these contrasting social capital and mental capital views of wellbeing lies a strong interdisciplinary consensus on the importance of *relationships*, and it is this which is of great interest in mental health. A middle position integrates subjective, internal states *and* observable measurable social conditions, related to deprivation for example. It unites personal subjective experience with broader sociological or societal issues. In other words, wellbeing can be seen wholly as something that is not simply about social experience, nor purely as a psychological state. It is not 'either/or', but both; a *psychosocial* phenomenon.

For example, the feeling of belonging that a person gets from participating in the life of their community has been termed *cognitive* social capital because it has become internalized by them. This is distinguished from *structural* social capital, which is the availability of networks and relationships in a given area. Cognitive social capital is a reliable predictor of wellbeing while structural social capital may not be; particularly if a person is living in the same street as other people but leads a separate, excluded life (McKenzie and Harpham 2006).

Promoting social inclusion could therefore be understood in terms of converting structural social capital into cognitive social capital; accessing the opportunities that are 'out there' and transforming that capital into an intrapersonal sense of belonging, which is a vital dimension of wellbeing and quality of life (Chan et al. 2005).

Supporting this process requires collaboration between mental health *services* and mainstream community agencies (Fieldhouse 2012). This brings together different stakeholders with their contrasting notions of wellbeing; some health-orientated, others orientated to citizenship (Bates 2010). A psychosocial definition of wellbeing is helpful in this context:

> *Wellbeing consists of individual components (personal, relational and collective needs) and of the synergy created by all of them together. In the absence of any one component wellbeing cannot really be achieved.*
>
> ***(Nelson and Prilleltensky 2010, p. 60)***

However, the vulnerability of a person's wellbeing to the impact of specific impairments associated with mental health problems should not be overlooked. A person may enjoy a strong sense of wellbeing most of the time, derived from well-established occupations and social networks, but this may be precarious and easily undermined by the onset of acute experiences, such as derogatory voices which may be associated with psychosis, or negative or catastrophic

thinking sometimes associated with depression and anxiety. On this basis, a person's ongoing experience of wellbeing may depend on many aspects of their life, including (at times) their use of medication to address the worst of these symptoms, giving them a platform from which to maintain their occupational and social engagement (see Ch. 23, where medication is discussed in detail).

Implications for Occupational Therapy

The multi-agency environment is a feature of contemporary mental health practice wherever institutional care has shifted to community-based care. Szaz (2010) urges mental health practitioners to regard their practice as helping service users to tackle problems with living rather than addressing the symptoms of a presumed underlying pathology. Enabling the occupations of day-to-day living is a fundamental goal of occupational therapy, but it cannot be assumed that its concepts and language are shared, understandable or acceptable to all the potential community-based partners that an occupational therapist may work with to promote community integration for service users. This is precisely where an ill-defined health-centric concept of wellbeing can cause problems. Providing a good service to *clients* may be at odds with an individual's developing sense of *citizenship* (Seebohm and Gilchrist 2008; Bates 2010). The very notion of *care* may itself be the problem when what is preferred by service users is greater access to ordinary life opportunities (Beresford et al. 2010). This underscores the importance of combining micro- (client-centred) and macro-level (community-orientated) working, and appreciating the full range of factors that contribute to a person's sense of wellbeing. Occupational therapy's in-depth appreciation of the influence of person, environment and occupation on people's abilities to act in the world supports this kind of work (Turpin and Iwama 2010). This approach is explored further in Ch. 29.

In mental health terms this means focusing on promoting individuals' personal skills and resources *and* on addressing the socioeconomic environment; acknowledging how disability, exclusion, and stigmatization operate societally (Wilcock 2006). Examples of macro-level intervention include improving housing, supporting access to education and/or training, and strengthening community networks (Hosman and Jane-Lopis 2005). This kind of work offers unique opportunities for mental health promotion through inter-sectoral, cross-cutting programmes as well as specific healthcare interventions to address mental health *problems*. It reflects occupational therapy's aspiration to empower its service users (Wilcock 2006). In these ways, occupational therapy can be a bridge between services and everyday life:

> *We are, perhaps, the sturdiest and most accessible bridge between these two worlds. Maybe being the bridge is our unique role …*
>
> ***(Hasselkus 2011, p. 136)***

Health promotion professionals concur on two points; that greater health equity (or social justice) is their overriding goal, and that the 'unjust gap' between those with the best and those with the worst health is widening (Mittelmark et al 2005). Consequently, upholding the values of social justice is essential to personal and relational wellbeing. On an individual (micro-) level, many of the people in contact with mental health services lack experience of warm and supportive relationships and the therapist can facilitate the expansion of social networks to enhance feelings of wellbeing. Some of the factors that promote a sense of wellbeing are summarized in Box 2.1.

AN OCCUPATIONAL PERSPECTIVE OF WELLBEING

Wellbeing can be seen as an essentially *occupational* phenomenon, whereby health is a resource for living rather than an end in itself; in other words, wellbeing as 'well doing' (Wilcock 2006 p. 323) or 'active living' (Hasselkus 2011 p. 87).

Wilcock (2006) suggests that *wellbeing through doing* is founded on the premise that, to enjoy health and wellbeing, people's occupations must provide meaning and purpose as well as being a context for self-esteem and socialization. Wilcock (2006) further suggests the range of a person's occupations should include physical activity, intellectual challenge, spiritual experiences, experiences of timelessness and

higher-order meaning, emotional highs and lows, solitary and social experiences, effort and relaxation. The phenomena highlighted earlier – belonging, resilience, hope, spirituality, self-efficacy, self-esteem, self-acceptance, flow, happiness, autonomy, purpose, meaning, occupational justice, social inclusion, citizenship and recovery – resonate across this range of experiences. In short, Wilcock (2006) sees wellbeing as the net result of people striving to reach their potential through what they *do*.

Interestingly, the New Economics Federation echoes and popularizes this occupational perspective by identifying ways of promoting one's wellbeing based on 'evidence from the science of wellbeing' (nef 2008), provided by the UK government's Foresight Project on mental capital and wellbeing (Kirkwood et al. 2008). Five ways are suggested: to connect socially; to be physically active; to take notice of the world around one in the moment; to keep learning and to give of oneself and one's time to one's wider community.

In addition to considering how occupation promotes wellbeing at any given point in time, occupations are also essential in maintaining wellbeing throughout the developmental stages of a person's life. Wellbeing is indicated by changes in occupational performance and engagement at transitions throughout life, and has been described as:

> *a flourishing condition that derives from a life where there is congruence among the person's occupations and their values and meaning.*
>
> ***(Pentland and MacColl 2009, p. 169)***

Hasselkus (2011) sees the embeddedness of occupation across the lifespan as the most powerful dimension of the relationship between occupation and wellbeing; more so than occupation as *therapy*. This dimension of wellbeing is a universal phenomenon across cultures and for all people. Self-actualization through occupation underpins human biological, psychological (emotional and cognitive), social, and spiritual development, and is responsible for the development of each person's unique personality and social behaviour. It is a view of the individual as a self-interpreting being. In short, individuals become defined (and define themselves) in the course of living a life (Hasselkus 2011). This echoes the idea that occupational therapists need to align their practice to the broad challenge of *enabling occupation*. Focusing on wellbeing (rather than simply health) can be a powerful stimulus to innovative practice. It can liberate practitioners from delivering occupational therapy *as it is known to be* and open up possibilities for occupational therapy *as it might become*.

In this wellbeing-focused endeavour, occupational therapy has much to offer. It is strengths-orientated, solutions-focused (as opposed to adopting an illness perspective) and person-centred (see also Ch. 23). It appreciates the contextual nature of occupation, understands the need to work at community, population, and global levels to promote occupation, and straddles health and social care in its education and practice settings. It recognizes the transformative power of occupation as a therapy and also appreciates how embedded occupation is in human wellbeing throughout the lifespan. It combines psychological, physiological, and sociological perspectives, and has developed models of practice that encompass this complexity and appreciate the human drive to flourish.

Summarizing these characteristics underlines how they cohere as one single, holistic professional perspective; one that offers a multifaceted approach to understanding and promoting wellbeing. In this way, an argument builds for an occupational perspective of wellbeing and the contribution of occupational therapy to the wellbeing agenda. However, it is unclear how occupational therapy, as a profession, will consider its role, and how its potential contribution might be presented in wider social and political arenas:

> *Occupational therapy is said to be based on the belief that there exists a universal and fundamental relationship between people's dignified and meaningful participation in daily life and their experience of health, wellbeing, and quality of life. However, who decides what occupations are dignified and meaningful is not only culturally informed but is also probably politically negotiated. It requires occupational therapists to view enabling access to meaningful occupation as a right, not just 'treatment' but a political endeavour.*
>
> ***(Pollard et al. 2009, p. 3)***

WELLBEING AS A POLITICAL PRIORITY

The world recession of 2008 highlighted the need for measures of progress beyond the economic. Many developed countries have now had almost continuous rises in average incomes for over 150 years but are seeing that additional wealth is not as beneficial to individuals' wellbeing as it once was (Wilkinson and Pickett 2010). Indeed, economic growth in market democracies across the world has been accompanied by increased rates of depression, suicide, addictions, family breakdown, and interpersonal violence (Carlisle et al. 2010). Beyond a certain level of affluence, increasing prosperity counts for less and less. The relationship between good health and prosperity levels off and weakens after the early stages of economic growth, and the same is true of happiness (Wilkinson and Pickett 2010);

> *This is a predictable pattern. As you get more and more of anything, each addition of what you have – whether loaves of bread or cars – contributes less to your wellbeing.*
>
> ***(p. 8)***

Despite (or maybe because of) the lack of clarity about what wellbeing means, it features prominently as a declared political priority in much of the developed world as an alternative to the historical goal of economic prosperity (Pilgrim 2009). Even when wellbeing is presented in this way, it is done with no explicit definition (McNaught 2011). For example, the UK government's definition (see earlier) states that wellbeing is a 'positive' state and an 'important' part of health (DH 2011). The very vagueness surrounding wellbeing is perhaps what makes this expedient as a rallying-call, in political terms. It is hard to hold politicians accountable when indicators of wellbeing are unformulated and ambiguous.

Nevertheless, the health implications of inequality are striking. Social inequality is conducive to poor health and wellbeing outcomes for entire populations, not just for the poor and disadvantaged in a society (Wilkinson and Pickett 2010). It is widely acknowledged that societies with the biggest gaps between rich and poor are damaging for everyone in them, including the well-off. Moreover, while greater social equality yields the greatest benefits for the poor, the benefits of equality are seen to extend to the majority of the population too (McNaught 2011).

Social justice has implications for the incidence of mental health problems in particular. There is a relationship between common mental health problems and a poor standard of living (Lewis et al. 2011) and a much higher percentage of the population experience mental health problems in more unequal countries; particularly from anxiety disorders, impulse-control disorders, and severe mental health problems (Wilkinson and Pickett 2010). As described, a broad range of factors influence wellbeing. Bio-medical health is but one component and modern conceptualizations of wellbeing acknowledge that it cannot be developed appropriately by health agencies acting alone. The wellbeing agenda is necessarily a cross-cutting one. For example, in the UK, Health and Wellbeing Boards were established under the Health and Social Care Act (DH 2012) to bring leaders from the health and care system together to improve the health and wellbeing of their local population through integrated services. The UK Government also plans to introduce questions about subjective wellbeing into the next UK national census in 2021 (Knight and McNaught 2011).

There is a paradox here, however. Although the World Health Organization (WHO 2001a) described wellbeing in terms of a good life it is clear that unilateral striving for the 'good life' – as manifested in the economics, individualism, materialism, and consumerism of post-industrial Western society – is increasingly recognized as being ultimately pathological for people's wellbeing (Eckersley 2000). From this perspective individuals' wellbeing can more accurately be seen as a reflection of a 'successful society' (see below); one where economic activity produces high, sustained levels of wellbeing for all citizens, without placing unsustainable pressure on environmental resources (nef 2013).

On this basis, the notion of gross national happiness is an emerging perspective. This concept is gaining credence as an attempt to find an indicator that measures quality of life more holistically than the conventional method of assessing gross domestic product (the value of goods and services produced in a country in a year), on the basis that most people aim to be happy and

healthy, rather than wealthy (McNaught 2011). The Happy Planet Index (Abdallah et al. 2009) was introduced as a socioecological measure indicating the environmental efficiency of supporting wellbeing in a given country using life satisfaction data, life expectancy and ecological footprint. In short, it measures 'happy years of life per unit of resources consumed' (Carlisle et al. 2010) and highlights how much of the planet's natural resources it costs to sustain a country's lifestyle. Rich developed nations fall somewhere in the middle. It has been suggested that, considered in this way, wellbeing can be a reflection of personal, societal, national and global connectedness (Nelson and Prilleltensky 2010). In other words, it highlights how our personal, individual occupations impact on, and are impacted upon by, societal and global patterns of occupation.

A 'Successful Society'

Societal wellbeing refers to both the collective wellbeing of individuals and the quality of interactions between and among individuals and social institutions (such as communities, the labour market, the healthcare system, the education system and the social security system). Furthermore, self-determination is based on opportunities and resources within the community which is inhabited by everyone, so collective values complement individual and relational ones. In the UK, Skilton (2009) defined societal wellbeing as a positive social and mental state requiring that basic needs are met, that individuals have a sense of purpose, and that they feel they can achieve important personal goals and participate in society. It is enhanced by supportive personal relationships, empowered communities, good health, financial security, rewarding employment and a healthy and attractive environment.

The Political Imperative of an Occupational Perspective of Wellbeing

Occupational therapy's capacity to engage with and develop concepts of wellbeing (both theoretically and practically) highlights the political dimensions of occupational science and presents occupational therapy as a political practice (Pollard et al. 2009).

Given that wellbeing is a broader concept than bio-medical health, that a national and international wellbeing agenda exists, and that the political will to address inequality is subject to the vagaries and expediencies of party politics, a question arises: *Where does the expertise for promoting wellbeing lie within health and social care*? If occupational therapy's contribution to a national wellbeing agenda is to truly reflect its macro-level health promotion perspective (as indicated in the earlier discussion), it would require occupational therapists to think and act politically (Wilcock 2006). This is a significant challenge. It is hoped, by exploring some of the concepts and terminology with which wellbeing is being discussed and developed outside occupational therapy, that this chapter will highlight connections with occupational therapy's own constructs and practices. In this way, occupational therapists will be able to continue to develop their work as enablers of occupation, appreciate fully the connection with being enablers of wellbeing, and feel better equipped to do so with a wider range of inter-professional and inter-agency partners.

Other professional groups have seen the wellbeing agenda as an opportunity for their own advancement. For example, mental capital and wellbeing has been investigated by psychologists and psychiatrists on behalf of the UK Government in the Foresight Project, described earlier (Kirkwood et al. 2008). However, Pilgrim (2009) notes how the wellbeing *agenda*, and the opportunity for professional advancement it affords some, may work against its own aims. Not only does professional self-promotion undermine inter-professional collaboration (which is in service users' interests) but it could result in an over-exclusive emphasis on individuals and their 'treatment' coming to shape the wellbeing agenda. In short, it misses the bigger picture that the social model of disability can reveal:

> *if we are to gain further improvements in the real quality of life, we need to shift attention from material standards and economic growth to ways of improving the psychological and social wellbeing of whole societies. However, as soon as anything psychological is mentioned, discussion tends to focus almost exclusively on individual remedies and treatments. Political thinking seems to run into the sand.*
>
> ***(Wilkinson and Pickett 2010, p. 4)***

MEASURING WELLBEING

If wellbeing is a goal and outcome of occupational therapy, then measuring it becomes an important professional consideration. Ch. 5 is about assessment and outcome measurement and explains the importance of measuring outcomes more fully.

While it is acknowledged that the term wellbeing is used inconsistently and uncritically, there is general acceptance that it is shaped by a wide range of factors (Carlisle et al. 2009). Consequently, any attempt to measure wellbeing must recognize this complexity (Jones-Devitt 2011). However, this can create difficulties when selecting an appropriate measurement tool.

There are several measures of wellbeing in existence; some of which are presented in Box 2-2, as examples. This is not an exhaustive list and inclusion in the list does not indicate endorsement of the measure by the authors. The diverse ways in which the term wellbeing is used across the measures in Box 2-2 reflect some of the linguistic issues highlighted earlier in the chapter. For example, the term wellbeing may be no more than a linguistic flourish if the phenomena linked together by Stride et al (2007) (job satisfaction, organizational committment, and mental health) are not justifiably shown to be components of 'job-related wellbeing'. Similarly, the KIDSCREEN-10 score is described as a measure of children and adolescents' wellbeing and health-related quality of life (Ravens-Sieberer et al. 2010), yet there is no examination of, nor certainty that, wellbeing and health-related quality life are comparable phenomena.

BOX 2-2

A LIST OF OUTCOME MEASURES OF WELLBEING INDICATING THE RANGE OF MEASURES AVAILABLE

- Body-Mind-Spirit Well-Being Inventory (Ng et al. 2005)
- BBC Wellbeing Scale (Kinderman et al. 2011)
- General Psychological Wellbeing Scale (Khumalo et al. 2010)
- KIDSCREEN-10 score (Ravens-Sieberer et al. 2010)
- Subjective Wellbeing under Neuroleptic Treatment scale (Naber et al. 1994)
- Measures of job satisfaction, organizational commitment, mental health and job-related wellbeing (Stride et al. 2007)

Proxy Measurement of Wellbeing

Acknowledging its complex nature, wellbeing can also be measured using a proxy measure or by an assessment battery. A proxy measure may be used to 'get at' a healthcare phenomenon which is elusive or very complex. One might see it as allowing practitioners to use a process measure instead of an outcome measure, perhaps; that is, accessing a measurable process in place of a phenomenon that is harder to access or identify;

> *Using a proxy measure means when you can't measure exactly what you want/need, you measure what you can*
>
> ***(Department of Community and Family Medicine 2005).***

The Beck Depression Inventory, for example, has been assessed as a proxy measure of subjective wellbeing (Van Hemert et al 2002) and dementia care mapping (See Ch 24 on older people) has been assessed as a proxy measure of the wellbeing of people with dementia (Innes and Surr 2001). In terms of using an assessment battery (a number of measures), Hayes et al. (2010) conducted a study to identify a range of measures to measure the wellbeing of spouses assisting with veterans' recovery, and Smith and Brun (2006) conducted a review to identify a range of measures to measure children's wellbeing.

However, it is not possible to identify a universally accepted measure of wellbeing, nor a widely accepted strategy for measuring wellbeing generally or in occupational therapy specifically (Aldrich 2011). This means great care needs to be taken in selecting measures of wellbeing. To select a measure one needs to be clear about how wellbeing is conceptualized (Aldrich 2011). It is hoped that this chapter will be a useful guide to practitioners and researchers in this respect. Once conceptualization is clear, a search strategy must be developed to identify a measure of wellbeing that exhibits these properties. Any measure selected needs to be evaluated to assess its psychometric properties; that is, its reliability, validity and utility (see Ch. 5 for more details).

CONCLUSION

Occupational therapy's contribution to understandings of wellbeing has been considered, recognizing how wellbeing is multifaceted and may be approached from philosophical, social, clinical and economic perspectives. Drawing on contemporary conceptualizations of wellbeing, the key components have been highlighted. The challenges associated with measuring wellbeing have been presented and an indication has been given of the range of measures available. The national and international wellbeing agenda has been presented as a cross-cutting political agenda that occupational therapy and occupational science can speak clearly to.

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3 THE KNOWLEDGE BASE OF OCCUPATIONAL THERAPY

JENNIFER CREEK

CHAPTER CONTENTS

INTRODUCTION

There are two main parts in this chapter. The first section describes philosophical assumptions and beliefs that underpin the theory and practice of occupational therapy. This includes a brief discussion of the origins of occupational therapy philosophy, an account of how it has changed over the past 100 years and an outline of the main beliefs and assumptions held by occupational therapists today.

The second part describes the breadth of theory used by occupational therapists. It begins with an explanation of what we mean by theory and goes on to consider the different types of theory needed to support occupational therapy practice. Key occupational therapy concepts are identified and defined, including core concepts and emerging concepts. Definitions are given of the terms used when talking about theory for practice, such as frame of reference and model. The chapter finishes with an explanation of how knowledge is organized for use in practice, illustrated with an example of an occupational therapy theory: the European conceptual framework for occupational therapy (Creek 2010).

PHILOSOPHICAL DEVELOPMENT OF THE PROFESSION

The modern profession of occupational therapy dates from about 1917. Since then, the profession has undergone, and is still undergoing, changes in its outlook and philosophy. Philosophy is a 'system of ideas, opinions, beliefs, or principles of behaviour based on

an overall understanding of existence and the universe' (*Shorter Oxford English Dictionary* 2002). The philosophy of occupational therapy includes ideas and beliefs about the nature of human beings, society, health, ill health and the relationships between these various elements. Occupational therapy philosophy also includes principles of professional behaviour, and these are discussed in Chapter 7.

Early Influences

Initially, occupational therapy operated with a pragmatic and humanistic view of human beings and their relationship with occupation. Some of the main proponents of this philosophy of pragmatism worked in Chicago, where the first occupational therapy course was started in 1908. Pragmatism stresses the relationship between theory and action (Audi 1999): it has been described as 'the philosophy of "common sense", problem solving, activity, and adaptation' (Breines 1986, p. 56). Pragmatism 'recognizes the inextricable influences on each other of the mental and physical aspects of human beings, their artifacts, their environments, and the societies and times in which they live' (Breines 1995, p. 16).

Adolph Meyer, one of the founder members of the National Society for the Promotion of Occupational Therapy in the USA, was a friend of the two most famous pragmatic philosophers of his day, John Dewey and William James, sharing their perspective (Serrett 1985). From 1913 to 1914, Meyer worked with Eleanor Clarke Slagle to develop a method of treatment called habit training, based on the work of James. This has been described as the oldest model of occupational therapy practice (Reed and Sanderson 1999).

Meyer wrote a paper on *The philosophy of occupation therapy*, which shows clearly the influence of pragmatism (Meyer 1922/1977, pp. 640–641).

> *Direct* experience *and performance [are] everywhere acknowledged as the fullest type of life. Thought, reason and fancy [are] more and more recognised as merely a* step *to* action*, and the mental life in general as the integrator of* time*, giving us the fullest sense of past, present and future …* performance *is its own judge and regulator and therefore the most dependable and influential part of life …*
>
> *Our conception of man is that of an organism that maintains and balances itself in the world of reality and actuality by being in active life and active use, i.e., using and living and acting its* time *in harmony with its own nature and the nature about it. It is the* use *that we make of ourselves that gives the ultimate stamp to our every organ.*

The humanistic perspective taken by occupational therapists grew from the profession's connection with the arts and crafts movement in the UK (Mattingly 1994b). The first occupational therapists believed 'that unleashing people's creativity might help them transcend the stultifying effects of incapacity, hospitalization and industrial labour' (Hocking 2007, p. 23). Humanism views people as 'growing, developing, creating being(s), with the ability to take full self-responsibility' (Cracknell 1984, p. 73). This includes taking responsibility for maintaining their own health and for making choices that determine what they become.

The Influence of Service Settings

Several of the early influences on occupational therapy came from outside health and social care services, for example, the arts and crafts movement and pragmatism (Paterson 2010). Nonetheless, the first occupational therapists worked in hospitals for people with mental and physical illness or disability and their actions were constrained by the ethos and expectations of these settings.

During the 1950s and 1960s, the reductionist model of science was being adopted by all the life sciences. Reductionism is based on the belief that the structure and function of the whole can best be understood from a detailed study of the parts by observation and experiment (Smith 1983). Western medicine is based on a reductionist medical model, with a 'focus on pathology … and on the minute and measurable' (Shannon 1977, p. 231). Scientific advances in medicine in the second half of the twentieth century led to an increasing use of technological interventions and an accompanying need for specialization, so that the focus of health services moved from health to illness and the responsibility for wellness moved from the individual to the medical profession.

In the first half of the twentieth century, the profession of occupational therapy did not have its own knowledge base with which to justify a pragmatic approach to intervention; occupational therapists worked under the direction of doctors. This left them vulnerable to pressure to adopt reductionist theories into the educational curriculum:

> *early occupational therapists had a moral imperative to train more practitioners but no knowledge base of their own with which to educate them or much of any status or expertise with which to argue for particular educational practices. This vacuum was largely filled by deference to medical authorities … under the strong influence of physicians, basic medical sciences and applied medical lectures occupied more of the field's core curricula over ensuing decades.*
>
> *(**Hooper and Wood 2002, p. 46**)*

By adopting a reductionist paradigm, occupational therapists were able to develop a great depth of expertise in various fields of practice – for example, many therapists became highly skilled in the use of projective media in analytic group psychotherapy – but the profession as a whole suffered from role diffusion and loss of identity (Kielhofner and Burke 1977). The broad, humanistic perspective was lost and occupational therapists' concern gradually shifted from people with complex, long-term needs to those who could be cured, while their goals changed from adaptation to the reduction of symptoms.

Reassessing Our Beliefs

In the 1980s, there was a general move away from a mechanistic view of man and health to a systems view that is more congruent with the pragmatic and humanistic perspective of occupational therapy. Occupational therapists saw the possibility that 'health care of the future will consist of restoring and maintaining the dynamic balance of individuals, families and social groups, and it will mean people taking care of their own health individually, as a society, and with the help of therapists' (West 1984, p. 21). This prompted them to reassess the original philosophy of occupational therapy, which had become obscured during the 1950s and 1960s.

More recently, the profession attempted to reassert the validity of occupational therapy traditions and values without losing the very real advances in theory and practice made during the reductionist era. The areas of belief that are still relevant to occupational therapy practice in mental health are summarized here and will be explored in more detail later in the chapter:

- concern with the person as a physical, thinking, emotional, spiritual and social being, who has a past, present and future, and who functions within physical and social environments
- belief in intrinsic motivation, which is an innate predisposition to explore and act on the environment and to use one's capacities
- recognition of each person's need for a balanced range of occupations in their life in order to facilitate development, give meaning to life, satisfy inherent needs, realize personal and biological potentials, adapt to changing circumstances and maintain health
- acceptance of the social nature of people and of the importance of social interaction in shaping what we become
- recognition that what we do influences what we become – the primacy of function over structure
- view of health as a subjective experience of well-being that results from being able to achieve and maintain a sense of meaning and balance in life
- belief in the capability and responsibility of people to find healthy ways of adapting to changing circumstances through what they do
- acceptance of the role of occupational therapy in serving the occupational needs of people in order to help them restore meaning and balance to their lives
- belief in occupation as the central organizing concept of the profession and in the use of activity as our main treatment medium.

Philosophical Assumptions

Professional philosophy is the system of beliefs and values shared by members of a profession. Philosophical assumptions are the basic beliefs which make up this system and show how members of a particular profession view the world and their own goals and function within it (Mosey 1986). In occupational therapy, we accept as true certain beliefs about the nature of people, for example that; 'All people experience the need to engage in

occupational behaviour because of their species common combination of anatomical features and physiological mechanisms. Such engagement in occupation is an integral part of complex health maintenance systems' (Wilcock 1995, p. 69). Without this belief, we would not be convinced of the value of occupation as therapy. It is healthy for us to question and challenge our basic assumptions, which are inevitably modified over time, but the sharing of a set of fundamental beliefs contributes to our sense of identity as a profession.

The three areas of belief central to occupational therapy are concerned with:

- The nature of human beings
- The nature of health and illness
- The goals and function of occupational therapy.

View of Human Beings

Occupational therapy is essentially client-centred, which means that: 'the occupational therapist does not force his value system upon the client. But rather, through using his skills and knowledge, exposes the client to a range of possibilities which constitute his external reality. The client is the one who makes the choice.' (Yerxa 1967, p. 8).

This belief in the right of people to make their own choices is made up of three separate beliefs:

- A concern with the whole person within their environment
- A belief in intrinsic motivation to be active
- An understanding of the social nature of people.

Concern with the Whole Person. Occupational therapists see each person as a unique individual, whose body, mind and spirit function together and cannot be understood as separate entities. People change, according to this view, if they are separated from the environmental influences that shape who they are. These influences include the physical environment, the cultural environment, societal factors and social support (Christiansen 1997).

This whole-person approach assumes that people can only be understood by seeing the relationships between body, mind, spirit and environment over time because the unique feature of humanity is the 'capacity of imagination and the use of time with foresight based on a corresponding appreciation of the past and the present' (Meyer 1922/1977). Occupational therapists are concerned with the person as they are now, at this moment, and with how they function at different times and in different environments. We are concerned with the balance of occupations in the course of the individual's lifetime, not just with single activities.

People as Initiators of Action. Western medical science is founded on the principle that human life should be preserved if possible. Occupational therapy takes the principle that human function should be preserved or restored where possible. It is the basic premise of our profession that being able to function and participate in a range of occupations is a desirable condition (Reilly 1962).

Indeed, it can be argued that human life and human function are the same thing. People have an intrinsic motivation to act on the environment in order to discover their own potential and to develop their capacities. We do not wait for the environment to impinge on us and then respond; we are able to visualize the ends we wish to achieve and act to realize them. West (1984, p. 13–14) summarized writings on occupational therapy philosophy as follows:

> *Activity is the essence of living and is significantly interrelated with high morale … to some degree life itself is seen as purposeful occupation – that is to say, as activity, as task, as challenge … it is the purposefulness of behaviour and activity that gives human life order … the basic philosophy of occupational therapy speaks to Man as an active being and to the use of purposeful activity as Man's interaction with and manipulation of his environment.*

People as Social Beings. People do not act in isolation: we are essentially social animals who develop and live in the context of groups. Human interaction stimulates biological, psychological, emotional and social development, and people deprived of human company do not thrive. There is a long period of physical and emotional dependency in childhood, and it is both normal and healthy to retain some emotional dependence on others once physical maturity is reached.

Social groupings take different forms in different cultures but a small and stable social group is considered most desirable within all cultures. People do not

cope well with living in groups that are too large for us to have meaningful contact with everyone else. This means that we have had to devise coping strategies for living in larger groups, for example in cities.

View of Health

Occupational therapists view health as not merely the absence of disease but 'a dynamic, functional state which enables the individual to perform her/his daily occupations to a satisfying and effective level and to respond positively to change by adapting activities to meet changing needs' (Creek 2003, p. 54). The individual is seen as healthy, or functional, when they have learned the skills necessary for successful participation in their expected range of roles throughout their life.

Not only do occupational therapists believe that health can be defined by what we are able to do, we also believe that what we do makes us healthy or unhealthy. What people do creates functional demands that drive neuroplastic changes and organization, and therefore occupations shape what we become: physically, mentally, socially and spiritually. This belief was expressed in a much quoted phrase: 'that man, through the use of his hands as they are energized by mind and will, can influence the state of his own health' (Reilly 1962, p. 2). An even stronger expression of this belief is that 'engagement in occupation is a central, evolutionary mechanism for the maintenance and promotion of health' (Wilcock 1998a, p. 1). An inability to achieve a desired state of function is called *dysfunction* but the two states can be seen as a continuum: 'there is essentially no break or line of demarcation between that which is considered function and that which is considered dysfunction' (Mosey 1986, p. 13).

Dysfunction. Dysfunction is 'a temporary or chronic inability to meet performance demands adaptively and competently and to engage in the repertoire of roles, relationships and occupations expected or required in daily life' (Creek 2003, p. 52). Dysfunction occurs when people are unable to maintain themselves within their environment because they do not have the skills necessary for coping with the current situation. It is therefore very individual: for a pilot, fear of flying could be a major disability while, for an occupational therapist, the same phobia may be only a minor inconvenience.

Causes of dysfunction fall into four main groups:

- Failure to develop and mature normally due to physical abnormality or environmental deprivation, for example chromosomal abnormality or emotional abuse
- Environmental or personal changes that the individual cannot cope with, such as war or bereavement
- New physiological or psychological demands that cannot be met using existing skills, such as parenthood
- Pathology or trauma causing loss of skills.

When the individual encounters a new situation, they use their existing skills to try to master it. If these fail, they try to learn effective new skills. Eventually, if the situation still remains outside their control, they experience disequilibrium or crisis. The pace at which change occurs is important for maintaining equilibrium; too fast a pace means that new skills are not learned quickly enough, adaptation is disturbed and a state of dysfunction may occur (Mosey 1968). The degree and pace of change that a person can manage without losing equilibrium are dependent on both internal factors (e.g. the ability to learn new skills quickly) and external factors (e.g. the amount of support available in the social environment).

The occupational therapist's perspective on health and dysfunction is similar to that described in the International Classification of Functioning, Disability and Health (ICF). The ICF defines *functioning* as 'an umbrella term encompassing all body functions, activities and participation', while *disability* is 'an umbrella terms for impairments, activity limitations or participation restrictions' (WHO 2001, p, 3). Diseases and disorders are called *health conditions*. The word *illness* is sometimes used synonymously with disease but is more often used to refer to a person's subjective experience of having a health condition.

View of the Profession

The uniqueness of the occupational therapy approach to mental health difficulties lies in the assumption that human beings have the ability to influence their own health through what they do. If people can maintain or improve their health by engaging in occupation, it follows that occupation can be used as a treatment

medium to 'remediate disability, encourage adaptive behaviour, teach skills and build individual and group identity' (Creek 2007, p. 127).

Occupational therapy has been described as a 'two-body practice' because it encompasses both a disease perspective, focusing on problem identification and treatment, and an illness experience perspective, which is concerned with the ways that disease affects a person's life (Mattingly 1994a, p. 37). Occupational therapy addresses the consequences of disease or injury, as they affect a person's ability to function, rather than the primary pathology. For example, the occupational therapist tries to teach a person how to manage their anxiety so that it does not interfere with their activities and occupations, rather than working directly on the anxiety. However, reduction in anxiety often follows as the individual's quality of life improves through this approach.

The core skills of occupational therapy are activity analysis, adaptation, synthesis and application. The outcome of intervention should be that the client is able to enact a satisfying range of occupations 'that will support recovery, health, wellbeing, satisfaction and sense of achievement' (Creek 2003, p. 32). The main aim of intervention is to develop each person's potentials to the highest possible level, to enhance their quality of life and sense of wellbeing, to increase their satisfaction in daily living and to improve access to opportunities for participation in life situations through occupation.

Domain of Concern. Occupational therapy is concerned with the things that people do in their daily lives, the meanings that people give to what they do and the impact that doing has on their health and wellbeing. This broad focus on 'the ordinary and extraordinary things that people do every day' (Watson 2004, p. 3) means that occupational therapy not only contributes to the restoration of health and function but also meets people's needs within broader occupational and social contexts. Occupational therapy contributes to building people's occupational identities as much as to restoring physical and mental function, and to building healthy communities that can include all their members, whatever disadvantages or disabilities they may experience.

> *The unique goal of occupational therapy is to help people with performance deficits of any kind make and express meaning through occupation, or intentional, organized performance … Occupations are applied to promote, achieve and maintain human functioning and a quality of life that gives meaning and purpose to living. The primary aim is to address issues of occupational dysfunction, disruption, deprivation, alienation, and unfulfilled potential.*
>
> ***(Watson and Fourie 2004, p. 26).***

Occupational therapy is often concerned with multiple and complex needs and problems but can also be of benefit to people who have minor coping difficulties or for those who wish to maintain and promote their wellbeing (Creek 2003). Intervention may be at an early stage of the person's difficulties, in order to mitigate or prevent any ongoing adverse effects, or may be appropriate at any stage of a long-term health condition.

Client-Centred Practice. Occupational therapists work with people of all ages who have problems with carrying out the activities and occupations that they expect or need to do, or with carers or care staff who support people's daily activities and occupations. Occupational therapy can be focused on individuals and groups, such as a family, or an organization, such as a school.

Occupational therapists recognize that their interventions are most effective when the person is involved and engaged in the process of setting and working towards goals. It is a requirement of the *Code of Ethics and Professional Conduct* (College of Occupational Therapists 2010, p. 16) that the therapist 'should work in partnership with the service user and their carer(s), throughout the care process, respecting their choices and wishes and acting in the service user's best interests at all times'.

In the traditional professional–client relationship, the therapist is the expert and the client is the passive recipient of that expertise. When the therapeutic relationship is seen as a partnership, the professional is the expert in managing disease or illness while the person is the expert in their own life. Client-centred occupational therapy intervention is a collaborative process in

which everyone involved aims to negotiate and share choice and control. This can be at two levels:

- **The level of the intervention**: throughout the occupational therapy process, the focus is on the person's needs, wishes and goals rather than on the requirements of the health or social care system. This includes determining the need for occupational therapy, assessing, gathering data, setting goals, working in partnership to attain goals and evaluating the outcomes of intervention (Sumsion 1999)
- **The level of service planning, delivery and evaluation**: service users are represented and take an active role in those committees and working groups responsible for the design, delivery and evaluation of services.

There is a third model for the professional–client relationship and this is full self-management, in which the professional is only one of the resources that the person draws on in managing their own health condition (Van Olmen et al. 2011). Choice and control are not shared but are located with the person.

When a person is too ill or disabled to take control or to participate fully in the intervention process, the therapist may have to take responsibility for making decisions, remaining aware of the risk of imposing their own goals and values and actively trying to avoid this. One of the goals of intervention will be 'to work towards increasing client understanding, autonomy and choice' (Creek 2003, p. 30).

The understandings that occupational therapists have of people, occupation and health, and of the relationships between them, determine what they see as their professional purpose. In order to fulfil that purpose, the profession builds a knowledge base to explain, support and justify the practice of occupational therapy. The current knowledge base is outlined in the next section.

OCCUPATIONAL THERAPY THEORY

Theories are conceptual systems or frameworks used to organize knowledge in order to understand or shape reality: they give the mind a conceptual grasp on reality (Dickoff et al. 1968). Theories are constructed for particular purposes and a good theory will fulfil the purpose for which it was designed. For example, the ICF is a theory that was developed to promote international communication about health at every level (WHO 2001).

Theory in a practice discipline must provide ways of conceptualizing reality that can guide action towards fulfilling the profession's professional goals (Dickoff and James 1968). For occupational therapists, theory must enable individualized, responsive, client-centred practice. Occupational therapists use theory:

- as a guide to practice, to encourage coherent and systematic treatment
- to suggest alternative treatment strategies
- to enable effective communication
- to provide a rationale for practice
- to provide a basis for researching practice (Creek 2003, p. 35).

It has been suggested that occupational therapy theory is not something we learn and then apply in practice.

> *In occupational therapy, theorising is an integral aspect of practice. We do not contribute to theory by first understanding what theory is and then developing a theory of our own. We* do *theory by developing collaborative models of thoughtful practice that challenge assumptions and suggest new lines of inquiry; we* do *theory by learning how to align thoughtfulness and practice within specific contexts that require constant negotiation across complex professional, cultural and social boundaries.*
> ***(Nixon and Creek 2006, p. 77)***

This view describes a practitioner who is continually thinking about what they are doing, reasoning about the most appropriate course of action, reflecting on the effects of their interventions and negotiating with everyone involved to reach agreement on the best way forward. Formal theories, learned from lectures and books, are only one part of theorizing in complex, client-centred interventions.

Epistemological Underpinnings of a Two-Body Practice

As described above, occupational therapists work with both a disease perspective that focuses on the identification and treatment of disease-related problems and

an illness perspective that considers the ways a health condition affects a person's life (Mattingly 1994a). These two perspectives represent different ways of knowing, or epistemologies. An American occupational therapist, Hooper (2006), claimed that our chosen epistemology 'functions as a screen through which we filter the experiences we consider important from those we do not' (p. 16). It is important to understand not just *what* we know but also *how* we know, that is, how we take in and make sense of experience.

The two epistemologies espoused by occupational therapy enable us to move, without losing sight of the complexity of occupation, from the 'minute and measurable' (Shannon 1977, p. 231) consequences of disease, such as short-term memory loss or sleep disturbance, to the wider aspects of illness experience and its impact on performance. Mattingly (1994a, p. 37), called this a 'two-body practice'. The capacity to support a two-body practice, by moving between two epistemologies, is one of the strengths and unique features of occupational therapy.

> *Occupational therapists have bridged two contradictory value systems for more than 75 years. The ability to combine the biomedical aspects of patient illnesses with the humanistic values of the Arts and Crafts Movement requires complex patterns of integrative treatment planning. This skill is an asset in today's healthcare arena where the limitations of scientific medicine encourage practitioners to emphasize the art of patient care. Occupational therapists who have struggled with ways to balance the scientific and artful aspects of practice can guide other professionals to develop more integrative health services.*
>
> ***(Schemm 1994, p. 1086–1087)***

Types of Theory

A good theory for practice is predictive, in that it helps the therapist to understand cause and effect and to make predictions about the likely outcomes of intervention, so that the most appropriate and effective course of action can be undertaken (Dickoff et al. 1968). Predictive theory is underpinned by more basic types of theory: naming and descriptive. Naming theory involves isolating and categorizing concepts, such as objects, ideas and feelings. Different names may be given to the same phenomenon, for example a person who does not want to attend occupational therapy groups may be called non-compliant, antisocial, independent or unmotivated. Each of these words represents a different way of understanding the person's behaviour. The names that a discipline selects for its core concepts indicate how its members view the world.

Descriptive theory depicts the relationships between concepts. The ICF is an example of a descriptive theory. Concepts that represent functioning and disability associated with health conditions are first named and defined, including body functions, body structures, impairments, activity and participation (WHO 2001). These concepts are then organized into a framework that depicts how they interact with each other.

The next section defines the concepts that have been identified as core to occupational therapy theory and discusses some of the newer concepts that are emerging to support more recent theoretical and practical developments.

Occupational Therapy Concepts

A concept is a mental representation of an object or idea (Creek 2003). Giving a name to a concept enables us 'to point out, denote, or attend to conceptually a factor within the mind's consciousness' (Dickoff et al. 1968, p. 420). For example, the word *activity* represents a concept that can be differentiated from other concepts that are not called activity. In a sense, until something is given a name it does not exist.

All disciplines identify the key concepts that underpin their subject area and the names of these concepts form the vocabulary of the field. Concepts are the building blocks of theory, just as words are the building blocks of language. In order to build theories that support the practice of occupational therapy, it is necessary to identify key concepts, agree on their precise meanings and find words to name them. Clearly defined and named concepts allow us to think and communicate about occupational therapy, to describe what we see and what we are doing, and to explain why certain situations or actions lead to change in one direction or another.

Core Concepts

Most occupational therapists are able to agree on the names that represent core concepts underpinning the profession's knowledge base, such as occupation, activity and function. However, there are many different ways of defining these concepts, leading to confusion and a weak foundation for building higher levels of theory. If we cannot agree on the precise meaning of *activity* and on how it differs from *occupation*, it is not possible to describe clearly the relationship between the two concepts or to predict how change in the way a person performs an activity will impact on their occupations.

The definitions presented in this section were developed by the terminology working group of the European Network of Occupational Therapy in Higher Education (ENOTHE) from 2002 to 2008 (Creek 2010). This terminology project was a collaboration between occupational therapists from six countries, representing six European languages. The ENOTHE definitions are based on a review of existing definitions in the occupational therapy literature worldwide. The terms that refer to aspects of the performer's perspective on occupation, and their definitions, are given in Box 3-1.

BOX 3-1

ENOTHE TERMS AND DEFINITIONS

- **Ability:** A personal characteristic that supports occupational performance.
- **Activity:** A structured series of actions or tasks that contribute to occupations.
- **Autonomy:** The freedom to make choices based on consideration of internal and external circumstances and to act on those choices.
- **Context:** The relationships between the environment, personal factors and events that influence the meaning of a task, activity or occupation for the performer.
- **Dependence:** The condition of needing support in order to be able to perform everyday activities to a satisfactory level.
- **Engagement:** A sense of involvement, choice, positive meaning and commitment while performing an occupation or activity.
- **Environment:** External physical, sociocultural and temporal factors that demand and shape occupational performance.
- **Function 1:** The underlying physical and psychological components that support occupational performance.
- **Function 2:** The capacity to use occupational performance components to carry out a task, activity or occupation.
- **Habit:** A performance pattern in daily life, acquired by frequent repetition, that does not require attention and allows efficient function.
- **Independence:** The condition of being able to perform everyday activities to a satisfactory level.
- **Interdependence:** The condition of mutual dependence and influence between members of a social group.
- **Motivation:** A drive that directs a person's actions towards meeting needs.
- **Occupation:** A group of activities that has personal and sociocultural meaning, is named within a culture and supports participation in society. Occupations can be categorized as self-care, productivity and/or leisure.
- **Occupation/activity/task performance:** Choosing, organizing and carrying out occupations/activities/tasks in interaction with the environment.
- **Occupational performance areas:** Categories of tasks, activities and occupations that are typically part of daily life. They are usually called self-care, productivity and leisure.
- **Occupation performance components:** Abilities and skills that enable and affect engagement in tasks, activities and occupations. These can be categorized, for example, as physical, cognitive, psychosocial and affective.
- **Participation:** Involvement in life situations through activity within a social context.
- **Role:** Social and cultural norms and expectations of occupational performance that are associated with the individual's social and personal identity.
- **Routine:** An established and predictable sequence of tasks.
- **Setting:** The immediate surroundings that influence task, activity or occupational performance.
- **Skill:** An ability developed through practice which enables effective occupational performance.
- **Task:** A series of structured steps (actions and/or thoughts) intended to accomplish a specific goal. This goal could either be: (1) The performance of an activity or (2) A piece of work the individual is expected to do.
- **Volition:** The ability to choose to do or continue to do something, together with an awareness that the performance of the activity is voluntary.

Activity and Occupation. The words *activity* and *occupation* are often used synonymously by occupational therapists but it is important to clarify the differences, for the reasons given above. Traditionally, occupational therapists have classified these two terms in a hierarchical relationship, with occupation at a higher level so that activities are seen to contribute to occupations (Hagedorn 2000). A hierarchical taxonomy of occupational therapy terms, developed in Canada, described seven levels of occupation, from occupational grouping at the highest level to voluntary movement at the lowest (Polatajko et al. 2004). In this classification, occupations are made up of activities, which are made up of tasks, which are made up of actions.

A different approach to understanding the relationships between occupation, activity and task was suggested by the ENOTHE terminology group, who described the concepts as a network rather than a hierarchy. In this conceptualization, a piece of performance can be experienced as an occupation, an activity or a task, depending on the context and the perspective of the person performing the action: 'the terms do not refer to the action itself but to how the performer conceptualizes it' (Creek 2010, p. 80). For example, cooking might be an occupation for a chef, an activity for a housewife and a task for a person undergoing rehabilitation. But each person's perspective can change so that there may be times when the chef experiences cooking as a leisure activity or, within rehabilitation, cooking becomes a purposeful activity, contributing to recovery.

The purpose of an activity is its goal and an intrinsic part of the activity (Creek 2010); for example, when I am making a cup of tea, my goal is to make a cup of tea. A single activity can have more than one goal; for example, walking to work may be for the dual purpose of getting to work and keeping fit. When an activity is used as a therapeutic medium, it has both an intrinsic goal (make a cup of tea) and a therapeutic goal or goals (complete a simple activity, without prompting, by planning and executing the appropriate sequence of tasks).

The meaning of an activity is its significance for the person performing it; therefore meaning is located in the person, not in the activity (Creek 2010). Much of the meaning of an activity comes from the context in which it is performed and can change each time it is performed, or even during the performance. For example, I make a cup of tea mid-morning to give myself a short break from working at the computer. The meaning of this activity comes from my liking tea and needing to move around. However, making tea takes on a more formal and social meaning if a friend arrives as I put the kettle on.

A person receiving occupational therapy intervention may perceive a different meaning in the activity from that intended by the therapist. For example, in order to assess sequencing ability the therapist asks someone to make a cup of tea, but the person perceives this task as a test to be passed before being allowed to leave hospital.

Occupations are frequently classified into different categories, such as self-care, productivity and leisure, which are sometimes called occupational performance areas (ENOTHE 2006). These are artificial differentiations, since an occupation can move from one category to another or belong in more than one category at the same time. For example, cooking a meal may be self-care if it is to satisfy an individual's hunger, it may be productive work if it is to feed a family, it may be leisure if it is a dinner party for friends, or it may serve more than one purpose.

Self-care activities and tasks enable the individual to survive and to promote and maintain health. They include:

- basic physical functions such as eating, sleeping, excreting, keeping clean and keeping warm
- survival functions such as cooking, dressing, shopping, maintaining one's living environment and keeping fit.

Work is any productive activity, whether paid or unpaid, that contributes to the maintenance or advancement of society, as well as to the individual's own survival or development. Work may help to maintain society (e.g. housework) or contribute to its advancement (e.g. theoretical physics).

The work in which a person spends most of their time usually becomes an important part of their personal identity and a major social role, giving them their position in society and a sense of their own value as a contributing member. Different jobs are given different social values so that people in certain jobs are considered to be more important than others, irrespective of how necessary their work is to the

continuation of society. For example, the work of a doctor is more highly valued in Western society than that of a housewife.

Man is a very adaptable species and this adaptability has been achieved by developing flexible behaviour rather than specialized behaviour (Kielhofner 1980). Play is the medium through which children are able to learn and rehearse a wide range of skills that will enable them to respond appropriately and adaptively in different situations. Even in adult life, new skills are learned more thoroughly and integrated more successfully into the pattern of daily life if the individual approaches learning in a playful and explorative manner.

In adult life, play is usually called leisure and is often used to satisfy individual needs that are not met by either self-care or work occupations. For example, amateur dramatics can improve the physical wellbeing of a person who has an otherwise sedentary lifestyle, provide intellectual stimulation for a full-time mother of small children, create social contacts for an unemployed person or enhance the social status and self-esteem of someone who has a low-level position at work.

Occupational Performance. The word *occupation* is used to refer both to the pre-existing format that guides or structures how someone performs an activity and to the performance itself (Nelson 1988). For example, there is an established format of rules, procedures, equipment and environment for playing football. This is the occupational form, which is socially constructed and exists independently of performance. Football has a physical environment that includes materials, location, human context and temporal context. It also has a sociocultural reality that depends on a social or cultural consensus and allows the occupational form to be interpreted differently in different social contexts, such as the differences between a game of football for schoolchildren and a professional championship match.

Playing football, the doing, is performance. Depending on how a person feels about playing football on a particular occasion, this may be experienced as occupational performance, activity performance or task performance. The way in which we perform an occupation, activity or task depends not only on the given occupational form but also on our level of competence and the meanings that we give to it. For example, a professional goalkeeper may deliberately allow the ball into the net if they are trying to encourage a young child to learn the game, or they may do their best to keep it out when their team is playing an international match.

Occupational Performance Components. The intrinsic factors that enable or support occupational performance are called occupational performance components (ENOTHE 2006), performance enablers (Christiansen 1997) or personal requisites for action (ENOTHE 2006). These factors include:

- abilities, such as the ability to sing in tune
- skills, including motor, sensory, cognitive, intrapersonal and interpersonal skills
- functions, such as grasping a bat or using it to hit a cricket ball.

It should be noted that the word *function* has two related meanings for occupational therapists and this can lead to misunderstandings. In the phrase *upper limb function* it is being used in the sense of 'the underlying physical and psychological components that support occupational performance' (Creek 2010). In the phrase *function in personal activities of daily living* it is being used in the sense of 'the ability to perform competently the roles and occupations required in the course of daily life' (Creek 2010).

Habit and Routine. Each person organizes their occupations, activities and tasks over time into patterns that meet their needs and satisfy the demands of their environment. The organization of time in this way is known as *temporal adaptation*. The healthy individual has their daily life activities organized into a satisfying and flexible pattern of habits and routines that meets their needs and is socially acceptable.

A *habit* is a way of structuring the performance of tasks, activities and occupations (Creek 2010). Habits enable efficient function because they are practised sequences of action that do not require conscious attention, such as changing gears when driving a car. When most of the actions involved in driving are habitual, the driver's mind is free to concentrate on the route, on safety or on other matters.

The terms *habit* and *routine* are sometimes used synonymously by occupational therapists but it is useful to think of them as two distinct concepts. A *routine* is an established and predictable way of doing something, for example following the same route to work every day, even when there are alternatives. Some routines are repeated until they become habitual and so do not require conscious thought. Habits and routines create stability and security for both individuals and communities.

Independence, Interdependence and Autonomy. Independence has sometimes been described as the goal of occupational therapy interventions but, in recent years, the concept of interdependence has been gaining ground. Baum and Christiansen (1997) pointed out that no person who lives in a community is truly independent because we all collaborate and cooperate with each other. They suggested that:

> *The concept of interdependence is embodied within the idea of occupational therapy as a helping profession. That is, by working with our clients and their families, we can achieve goals that we could not achieve working independently.*
>
> ***(p. 35).***

The occupational therapist may work towards increasing independence or interdependence – the goal will be determined by what the person wishes. When a person is not able to make decisions, it may be because their autonomy is compromised. The ability to make and enact choices rests on three types of autonomy (Gillon 1985/1986):

- **Autonomy of thought**: being able to think for oneself, to have preferences and to make decisions
- **Autonomy of will**: having the freedom to decide to do things on the basis of one's deliberations
- **Autonomy of action**: the capacity to act on the basis of reasoning.

It is possible to make autonomous decisions without compromising healthy interdependence. For example, an individual with severe physical disabilities may take the decision to be dependent on others for their self-care so that they can put their time and energy into pursuing an interesting career.

Another term that is used when referring to people's ability to make their own decisions is *mental capacity*. This is a legal term that denotes competence. Competence is a 'skilled and adequately successful completion of a piece of performance, task or activity' or being adequately qualified to perform a task (Hagedorn 2000, p. 308).

The 2005 Mental Capacity Act makes provision for people who are identified as lacking the capacity to make their own decisions in the areas of finance, social care, medical treatment, research and so on. Each decision is treated separately, so that someone can be deemed to have mental capacity in some areas of life but not in others.

Environment. Occupational performance always takes place within environments, contexts and settings that influence why and how the person performs. Occupational therapists sometimes use these three terms interchangeably but we can think more clearly, and communicate more precisely about the influences on performance, if we understand their subtle differences in meaning.

Environment is a broad concept that includes physical, social, cultural, temporal, economic and political influences. Environment influences occupational performance by making demands on the individual or group: these demands shape when and how people perform while performance, in turn, shapes the environment. For example, a person with a large garden has to make decisions about how to care for it, including the layout, what to plant and what standard they want to achieve. The garden demands some type and level of action, however minimal, and that action changes the garden. Hagedorn (2000) described three levels of environment, recognizing *familiar, possible* and *inaccessible* elements.

The *context* for action refers to the relationships between environment, personal factors and events. For example, the way a person cares for their garden is influenced not only by where they live, and the appearance of other neighbouring gardens, but also by their own tastes and skills, the amount of money they can afford to spend, any help available and many other contextual factors. An event, such as a violent storm, will also influence what they do in the garden.

The reason why context influences performance is that it shapes the meaning of a task, activity or occupation for the individual or community. The meaning of an action changes depending on the context; for example, preparing the garden for an open garden day, in which people raise money for charity by allowing the public into their gardens, has a different meaning from organizing the garden as a setting for children's games and sports.

The *setting* for action is the immediate environment in which the person or group is performing, such as the treatment setting, work setting or community setting. The setting influences how a task, activity or occupation is performed; for example, a person cooking a meal in the setting of their own kitchen is likely to perform differently from when they cook with an occupational therapy group in the hospital setting.

Role and Participation. Three concepts associated with the social context in which a person performs are *task*, *participation* and *role*, as defined in Box 3-1. It should be noted that occupational therapists use the word *task* with two distinct meanings. A task can be a step taken in the performance of an activity, as described in the earlier section on occupation and activity. It can also be a piece of work that the individual is expected to do; for example an occupational therapy tutor might set a group of students the task of critically appraising a research paper.

Participation is defined in the ICF as 'involvement in a life situation' (WHO 2001, p. 10). The ENOTHE terminology group added two elements to this definition: activity and social context (ENOTHE 2006). For occupational therapists, the key features of participation are that it involves action by the individual and that it always has a social context, even when the person is acting alone. Voting in a local election is an example of participation: it requires the person to take action, either by sending a postal vote or going to the polling station. Whether postal or personal, casting a vote is a solitary activity but it takes place in a social context and has a social impact.

The process of creating opportunities 'to participate in life's tasks and occupations irrespective of physical or mental impairment or environmental challenges' has been called *enablement* (Christiansen and Townsend 2004, p. 276) and is a key part of the occupational therapist's role.

Roles are allocated by society and adopted by the individual, so that a role is both a social position and a set of tasks performed by the individual. Each person will interpret a role in a unique way. For example, the role of mother carries expectations about the care and nurturing of children. Women in the UK normally play a major part in bringing up their own children because that is the expectation in Western society. However, different women interpret the role in different ways, perhaps delegating some aspects to a relative or a paid childminder. If society feels that a woman is not fulfilling her role adequately, then it may be taken away from her and her children given into the care of others. Or a woman may choose not to accept the role of mother and may give her children into some form of care.

An occupation and a social role may share the same name, although a role is more likely to be described by a noun and an occupation by a verb. For example, *mother* is a role, while *mothering* is an occupation. The concept of occupation is mainly concerned with the actions that a person takes to achieve their purposes, while the concept of role is mainly concerned with social expectations and the mechanisms by which society shapes the actions of individuals.

Social role is linked to social status, which refers to the position of the individual within the social structure. The status we achieve through our major social roles influences both the way that other people in our social group treat us and our expectations of how we will be treated. For example, if we have a high social status, we are more likely to expect to be treated with respect and consideration.

Roles carry both rights within society and obligations to that society. For example, a university student has the obligation to attend a certain number of teaching sessions, behave in an acceptable way during those sessions, make an effort to learn the topics presented and complete a prescribed number of assignments within a given timescale. In return, the student is provided with money, a valued position in society and the possibility of paid employment at the end of the programme of study.

Motivation, Volition and Engagement. Person-centred practice requires a person's active involvement in the process of therapy, and three terms are used to refer to this involvement: motivation, volition and engagement.

Motivation is the energy source for action, the 'drive that directs a person's actions towards meeting needs' (ENOTHE 2006). The term is sometimes used synonymously with volition and there are similarities in meaning between the two words.

However, the concepts can be differentiated by thinking of motivation as the drive to act and *volition* as an ability to make choices about action. Exercising volition becomes easier with practice so it can also be thought of as a skill.

Engagement in activity suggests attention and commitment to what is being done, not simply being present in body. When someone is engaged in an activity, their attention is focused on a goal and/or on the experience, not on the skills and effort required. They are absorbed in the activity and pay minimal attention to extraneous thoughts and feelings or to their physical state (Creek 2007). Engagement is not an absolute condition; rather, there are degrees of engagement. Occupational therapists sometimes use the word *flow* to refer to total absorption in an activity, when performance becomes unconscious and spontaneous (McNulty 2009).

Emerging Concepts

As occupational therapy theory develops, new concepts are identified and new terms coined to refer to them. Many of these terms are prefixed with the word *occupational*, such as occupational justice (Townsend and Wilcock 2004), occupational balance (Wilcock 2006) and occupational alienation (Wilcock 1998b). This usage highlights the centrality of occupation in all aspects of human life.

People have an occupational nature. This means that we seek to be occupied and that occupation fulfils many functions for us as individuals, including promoting survival and health. However, occupation also has a social dimension. Societies determine how occupations should be performed, which occupations are socially useful or acceptable and what occupations are available to particular groups of people.

Ideally, a wide range of occupations would be available to each person throughout the lifespan, so that an individual occupational profile can be developed through the choices made. However, individual and social factors sometimes combine to block access to an adequate number of occupations, so that the person may experience occupational imbalance, occupational deprivation or occupational alienation (Wilcock 1998b). These concepts draw attention to inequalities between those people who have access to a satisfying, personally enriching range of occupations and those who do not.

Occupational Balance. Each person engages in many occupations in the course of their life. These fit together in what has been called 'the framework of a life' (Bateson 1997, p. 7). Self-care, play and work exist in a balance that is not static but changes at different stages of the life course. People are not pre-programmed to follow a daily routine of activities; they continually make choices about what to do with their time and how to structure their daily routines.

Occupational therapists understand *occupational balance* as 'managing [occupation] in a way that is personally fulfilling … and meets role demands (Reed and Sanderson 1999, p. 99). The balance of occupations in a person's life is determined by personal interests and abilities, social expectations, age, environment and personal circumstances. For example, a professional woman with no children may find that she enjoys a variety of social and sporting activities that keep her fit, relieve the stress of working and enable her to meet people. On the other hand, a single mother with four children and a low-paid job may not have the resources of time, energy or money to engage in a range of leisure activities.

A healthy balance includes a variety of physical, mental and social activities, so that the individual is able to develop and exercise their capacities in all these areas. The balance may also be 'between chosen and obligatory occupations; between strenuous and restful occupations; or between doing and being' (Wilcock 2006, p. 343). Each person seeks a balance that is comfortable for them and that promotes health and well-being. For occupational therapists, the balanced use of time in daily living activities both influences health and is an indicator of health (Creek 2003).

Occupational balance may be disrupted if a person focuses too much time and energy on one occupational area to the detriment of others, or if they do not have access to enough occupations, so that there are empty times in the day when there is nothing worthwhile to do. The inability to manage occupations in

a way that is personally fulfilling and meets role demands is called *occupational imbalance* and can lead to health and quality of life being compromised (Reed and Sanderson 1999; Christiansen and Townsend 2004). One cause of occupational imbalance is occupational deprivation.

Occupational Deprivation. *Occupational deprivation* is 'a state of prolonged preclusion from engagement in occupations of necessity or meaning due to factors outside the control of an individual, such as through geographic isolation, incarceration or disability' (Christiansen and Townsend 2004, p. 278).

Wilcock (2006, p. 164) identified some of the social factors that can lead to people being deprived of access to a broad range of occupations, including 'technology, the division of labor, lack of employment opportunities, poverty or affluence, cultural values, local regulations, and limitations imposed by social services and education systems, as well as the social consequences of illness and disability'. A recent example of this is the reduction in numbers of public sector jobs in the UK, leading to a massive loss of paid employment in some areas. Compulsory detention in hospital under the Mental Health Act can also lead to occupational deprivation when there is little or no access to activity on the wards.

Whiteford (2004) suggested that when occupational deprivation is a temporary phenomenon, such as during a period of mourning, and when it is due to personal factors, such as a broken leg, it should be called disruption rather than deprivation. *Occupational disruption* is 'a transient or temporary condition of being restricted from participation in necessary or meaningful occupations, such as that caused by illness, temporary relocation, or temporary unemployment' (Christiansen and Townsend 2004, p. 278).

Occupational Alienation. Some occupations are experienced as spiritually and mentally enriching, in addition to having more practical functions. These occupations provide opportunities for choice and individual expression, and often have an element of creativity. Other occupations may be experienced as confining, regimented and lacking in meaning, leading to boredom and alienation. When people experience daily life as lacking meaning or purpose, either because they cannot find anything important to do or because they have to spend all their time and energy on tasks that they do not value, the outcome is occupational alienation (Townsend and Wilcock 2004).

Occupational alienation refers to 'a sense that one's occupations are meaningless and unfulfilling, typically associated with feelings of powerlessness to alter the situation' (Hagedorn 2001, p. 166). Having to spend a lot of time performing occupations that do not enhance, or that diminish, a person's sense of self can damage personal identity (Townsend and Wilcock 2004).

Occupational Justice. In its most general meaning, justice is 'each getting what he or she is due' (Audi 1999, p. 456). However, several aspects of justice can be differentiated, including:

- **formal justice**: the maintenance of legal, social or moral principles by the exercise of authority or power (*Shorter Oxford English Dictionary* 2002)
- **retributive justice**: when and why punishment is justified
- **substantive justice**: the rights that people can legitimately claim in relation to each other or what they can demand of their government
- **distributive justice**: the fairness of the distribution of resources (Audi 1999).

The term *occupational justice* mainly refers to substantive and distributive justice because it is based on the belief that people have rights in relation to occupation and that it is unfair to block access to occupation for particular groups of people. The rights underpinning the concept of occupational justice can be summarized as (Townsend and Wilcock 2004):

- The right to experience occupation as meaningful and enriching
- The right to participate in occupations for health and social inclusion
- The right to exert autonomy through choice of occupations
- The right to benefit from diverse participation in occupations.

Occupational injustice is a social condition that offers unequal access to occupation for different groups in society. Occupational injustice creates societies in which some people have too much to do, while

others do not have enough to occupy them (Townsend and Wilcock 2004), often in the area of work, where some sectors of the population are overemployed while other sectors are either underemployed or unemployed. Both over- and under-occupation are examples of occupational imbalance.

The concept of occupational injustice draws attention to the many ways in which participation in occupations can be 'barred, confined, restricted, segregated, prohibited, undeveloped, disrupted, alienated, marginalized, exploited, excluded or otherwise restricted' (Townsend and Wilcock 2004, p. 77).

The related concept of *occupational apartheid* refers to the 'more or less chronic established environmental (systemic) conditions that deny marginalized people rightful access to participation in occupations that they value as meaningful and useful to them' (Kronenberg and Pollard 2005, p. 65). This state results from 'political constraints which may extend to encompass all aspects of daily living and human occupation through legal, economic, social, and religious restrictions, and can be found as a consequence of chronic poverty and inequality' (Kronenberg and Pollard 2005, p. 66).

Occupational Science

Although occupational therapy was founded on a set of beliefs about the occupational nature of people, it is only relatively recently that the profession has begun to formulate its own theories about occupation. Occupational science is the academic discipline that studies people as occupational beings (Yerxa 2000). It brings together knowledge from different fields with the intention of providing a knowledge base in occupation for the practice of occupational therapy.

Occupational science was established in the last decade of the 20th century to promote the study of occupation, develop theories to explain why people choose certain activities over others and explore the complexity of factors that influence why, where and how people decide to live their lives in relation to work, rest and play (Clark et al. 1991). Elizabeth Yerxa, the founder of the first doctoral programme in occupational science at the University of Southern California, claimed that occupational science would 'address some of the major dilemmas of occupational therapy practice' (Yerxa 1993, p. 3).

In a relatively short time, occupational science has contributed to the knowledge base of occupational therapy at all levels, from elucidating key concepts, such as occupational alienation (Townsend and Wilcock 2004), through building theories to explain why people choose particular occupations, such as theories of meaning (Primeau 1996), to developing appropriate research methodologies (Carlson and Clark 1991) and carrying out research into the effects of occupation on health (Iwarsson et al. 1997).

The next section discusses some of the ways in which occupational therapy theory is organized for use in practice.

THEORY INTO PRACTICE

Occupational therapists use theories from a variety of disciplines as well as their own theories of occupation. The breadth of this theoretical base and the complexity of some of the theories used could seem overwhelming. However, not all occupational therapists need to know all the theories that make up the total body of knowledge of the profession. Different theories are used depending on the area of work, the kind of problems encountered most often by the therapist and their own knowledge, skills and preferences.

In this section, we look first at the vocabulary used when talking about theories for practice: frame of reference, approach, model and paradigm. We then look at how the different concepts relate to each other in a theoretical framework.

Terms Used When Talking About Theory

Theory acts as a guide to practice by offering explanations of what the therapist observes and making it possible to predict the outcomes of interventions. In order to use theory to support clinical and professional reasoning, the therapist has to select appropriate theories and organize them into useful frameworks. Theories that work well together and can be applied within a particular field of practice are organized as frames of reference that, in turn, are translated into practice through various approaches and models.

A *frame of reference* is an individual's 'personal notion of reality, their cultural, social, and psychological biases, their values and beliefs, and how these factors influence the practice of occupational

therapy' (Krefting 1985, p. 175). So, in its widest sense, a frame of reference is the way a person sees the world. Creek (2003, p. 53) offered a narrower definition for occupational therapists: 'a collection of ideas or theories that provide a coherent conceptual foundation for practice'. Bruce and Borg (1993) wrote that a frame of reference refers to the principles behind practice with different issues. Examples from occupational therapy include the psychodynamic, human developmental and occupational performance frames of reference.

An *approach* is 'the methods by which theories are put into practice and treatment is administered' (Creek 2003), for example, the rehabilitation approach. The terms *frame of reference* and *approach* are sometimes used synonymously.

Within occupational therapy, there are many frames of reference and approaches, some of which are appropriate to more than one field and some of which are used for very specific purposes. The choice of a frame of reference or approach is influenced by the presenting problems of the individual, the ethos of the unit where the intervention takes place and the knowledge of the therapist (Hurff 1985).

Frames of reference and approaches describe the principles of practice, enabling therapists to be consistent in their way of working. Models for practice give more guidance to the inexperienced therapist as they suggest a more structured procedure and tools for intervention.

A *model* is 'a simplified representation of the structure and content of a phenomenon or system that describes or explains certain data or relationships and integrates elements of theory and practice' (Creek 2003, p. 55). A *model for practice* acts as a guide for the practitioner, providing 'an explanation of clinical phenomena and [suggesting] the type of intervention the therapist should make' (Feaver and Creek 1993, p. 59). During the 1980s and 1990s, a large body of literature was developed on models for practice in occupational therapy.

The therapist's methods of intervention, that is, the tools and processes of therapy, are determined by the frame of reference, approach or model being used. For example, projective techniques are tools used for assessment and treatment within a psychodynamic frame of reference.

Another term sometimes heard in connection with the knowledge base of occupational therapy is *paradigm*, which is used to refer to the particular way in which a profession perceives itself, its relationship to other professions, and its association with the society to which it is responsible. Creek and Feaver (1993) suggested that a paradigm is 'the profession's world view that encompasses philosophies, theories, frames of reference and models for practice'.

Organizing Framework for Occupational Therapy Theory

The profession of occupational therapy began to develop its own theory base during the second half of the twentieth century. The building blocks of theory are concepts, which give us an understanding of a situation through how they relate to each other. For example, when we use a hierarchical system of classification to describe the relationships between occupations, activities and tasks, we understand that occupations are made up of activities, which are made up of tasks, which are made up of actions (Polatajko et al. 2004). Most of the occupational therapy models developed during the past 50 years employed a hierarchical system, called general systems theory, for classifying the relationships between core concepts.

Over the last 20 years, there has been an emerging recognition that organic systems are complex and cannot be fully described and understood through hierarchical systems of classification. One of the key features of a complex system is that the interactions between its components change how the system works. This means that the relationships and interactions between components in the system are more important than their properties. Think about the multidisciplinary healthcare team. Each member of the team is a skilled specialist but the effectiveness of interventions comes from the way that team members work together, not from the skills of individual staff. My role as an occupational therapist changes depending on the skills of other members of the team and on how we negotiate and share out tasks among us.

Complexity is manifested at the level of the system but it results from interactions between adjacent components of the system (Cilliers 1998). Complexity cannot emerge in a system if the interactions between components are preset or prescribed from outside: it occurs because interactions within the system change as

circumstances and needs change. In other words, complex systems are adaptive. This feature allows complex systems to learn from experience and to develop new ways of working in response to external demands.

Occupational therapists in Europe have developed a theory of occupational performance that uses complexity theory to explain the relationships between key concepts: the European conceptual framework for occupational therapy (Creek 2010).

The European Conceptual Framework for Occupational Therapy

The purpose of the framework is to help the occupational therapist to understand occupation and performance from the service user's perspective. A *conceptual framework* is a structure made up of concepts displayed together in a way that shows how they relate to each other and that supports thinking. The European conceptual framework for occupational therapy consists of 25 terms representing 27 concepts (*task* and *function* each have two definitions). These terms refer to aspects of occupation, such as *engagement* and *routine* (Fig. 3-1).

The terms in the framework are organized into eight clusters, each of which relates to a particular aspect of action. All the terms within a cluster share some of their meanings; for example, *setting*, *environment* and *context* are all terms that refer to aspects of the physical, social and temporal place for action.

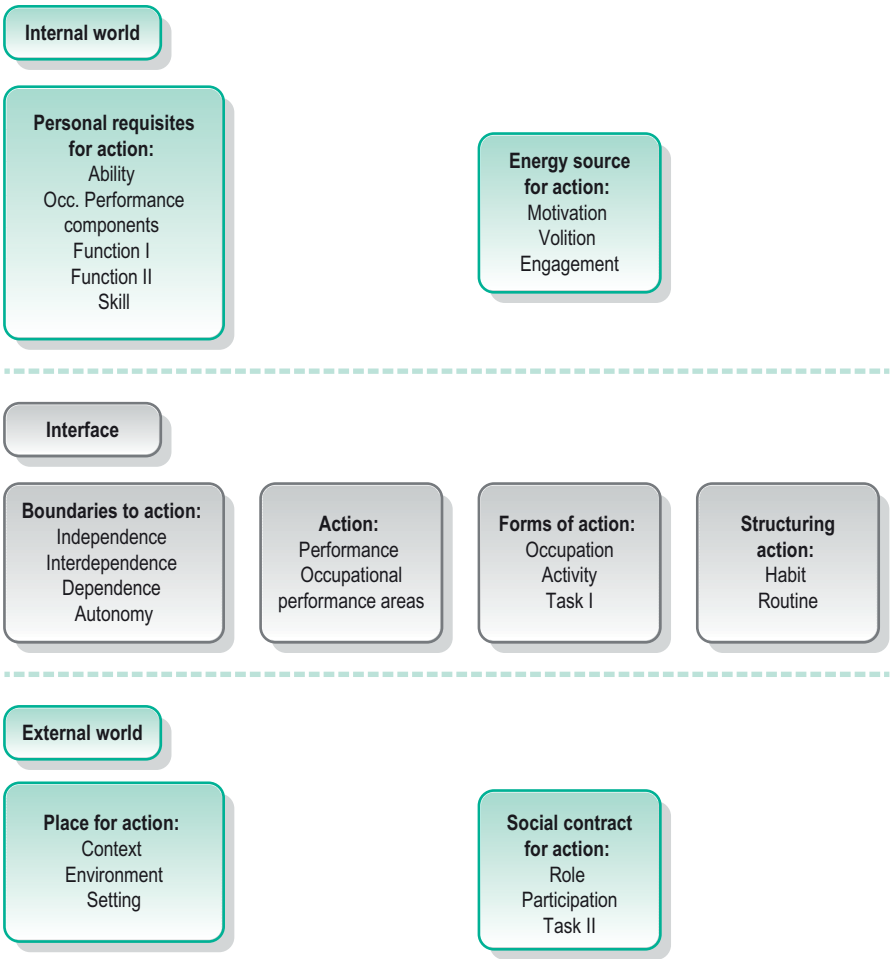

FIGURE 3-1 ■ European conceptual framework for occupational therapy. *Reprinted from Creek J (2010) The core concepts of occupational therapy: a dynamic framework for practice. Reproduced by permission of Jessica Kingsley Publishers.*

The clusters are grouped into three categories: the internal world of the performer; the external world of the performer; and the interface between the internal and external worlds.

- The **internal world** of the performer consists of two clusters: the *energy source for action*, which is the individual's emotional energy, and the *personal requisites for action*, which are the personal factors necessary for performance
- The **interface between the internal and external worlds** consists of four clusters: the *action* cluster, which is action by the individual; *forms of action*, which is how the performer perceives the action; *structuring action*, which is the ways that actions are organized, and *boundaries to action*, which are the individual factors that set limits to action
- The **external world** of the performer consists of two clusters: the *place for action*, which is the place where a task, activity or occupation is performed, and the *social contract for action*, which includes social supports and constraints on performance.

The internal and external worlds of the performer influence what a person does and shape how they perform. We can say that interaction between the internal and external worlds leads to action by the individual.

For the purposes of print, the European conceptual framework for occupational therapy is presented as a static diagram. However, relationships between terms in the framework are not fixed but change depending on the context in which the framework is being used. For example, I worked for 10 years as a freelance occupational therapist. The decisions I made about what jobs to take were strongly influenced by factors such as my role as a single parent and the context of being self-employed, so there were strong relationships between my volition and a range of contextual and social influences in my external world. Since retirement, my decisions about whether to work and what jobs to take are more strongly influenced by such factors as whether I have the up-to-date skills for the job and the extent to which my interest is stimulated: my volition is most strongly linked with other aspects of my internal world.

For more information about how to use the conceptual framework, the reader is recommended to look at the ENOTHE (2006) website or one of the books written by members of the terminology working group (e.g. Creek 2010).

SUMMARY AND CONCLUSION

This chapter presented the knowledge base of occupational therapy, including the philosophical assumptions and beliefs held by occupational therapists and the theories that support practice. Emphasis was placed on occupational therapy as a two-body practice that is concerned both with disorders of the body and with the experience of the person. The nature of theory was explored and the content of the occupational therapy theory base outlined. The chapter finished with a description of key occupational therapy theories and how they are organized.

The next chapter looks in more detail at how philosophy and theory are used to inform practice.

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SERVICE USER COMMENTARY

These theories are fundamental, yet how easy it is to leave them as theories, never to see how they could radically change a life. Seemingly basic ideas such as 'meaning to life' or 'choice' have been so powerful in my life, changing me from hopelessly institutionalized into functioning in society.

No matter what, I need to be able to choose. I have been fortunate enough to be listened to, to be encouraged empathetically towards goals which seemed impossible. However, I have also unfortunately overheard false ideas, such as 'Psychiatric patients are not like you and me, they don't get bored'. I may have been so depressed that I couldn't face the idea of putting on my own socks, but aimlessness has always been my biggest enemy. I have spent years hospitalized, detained under the Mental Health Act, where each day is full of nothing except thoughts of doom. Endless hours, crawling minutes, and timeless, landmarkless weeks that sucked away any hope that may have come my way. Hospital may have physically protected me from myself, but increased my misery, decreased my will to live, and took away my last self-respect or purpose. I had a slight increase in safety, yet a massive decrease in overall health. Heavily medicated, almost comatose, I was, by the medical model, almost cured due to a lack of mental health symptoms. However I couldn't use the toilet, read or hardly speak. I've been fortunate to choose, that I'd rather face more symptoms and live, than ever face that state again. Some people are not given that choice.

Once in the system, once I'd spent years in institutions, it's easy to give up on me as 'not wanting to leave'. The longer I spent in hospital, the further I felt from the 'normal' world, from 'having a life', the more impossible it seemed that I'd ever get there. It was safer not to want it, than to desire something I'm never going to get. I needed hope, meaning for today, a goal for next week, focusing on what I could do, not the overwhelming mountain of what I couldn't do.

How do you put a life together? It's easy to say 'pull yourself together' and harder to face the challenge with me: 'Which area is the most important to you, what are the problems, the goals?'. Life is what everyone manages every day, yet knowing where to start is almost impossible.

Slowly, my set routine began to have my passions in it. I began to enjoy life, to have a reason to get out of bed each day. I found people in the same situation, mutual support, I tried new things, made mistakes, had set-backs. Embraced my dreams, of a career, of flat-sharing, of a relationship. I've been told I want too much, that I should just accept my situation; that I'm not normal. The problem is that I can't, because I am normal. I won't achieve all my dreams; I will experience loss, just like everyone else. My reasons for struggling may be different, but fundamentally I am still human.

Philippa Lalor

Section 2 THE OCCUPATIONAL THERAPY PROCESS

4 APPROACHES TO PRACTICE

JENNIFER CREEK

CHAPTER CONTENTS

INTRODUCTION

Chapter 3 delineated the knowledge base of occupational therapy, including philosophical beliefs and theories, and introduced the structures that are used to organize that knowledge for practical application: frames of reference, approaches and models for practice. This chapter looks in more detail at how the occupational therapy knowledge base informs and supports practice. The chapter is in three parts. The first part outlines the content of occupational therapy practice,

including the goals of intervention, people who might benefit from occupational therapy, legitimate tools for practice, the skills of the occupational therapist and the art of occupational therapy. The second part describes the process by which occupational therapy is delivered. There are a number of stages in this process but it should not be seen as finite or linear: occupational therapy is individualized, iterative and complex. The third part gives examples of occupational therapy frames of reference used in the field of mental health: the psychodynamic, human developmental and occupational performance frames of reference.

CONTENT OF PRACTICE

Practice can be described as the actions taken by the therapist to serve the needs of the people they work with (Agyris and Schon 1974). A definition of the structure and scope of occupational therapy practice should derive from the philosophical and theoretical base of the profession, not from the constraints and demands of the service setting, although the way an intervention is carried out will be influenced by such external factors. Only if practice is based on a coherent philosophical and theoretical framework can the therapist make skilled predictions about the outcomes of intervention.

We will look at the content of practice under five headings:

- Goals and outcomes
- Populations served
- Legitimate tools
- Core skills
- Professional artistry.

Goals and Outcomes

The word *outcome* refers to two different things: the changes that are expected to occur as a result of intervention, the intended outcomes, and the results of intervention, the actual outcomes. *Goals* are specific and positive results to be attained by an individual from planned therapeutic interventions. *Process goals* are the conditions to be achieved during an intervention, such as an individual arriving on time for their sessions. *Outcome goals* are statements of measurable changes that the intervention is designed to bring about.

Desired outcomes are discussed with those involved before beginning the intervention, often following a baseline assessment to determine the current level of performance and set goals. After an agreed period of intervention, the assessment is repeated. By comparing the assessment results before and after intervention it is possible to see what changes have taken place, that is, to measure the outcomes of intervention. (See Ch. 5 for a detailed discussion of assessment and outcome measurement.) The focus of the intervention is usually agreed jointly, to produce a set of individualized outcome goals. If the overall goal of intervention is likely to take some time to achieve, it can be broken down into a sequence of short-term goals that represent steps to be taken towards reaching the long-term goal. For example, an individual's long-term goal may be to find full-time, paid employment. If the person has not worked for a long time, a short-term goal on the way to achieving this might be to establish a regular pattern of sleeping at night and waking at the same time every morning.

Populations Served

The occupational therapy premise, that people influence their health by what they do, can be applied to a wide range of problems once the appropriate specialist knowledge and skills to support it have been acquired. Anyone who has problems of doing, whatever the person's age, gender or diagnosis, could potentially work with an occupational therapist. In practice, occupational therapists work in two main settings: statutory services and the social field.

Statutory Services

The occupational therapist traditionally worked with people in a medical setting, which predetermined, to some extent, the range of problems seen, the degree of dysfunction people were experiencing and the amount of time the therapist could spend on intervention. As the profession continued to expand into new areas, people have also been encountered in other settings, such as social services departments, educational settings, health centres, community centres, day hospitals, day centres, prisons, the workplace and people's own homes. Occupational therapists increasingly work across service boundaries, in partnership with other agencies and other professionals, to provide integrated services (College of Occupational Therapists 2006).

Referrals often come from a doctor or other professional who makes the initial decision about who would benefit from occupational therapy. The occupational therapist accepts referrals on the basis of information gained from the referral and an initial assessment with the person referred. In some settings, such as continuing care units, occupational therapists select people to work with from the unit's population. In the multidisciplinary team, the decision about which professional should work with a particular individual is usually made by all the team members. An increasing number of people are referring themselves for occupational therapy, in part due to an increase in private practice.

The Social Field

In recent years, occupational therapists have extended their practice into a range of new areas outside mainstream health and social services. A Brazilian occupational therapist, Sandra Galheigo (2005, p. 87), called this 'the social field' because occupational therapy, with its humanistic principles and practices, has a significant contribution to make to social affairs.

The movement towards a more socially embedded way of working has been supported by two parallel developments: increased awareness of the contribution that occupational therapy can make to addressing occupational needs not met by hospital-based models of healthcare, and theoretical developments within the profession (Lorenzo 2004; Watson 2004; Galheigo 2005; Wilcock 2006; Crouch 2010; see also Chs 12, 13 and 29).

Galheigo (2005) highlighted the need for an occupational therapy vocabulary 'to refer to those in need … excluded, marginalized, vulnerable survivors, deviant, under apartheid, disadvantaged, disaffiliated' (p. 87) that would leave no room for misinterpretations of 'the phenomenon of inequality' (p. 88). As described in the last chapter, occupational therapists are developing a new vocabulary, using such terms as *occupational imbalance*, *occupational deprivation* (Wilcock 2006) and *occupational injustice* (Townsend and Wilcock 2004), to describe their professional purpose and goals in terms of occupational needs. This enables them to identify the occupational needs of people who do not necessarily have a medical diagnosis, including those living in chronic poverty, refugees, homeless people or those displaced by natural disasters. Occupational therapists working in these areas take a public health, health promotion and/or community development role, focusing on communities and populations rather than individuals or small groups.

The social field of occupational therapy is discussed further in Ch. 29.

Legitimate Tools

The occupational therapist may use a variety of techniques and media during an intervention. Mosey (1986) described the permissible means of carrying out occupational therapy as the profession's legitimate tools. These tools are: the self, activities and the environment.

Therapeutic Use of Self

The relationship between the therapist and the client is an important part of the therapeutic process, from first meeting a person who has been newly referred, through coping together with the successes and setbacks of the intervention process, to ending the relationship on a positive note.

Ideally, the therapeutic relationship is a partnership or collaboration between therapist and the client, in which the goals and methods of intervention are negotiated throughout the process. If an individual is unable to take a full part in negotiating the process, because of illness or disability, the therapist has a responsibility to facilitate their involvement as far as possible and to protect their interests to the best of the occupational therapist's ability (see also Ch. 22).

Mosey (1986) identified 11 elements that contribute to the therapist's ability to relate effectively to the people they work with:

- a perception of individuality – recognition of each person as a unique whole
- respect for the dignity and rights of each individual
- empathy – ability to enter into the experience of another person without losing objectivity
- compassion or sympathy – willingness to engage with another person's suffering
- humility – recognition of the limits of one's own knowledge and skill
- unconditional positive regard – concern for the individual without moral judgements on their thoughts and actions

- honesty – telling the truth to the people they work with; this is an aspect of being respectful
- a relaxed manner
- flexibility – ability to modify own actions to meet the demands of a situation
- self-awareness – ability to reflect on one's own reactions to the world and on the effect one is having on the world in any given situation
- humour – a lightness of approach which, used appropriately, can facilitate the therapeutic process.

Peloquin (1998) described the occupational therapist *being with* an individual by *doing with* them, and identified empathy as the most important element of the therapeutic relationship. Empathy involves the therapist turning to an individual in a genuine attempt to make a positive relationship, recognizing both what they have in common and what is unique about the person, entering into their experience, connecting with their feelings and being able to recover from that connection so that the therapist is not damaged by the therapeutic encounter.

The therapist uses interpersonal skills to deal with a whole range of needs, such as engaging the initial interest of someone with a volitional disorder, supporting a bereaved person through the grieving process, helping someone to express difficult feelings appropriately, valuing a person with chronic low self-esteem and helping carers to work out how best to balance their own needs with their caring role. These interpersonal skills can be the most valuable resource in an intervention.

Activities as Therapy

Activities are the means by which each person interacts with the world and the main therapeutic tools used by occupational therapists to bring about changes in an individual's function and performance. Activity is a flexible and adaptable intervention that can be used with all people in many different contexts to achieve diverse outcomes. The use of activity as a therapeutic tool requires that the therapist has a range of skills for manipulating activity, including analysis, synthesis, adaptation, grading and sequencing.

Activity analysis is the process of 'breaking up an activity into the components that influence how it is chosen, organized and carried out in interaction with the environment' (ENOTHE 2006). Activity analysis enables the therapist to evaluate the therapeutic potential of activities and select or design the most appropriate ones for each situation. For example, activity analysis of football reveals that it is socially valued by many young people, so that they are keen to play, and that it makes variable physical and social demands on the players, depending on the position they play. Analysis also shows that five-a-side football uses a smaller pitch and makes less physical demands on the players, making it a more suitable activity for people who are not fully fit.

The therapist selects activities that have the greatest potential to meet the person's needs, develop their skills and engage their interest. Alternatively, activity components may be combined into new activities (*activity synthesis*) that will better achieve these goals. For example, a craft activity could be done in a group so that interpersonal demands are added to the other skills required for the performance of the activity.

Activity adaptation means adjusting or modifying the activity to suit the individual's needs, skills, values and interests. For example, a traditional craft such as macramé could be done with modern materials to produce a modern piece of jewellery that an individual finds attractive.

Activity grading means adapting an activity so that it becomes progressively more demanding as a person's skills improve, or less demanding if their function deteriorates. For example, walking can be done for longer or over more difficult terrain to increase stamina.

Activity sequencing means 'finding or designing a sequence of different but related activities that will incrementally increase the demands made on the individual as her/his performance improves or decrease them as her/his performance deteriorates. It is used as an adjunct or alternative to activity grading' (Creek 2003, p. 38).

These techniques are described more fully in Ch. 6.

Environment

People function within human and non-human environments that influence both what they do and how they do it, by providing supports and barriers to occupational performance. For example, living in a town centre provides easy access to shops and other

community facilities (support) but means that a person has to travel a long way to their allotment, located on the edge of town (barrier).

A person's activities are shaped by environmental factors and those activities also change the environment. For example, washing the floor changes the physical environment and visiting a friend changes the human environment. A third aspect that may be changed by activity is the person performing it, who develops skills and abilities as they adapt their performance to suit the environment.

A person's environment consists of two main elements (Hagedorn 1995):

- Content – the physical and human elements in the environment
- Demands – the effect the environment has on behaviour.

For the occupational therapist, a third element is the potential for adaptation of the content and demands of the environment. The goal of intervention may be to enable adaptation to the environment, to adapt the environment to suit the person's needs and abilities, or to organize a move to a different environment.

When planning and implementing an intervention with an individual, the therapist considers many aspects of the environment: home; working environment; local area and resources; wider living environment, such as the town or geographical location; transport infrastructure; and potential new environments, such as a care home.

The therapeutic encounter always takes place within an environment that can be adapted or manipulated to change its demands and achieve the desired outcomes, whether it is a specialized intervention setting or the home or workplace.

Core Skills

Occupational therapists are characteristically flexible, innovative and responsive to the people with whom they are working and the context within which intervention is taking place. In order to achieve this flexibility, the occupational therapist requires a wide range of skills. Some skills are common to all therapists, whatever field they are working in, for example analysing and adapting activities. Other skills are developed for a specific field of practice. An example of a specific skill is integrated memory training, which is not requisite for every area of mental health practice (see Ch. 19 which is about older people and refers to memory clinics).

Skills that are required by all occupational therapists are called core skills. The College of Occupational Therapists in the UK defined *core skills* as 'the expert knowledge and abilities that are shared by all occupational therapists, irrespective of their field or level of practice' (College of Occupational Therapists 2009, p. 4). These core skills were identified as:

- **Collaboration** involves building a relationship with the client in which decisions are shared and actions negotiated. The aim of a collaborative relationship is to promote autonomy and engage the client in the therapeutic process.
- **Assessment** is a collaborative process through which the therapist and the client are able to identify and explore functional potential, limitations, needs and environmental conditions.
- **Enablement** is the process of helping clients to take more control of their lives, by identifying what is important, setting goals and working towards them.
- **Problem-solving** is a process involving a set of cognitive strategies that are used to identify occupational performance problems, resolve difficulties and decide on an appropriate course of action.
- **Using activity as a therapeutic tool** involves using activity analysis, synthesis, adaptation, grading and sequencing to transform everyday activities into interventions.
- **Group work** involves planning, organizing, leading and evaluating activity groups.
- **Environmental adaptation** involves assessing, analysing and modifying physical and social environments to increase function and social participation.

The occupational therapist's skills are made up of three elements (Creek 2007):

1. **Techniques**: such as communication, interpersonal and team-working skills, skills and techniques for assessment and therapy, time management and self-management skills. These practical skills are discussed in Chs. 4–8.

2. **Knowledge and understanding**: including concepts, theories, frames of reference, approaches and models (see Ch. 3).
3. **Thinking**: including clinical reasoning, decision-making, reflection, analysis and ethical reasoning. These skills are discussed in the next section.

Thinking Skills

Thinking means using the mind and includes such mental actions as applying rules, choosing, conceptualizing, evaluating, judging, justifying, knowing, perceiving and understanding (Creek 2007). Client-centred practice requires that the occupational therapist is able to process large amounts of information in order to select the most appropriate course of action with an individual, within a specific intervention context, to achieve the best possible outcome. Collecting information and incorporating it into the decision-making process demands a range of thinking styles that the therapist can employ for thinking about different aspects of the intervention.

Sinclair (2007) identified five distinct types of reasoning used by occupational therapists:

- **Evidence discovery** is used when the therapist and an individual are trying to frame the individual's problems and identify what they need to work on. It includes problem sensing, problem formulation and problem definition.
- **Theory application** means using both formal theory and personal theory. Task analysis and activity analysis are core skills of theory application, and are described in Ch. 6.
- **Decision-making** involves using clinical reasoning (Mattingly and Fleming 1994) to assess, plan, set priorities, predict, evaluate and determine the best approach to use in a particular context.
- **Judgement** is reflection by therapists on their practice, leading to recognition of strengths, weaknesses and biases, and of how the views of others might differ from their own. Reflection takes place both during an intervention and afterwards.
- **Ethical reasoning** is the process of thinking through ethical issues. It includes recognizing the ethical dimension of intervention, being sensitive to the differing views of others and maintaining personal integrity.

Professional Artistry

Occupational therapy has been defined as 'the art and science of directing man's participation in selected tasks to restore, reinforce and enhance performance' (AOTA 1972, p. 204). Art is 'skill as the result of knowledge and practice' or 'the application of skill according to aesthetic principles' and science is 'a particular branch of knowledge or study' (*Shorter Oxford English Dictionary* 2002). This definition identifies occupational therapy as the skilled application (art) of a particular branch of knowledge (science); therefore it is both an art and a science. The skilled application of knowledge to practice requires the occupational therapist to think about what is being done, not just follow rules, guidelines or protocols.

The science of occupational therapy includes theoretical knowledge, research evidence, proven techniques and procedures. Universal theories identify the 'general systems in which people act, general structures common to all people, and general internal systems of all people' (Hooper and Wood 2002, p. 43). They can be learned from textbooks and lectures and serve several important functions for the occupational therapist:

- They set out what constitutes a normal range and performance of occupations for a person from a particular cultural and social background at each stage of life
- They explain how a health condition can affect an individual's function and impair their ability to engage in activities and occupations
- They offer ways of understanding of how an imbalance of occupations can adversely affect the health of individuals and communities.

The art of occupational therapy consists of principles, values, contextual knowledge, thinking skills, interpersonal skills and practical skills. Contextual knowledge is not universal but is specific to particular people, at particular times, in particular settings. It includes the individual's social circumstances, educational experiences, employment, cultural background, personal beliefs and values, relationships, skills, abilities, habits, interests, needs, aspirations and social roles, and how all of these influence their occupations and activities. Contextual knowledge also includes the living environment, family, neighbourhood, workplace,

financial situation, social networks and support systems, and how these support or inhibit occupations and activities. Contextual knowledge cannot be found in books but is gained through working with people in their own life world contexts.

The occupational therapist applies formal theories, research evidence, techniques, skills and contextual knowledge when working out the best way forward for an individual at a particular time and place. The science of occupational therapy enables an occupational therapist to think about the implications of the individual's health condition, the extent to which their occupational performance meets their own and society's standards, what frame of reference or approach might be most helpful and what actions the occupational therapist could take to bring about positive change. The art of occupational therapy lies in how this understanding is translated into action.

Through experience, the therapist gains both contextual knowledge about the worlds of the people they work with and practical knowledge of how occupational therapy works. Theoretical and contextual knowledge involve *knowing that* something is so; practical knowledge means *knowing how* to do something (Dreyfus and Dreyfus 1986). *Knowing how* is part of the art of occupational therapy. Artful practitioners know how to:

- talk appropriately to colleagues and clients, put nervous people at ease and match the moods of others by adjusting their tone of voice
- engage people in activities that will help them to develop skills to support their occupational performance
- provide aids or other forms of support and adapt environments to enable occupation
- manage their time and avoid unhealthy levels of stress.

THE OCCUPATIONAL THERAPY PROCESS

Occupational therapy is a process in the sense that change takes place over time. Life itself is more usually experienced as a process rather than as a series of steps or goals to be achieved. In many cases, going through the therapeutic process can be more important than reaching the original goal of an intervention.

Occupational therapy is also a process in that the therapist's actions follow a recognisable sequence. Mosey (1986, p. 9) said that 'Principles for sequencing various aspects of practice refer to the way in which a profession goes about the process of problem identification and proceeds through to problem solution relative to assisting the client'. There is an accepted first step to occupational therapy intervention, followed by a logical second step, and so on.

There is general agreement on the steps that make up the occupational therapy process, although not all the steps are carried out in every case. For example, in some settings the occupational therapist does not go through the whole process but merely assesses an individual and passes the results to others to carry out the rest of the intervention. For the novice therapist, the occupational therapy process may appear to be linear but the experienced practitioner uses it in a flexible and iterative way to suit the individual and the context of the intervention.

The 11 steps of the occupational therapy process are shown in Figure 4-1. Two of these steps may be carried out by the therapist alone, often before meeting the person they are working with, and nine of them take place in collaboration with the individual. The occupational therapy process is outlined here but more details can be found in Chs. 5 and 6.

Referral

Occupational therapists come into contact with the people they work with through various routes. In some settings, the therapist sees only those people who are referred to the service or identifies potential people to work with during team meetings. Many therapists usually see everyone who is admitted to the service and make their own decisions about whom to work with. Some therapists work in drop-in centres or other settings where there is no formal system of referral.

Depending on the setting, the therapist may or may not receive useful information about an individual before meeting them. Whether or not there is a formal referral, the therapist will want to know certain things about an individual before making a decision about whether or not to intervene.

Information Gathering

Certain information is necessary for the therapist to determine whether the referral is appropriate or if

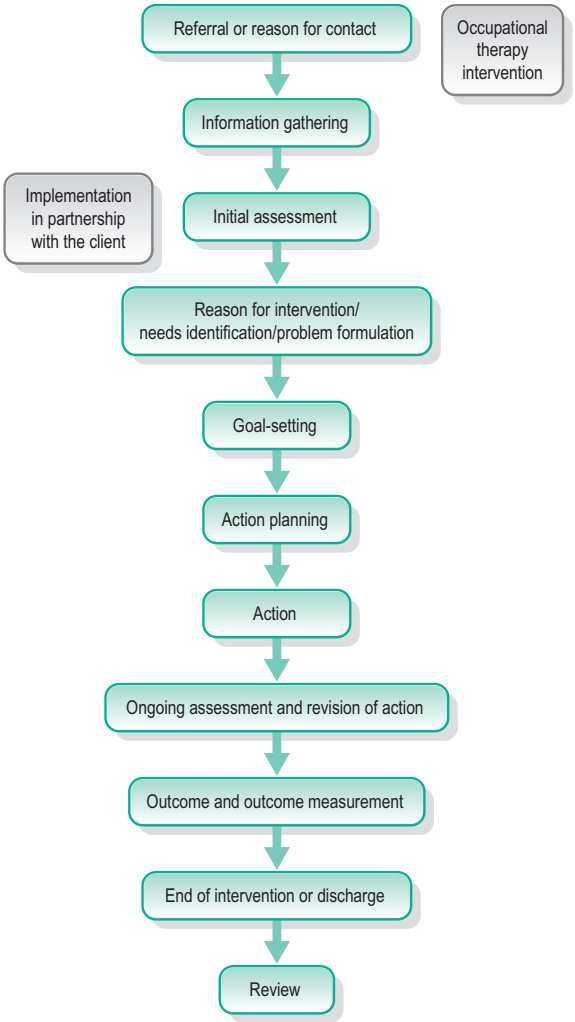

FIGURE 4-1 ■ The occupational therapy process.

someone will benefit from occupational therapy intervention. If it is decided that the referral is not appropriate, the referring agent is informed of the decision and the reasons for it.

The type of information sought includes the person's medical history and presenting problem, social history and present social situation, educational and work history, current work status, reason for referral to occupational therapy, other services involved and any risk factors. This information may be gleaned from case notes, other staff, the referring agent, family, carers and the person concerned.

If the referral seems appropriate and the therapist judges that the person or people might benefit from occupational therapy intervention, an initial assessment is carried out.

Assessment

Assessment is the basis for all intervention and must be both thorough and valid in order to ensure that intervention is appropriate. Assessment is in two stages, the initial screening assessment and more focused assessment.

Assessment begins from the moment a referral is received or the therapist starts to identify those people who could benefit from occupational therapy. The initial assessment is a screening process to determine the main areas of needs of the individual and whether or not occupational therapy can be of any value at this time. Factors influencing whether or not a referral is accepted include:

- the needs of the individual
- the individual's goals, expectations and views about occupational therapy
- the resources available, including manpower and expertise
- the individual's personal support systems and social networks
- the reason for referral
- the intervention contract.

Once a referral is accepted, a more focused assessment is carried out to determine the person's needs, strengths, interests and goals. Effective assessment leads directly to setting measurable goals or defining expected outcomes of intervention and to choice of intervention methods. It also establishes a baseline from which change can be measured.

There may be no clear division between assessment and intervention in occupational therapy, where people are often assessed through observation of their participation in activities, which also have therapeutic value. (This is explained in more detail in the Chapter 5.) However, at some stage the therapist and the person they are working with begin to formulate problems, establish goals and agree on a plan of action.

Problem Formulation

People are complex and it is usually possible to formulate their problems or needs in different ways, each of

which will indicate an alternative approach to intervention. For example, a woman with a diagnosis of severe depression may be experiencing low mood, suicidal ideation, fatigue, poor self-esteem, delusions about her body, loss of appetite, insomnia and agitation. If her problem is formulated as a biochemical imbalance, the main focus of intervention will be to remediate this with antidepressant medication. If her problem is seen as the result of faulty thinking, the object of intervention will be to provide her with cognitive strategies for managing her condition. The occupational therapist is more likely to formulate her problem in terms of activity limitation and restricted participation, so that intervention will focus on achieving a more healthy range and balance of activities.

The occupational therapist formulates the desired outcomes of intervention as goals (the individual will return to work), problems (the individual is too tired to get up in time for work) or needs (the individual needs to re-establish a normal sleep pattern). The way that problems are formulated influences the actions that are taken to achieve desired outcomes.

Goal Setting

In person-centred practice, the therapist and the person they are working with negotiate and agree the goals of intervention. Goals are the desired outcomes of the intervention. An actual outcome is the extent to which goals have been met following the intervention. Outcome goals can be expressed on different levels (Creek 2003):

- Adapting to fixed deficits, for example, the goal for a person who has developed a serious hearing impairment might be to read a newspaper every morning instead of listening to the news on the radio
- Developing skills, such as learning to read
- Carrying out tasks, such as putting aside the money to buy a newspaper every day
- Engaging in activities, for example, walking to the shop to buy a newspaper every morning
- Performing occupations, for example, keeping abreast of current affairs by reading the newspaper every day
- Participating in life situations, for example, reading the newspaper every morning and discussing the news with a group of friends.

A review date is set at the time when the goals of intervention are set. This is the date when measurement occurs. The more precisely a goal is defined the easier it will be to measure when it has been reached.

An individual may want to achieve several outcomes, in which case it will be necessary to decide which ones to work on first. When an individual is too unwell to express a view about what the priority should be, the therapist has to make a decision about initial goals. If possible, this should be discussed with colleagues, family and carers.

Action Planning

Once problems have been identified and priorities agreed, it is necessary to plan what approach to use and what actions are needed to achieve the desired outcomes. The preliminary action plan should be formulated by the therapist and the individual together, depending on the person's capacity for contributing to the process at this stage. Other significant people, such as carers, may also be involved.

The action plan includes the goals of intervention or desired outcomes, methods to be used, an individual programme and a list of the people who need to be informed about the programme. Occupational therapy interventions are usually designed to meet several goals or achieve several outcomes.

In person-centred practice, each programme of intervention is highly individualized. Factors taken into account in drawing up the intervention plan include:

- the person's needs, values and preferences
- the person's circumstances and environments, including social circumstances
- the therapist's style of working and preferences
- the quality of the relationship between the therapist and the person they are working with
- the intervention setting, including resources available and what is expected of the therapist
- the evidence base for intervention
- local and national policies and standards.

Action

Most occupational therapy interventions involve partnership working with other professionals, carers, community workers or volunteers. As far as possible, the therapist negotiates what action to take and how the

results can be interpreted so that the person involved in occupational therapy shares control over the process (Creek 2003).

Occupational therapy intervention usually involves engaging individuals in activity. The therapist may engage in activity with them or they may discuss activities that individuals carry out elsewhere. For example, a person may attend a cookery group run by the therapist or decide to join a cookery class at their local college.

There is an element of risk in all occupational therapy interventions and respecting an individual's choices can seem particularly alarming, especially for the inexperienced therapist. Assessing and managing risk is an essential aspect of intervention (see Ch. 5 for further discussion of risk assessment).

The occupational therapist remains responsible for the people they work with when they delegate interventions to others, such as students or support workers. This includes ensuring that they only delegate tasks to those who are competent to carry out the procedures and provide sufficient direction or supervision (Creek 2003).

On-Going Assessment and Revision of Action

An individual's progress is continually monitored, both during intervention sessions and over time, in order to measure progress towards agreed goals and ensure that the intervention is being effective. Collaboratively, the therapist discusses and agrees modifications to the programme in response to assessment findings. Minor changes can be agreed without having to organize a full review or alter the action plan.

Throughout the process of intervention, a close liaison is maintained with other disciplines involved so that any changes or problems can be shared. If the setting allows for a long period of intervention, regular reviews are held to evaluate the need for more radical programme changes. Clear and regular records of intervention sessions are kept to assist in the review process (see Ch. 7). Review meetings serve several purposes:

- They give the therapist and the team an opportunity to review what progress has been made and to judge the success or otherwise of the intervention programme
- They give everyone involved in intervention an update on the person's progress. Review meetings may be multidisciplinary, in which case everyone has a chance to discuss the person's progress, they may be within the occupational therapy team, or they may be between a single therapist and the individual
- They provide opportunities to set new short-term goals and to adjust intermediate and long-term goals in the light of new information or changes in the individual's circumstances.

Outcome Measurement

Change is measured by comparing the results of assessment following intervention with the baseline assessment. There are four possible results of intervention:

- the expected outcome is achieved
- the outcome falls short of what was expected
- the outcome is better than expected
- the individual's performance is worse than before the intervention.

If the expected outcome has been achieved, the therapist and the individual involved may set new goals or, if they feel that enough has been done, the discharge procedure may be started. If goals have been partially met, then the intervention programme may be upgraded. If goals have not been met or the individual's performance has deteriorated, then goal setting and action planning may have to be revisited.

End of Intervention

Planning for the end of an occupational therapy intervention should take place from the moment a referral is received or the therapist first starts working with an individual. If a person has been in hospital, or other place of residential care, discharge is planned so that their resettlement takes place as smoothly as possible.

Ideally, everyone involved recognizes when goals have been reached or outcomes achieved, and agrees on the best time for the intervention to end. However, it is not always possible to reach agreement between an individual, the multidisciplinary team and any caregivers, so compromises have to be made. This may involve some form of follow-up so that an individual does not experience the termination as too abrupt.

Review

Reviewing and evaluating interventions and services is a way of safeguarding standards and ensuring that services are fit for purpose. Evaluation is essential to demonstrate the effectiveness of intervention for the person involved, the therapist, the referring agent and other interested parties. Evaluation should be a part of the whole occupational therapy process, through self-appraisal, professional supervision, peer review and feedback from service users. Formal evaluation of a particular aspect of the service, such as a group, or of the service as a whole may be carried out at intervals in the form of an audit. Clinical audit is discussed in more detail in Ch. 7.

Evaluation of services should be carried out by occupational therapists themselves against their own standards of performance. Such evaluation may lead to: changes in skill mix in a service; a request for improved resources; restructuring the service, or a complete change of focus, such as relocating staff from specialist community teams to primary care.

FRAMES OF REFERENCE

In Ch. 3, a frame of reference was defined as: 'a collection of ideas or theories that provide a coherent conceptual foundation for practice' (Creek 2003, p. 53). As the knowledge base of occupational therapy has expanded, theories have been organized into an increasing number of frames of reference, approaches and models.

In 1946, a textbook on the theory of occupational therapy (Haworth and MacDonald 1946) described one approach to therapy (rehabilitation) and offered one chapter on occupational therapy in the treatment of mental disorders, which focused on engaging patients in activities to improve or maintain health. In 2008, the 4th edition of this book referred to eight frames of reference used in occupational therapy for mental health: psychodynamic; human developmental; cognitive behavioural; occupational behaviour; health promotion; cognitive; rehabilitative and occupational performance (Creek 2008). New developments in theory and practice may result in further frames of reference being developed in the future, such as a community development frame of reference.

A frame of reference delineates the field and the theoretical base for practice while a model gives more precise directions for putting theory into practice. Some models for practice are associated with more than one frame of reference. For example, Cole's seven steps, which are a model for group leadership, draw on elements of the person-centred, the cognitive behavioural and the developmental frames of reference (Cole 2012). Other models draw their theory from a single frame of reference: for example, adaptation through occupation (Reed and Sanderson 1992) developed within the occupational behaviour frame of reference. Table 4-1 shows eight frames of reference and examples of models that are associated with them.

Three frames of reference are introduced here: psychodynamic, human developmental and occupational performance. Each frame of reference is described in terms of seven characteristics:

- basic assumptions about the nature of people
- the knowledge base
- how function and dysfunction are conceptualized
- how change occurs
- the client group
- goals of intervention
- techniques for assessment and intervention.

Psychodynamic Frame of Reference

In the 1950s, a psychiatrist and a psychologist at McGill University carried out a partial survey of psychiatric occupational therapy in Canada (Azima and Wittkower 1957). They concluded that 'too much emphasis has been put upon the diversional and occupational aspects of activities to the neglect of psychodynamic problems of the individual receiving occupational therapy' (p. 1). Two years later, one of them published a paper outlining a theory of occupational therapy based on object relations theory (Azima and Azima 1959). This work was taken up and expanded by Fidler and Fidler (1963) in their book *Occupational Therapy: A Communication Process in Psychiatry*. These publications represented the first systematic attempts by occupational therapists to develop their own knowledge base for practice in the field of mental health.

Since the 1980s, psychodynamic theory has almost disappeared from the occupational therapy curriculum in many countries, although it is still included in

TABLE 4-1

Frames of Reference Used in Mental Health Occupational Therapy

Frame of Reference	*Example of a Model for Practice*	*Reference*
Psychodynamic	Occupational therapy as a communication process	Fidler and Fidler 1963
Human developmental	Recapitulation of ontogenesis	Mosey 1968
Cognitive behavioural	Cognitive therapy	Beck 1976
Occupational behaviour	Model of human occupation (MOHO)	Kielhofner and Burke 1980
Health promotion	Transtheoretical model	Prochaska and DiClemente 1983
Cognitive	Functional information-processing model (cognitive disability)	Allen 1985
Rehabilitative	Recovery	Deegan 1988
Occupational performance	Canadian model of occupational performance and engagement (CMOP-E)	Townsend and Polatajko 2007

Note: Original references have been given to highlight the sequence of development of the models for practice. There have been more recent developments and publications on all these models because they are still in use by occupational therapists.

some textbooks (Atkinson and Wells 2000; Blair and Daniel 2006) and a new textbook was published in 2013, discussing the place of psychoanalysis as a theory and method within occupational therapy (Nicholls et al. 2013). It is important to keep psychodynamic theory in the occupational therapy knowledge base because 'psychodynamic theory is one of the few occupational therapy (OT) approaches that deals effectively with emotional issues' (Cole and Tufano 2008, p. 255).

Basic Assumptions About People

Psychodynamic theory and approaches developed from the work of Sigmund Freud and his followers. Freudian thinking views people as having both a conscious and an unconscious mind. Behaviour is largely influenced by material in the unconscious mind, therefore people are usually not aware of why they act in particular ways and their actions are not always under conscious control. Actions are taken to gratify needs, but not necessarily those needs of which the individual is consciously aware.

People have an innate drive to be active that is directed towards gratifying needs and making satisfactory relationships. Action is used to express and communicate feelings and thoughts. Action arises from mental images, and feedback about the results of action allows these images to be modified to match external reality.

The infant strives for competence in actions that will both meet the infant's needs and increase their sense of personal identity and integrity. A sense of self-worth comes from intrinsic satisfaction in doing well in the areas of life that the infant values. The more situations and actions the child is able to experience, the greater will be their knowledge of their own potential and limitations, leading to greater adaptability. Knowledge of what patterns of action are most useful and acceptable in the individual's culture is learned through interaction with the social environment.

Knowledge Base

A number of different psychodynamic theories evolved, as many of Freud's followers developed their own approaches to psychotherapy. The occupational therapist working within a psychodynamic frame of reference will have knowledge and understanding of:

- Psychiatry
- Psychoanalytic theory
- Psychopathology
- Group dynamics
- The symbolic meaning and potential of activities and materials
- Object relations theory.

A recent edition of a standard text on group dynamics in occupational therapy (Cole 2012, p. 129) suggested that the psychodynamic frame of reference also encompasses 'concepts from ego psychology, humanism, and human spirituality'.

The psychodynamic approach is concerned with both intrapersonal aspects of the person, that is how the individual relates to him/herself, and interpersonal aspects, how individuals relate to other people (Atkinson and Wells 2000). For the occupational therapist, a third dimension is how the individual relates to activity, using activity to create her/himself, express him/herself and interact with objects in the world.

> *The term 'object relations' refers to the investment of emotions and psychic energy in objects for the purpose of satisfying needs …. Objects are any human being (including the self), abstract concept, or non-human thing which has the potential for satisfying needs or interfering with need satisfaction.*
> ***(Mosey 1986, p. 55)***

Objects have both actual meanings and symbolic meanings. For example, a woman wraps a woollen shawl over her coat in winter when she is using public transport, because it keeps her warm. This is the real and practical meaning of the shawl. But it also creates a symbolic barrier between her and the distracting environment of public transport. This is part of the shawl's symbolic meaning and value for her.

Symbols play a part in 'connecting the inner life and the consciousness of the individual with the collective belief systems of his or her culture' (Fine 1999, p. 13). Hence, symbolism can be used by the therapist as a route to understanding the meaning that activities have for individuals and how they use them to relate to their human and non-human environments.

People may use activity, without being consciously aware that they are doing so, as a way of managing the turmoil caused by 'their connection to (reliance on) others' (Nicholls 2007, p. 60). Engaging in activity can be an effective coping mechanism but, without self-awareness, we 'may work too hard, spend too much time in the gym or in the bar, become obsessively interested in our weight or use our hobbies as the main source of pleasure in our lives' (Blair and Daniel 2006, p. 244). This can lead to occupational imbalance.

Function and Dysfunction

There are several ways of conceptualizing dysfunction, depending on which theory is being used. For example, in Freudian theory, the ego has to balance the conflicting demands of reality, the id and the superego. Conflicts that are not dealt with as the individual grows and develops may be retained in the unconscious mind and surface as anxiety. The ego defends against anxiety by employing ego defence mechanisms. These use psychic energy so that it is not available for other uses. Dysfunction occurs when the individual is unable to contain the anxiety, because the conflicts are too great or ego defence mechanisms are not working effectively, and material from the unconscious interferes with function.

In object relations theory, as applied to occupational therapy, a functioning individual is one who has an integrated self-identity and a realistic concept of others, who continues to grow and develop throughout their life, who is able to satisfy their own basic needs and who contributes to the welfare of others. A well-organized personality has a positive and realistic sense of self and good object concepts. Dysfunction is characterized by immature object relationships which may be the result of a failure to develop healthy object-concepts or may be due to psychopathology and regression (Fidler and Fidler 1963). For example, people experiencing psychological disorganization in severe psychosis may have difficulty recognizing themselves as separate from others.

How Change Occurs

If dysfunction arises from unresolved conflicts located in the unconscious mind, change can be initiated by bringing these conflicts into the conscious mind to be verbalized and shared. Once the difficult or painful material has been accessed, the therapist can help the client to find alternative ways of coming to terms with the feelings it arouses or dealing with it in a more adaptive way. Alternatively, the therapist may decide not to engage in exploration of the unconscious mind but deal with anxiety by supporting the client's existing coping mechanisms or finding alternative ways of gratifying needs.

Mosey (1986) pointed out that resolution of conflicts does not necessarily lead to a person spontaneously learning the skills needed for successful

functioning. A psychodynamic approach may have to be used in conjunction with, or followed by, a more pragmatic approach to facilitate the acquisition of these skills.

Client Group

The psychodynamic approach is appropriate for use with people of all ages and for treating a wide range of psychosocial disorders. It has perhaps been most widely used with adults and adolescents with acute disorders but is also appropriate in child and family work, palliative care and substance abuse (Blair and Daniel 2006). Traditional forms of psychotherapy require good verbal skills but occupational therapists can use non-verbal media, such as paint or music, to facilitate expression and communication in people who lack verbal ability.

Goals

There are two main approaches associated with this frame of reference, each of which is associated with different goals. An explorative approach assumes that the content of the unconscious can best be dealt with by bringing it into the conscious mind where it can be shared and examined. The client then has the opportunity to find more adaptive ways of resolving conflicts and accepting difficult or painful feelings.

A supportive approach aims to keep unresolved conflicts and painful feelings hidden in the unconscious mind and to strengthen the client's ego defence mechanisms so that material does not leak into the conscious mind and cause problems.

Whichever approach is used, the goals of intervention may be to:

- assist in finding ways to gratify frustrated basic needs
- reverse psychopathology
- provide conditions for normal psychosexual and psychosocial development
- facilitate the development of a more realistic view of the self in relation to action and to others
- help to build a more healthy and integrated ego.

Assessment and Intervention

Within a psychodynamic frame of reference there may be no clear distinction between assessment and intervention. The activities that help to bring unconscious material into the conscious mind allow for a clearer understanding of underlying conflicts while at the same time beginning the process of resolving those conflicts. The client's progress is apparent in the way they respond to the activities provided as interventions.

Examples of assessment tools used within this frame of reference include the meaning of objects interview (Fidler 1999a), the Azima battery (Azima 1982) and observation of relationships in groups (Finlay 2002).

In both supportive and explorative approaches, the therapeutic elements of occupational therapy include: actions of the client; objects used in, or resulting from, action; human and non-human environments, and interpersonal relationships. Activities are selected for their symbolic potential as well as their potential to provide an appropriate level and type of social interaction. Activity analysis is in terms of the psychodynamics of activity, the symbolic potential of materials and actions, interpersonal aspects and sociocultural significance (Fidler 1999b). The choice of activities may be made by the therapist or client, depending upon their needs. However, the client has to be an active participant in the therapeutic process if it is to be of value to them.

During intervention, close liaison with other team members is essential and supervision is always part of the process (Blair and Daniel 2006). Intervention planning takes account of the amount of support and structure available to the therapist, as well as the support available to the client outside of intervention sessions.

Intervention may be individual or in groups but the group should always be small enough to allow the clients to relate closely to everyone in it: 8–10 members is usually considered to be the optimum size.

A supportive psychotherapy group would aim to:

- offer encouragement
- provide opportunities for mutual support
- provide a forum for exchanging information about resources
- provide a place to air problems
- help to relieve anxiety
- give opportunities to consider new ways of dealing with problems.

Explorative psychotherapy was traditionally a talking therapy, either one-to-one or in small groups.

Occupational therapy has contributed activity to the process, with the use of the creative arts as ego-explorative activities (Blair and Daniel 2006). This involves:

- the presentation of stimuli to which participants can respond with feelings or thoughts (e.g. a piece of music or a poem), or
- the creation of a piece of work through which participants can express feelings or thoughts (e.g. a painting or a piece of free clay modelling).

At the beginning of the 21st century, few occupational therapists are working solely within a psychodynamic frame of reference. However, knowledge of psychodynamic theories and processes can deepen the therapist's understanding of how people relate to activity, and to the world through activity, and so enhance any therapeutic approach.

Human Developmental Frame of Reference

The human developmental frame of reference, also known as the lifespan development frame of reference (Bruce and Borg 1993; Cole and Tufano 2008), fits comfortably with the temporal perspective taken by occupational therapists. The two names most-closely associated with this approach in occupational therapy are Anne Cronin Mosey and Lela A. Llorens.

Mosey's (1968) paper *Recapitulation of ontogenesis: a theory for the practice of occupational therapy* outlined a developmental model that can be used in the field of mental health. She subsequently expanded and developed the model, drawing out general principles of a human developmental frame of reference.

Llorens (1970) gave the 1969 Eleanor Clarke Slagle lecture, entitled *Facilitating growth and development: the promise of occupational therapy*. In this lecture, she outlined a framework for intervention based on developmental theory, which had grown out of her work in the fields of psychiatry, paediatrics and community health. This was followed by a series of publications expanding and clarifying the frame of reference and exploring aspects of its application.

This outline of the human developmental frame of reference draws on the work of both Mosey and Llorens, as well as on the work of more recent occupational therapy theorists such as Fortmeier and Thanning.

Basic Assumptions About People

People are dynamic, developing organisms whose lives go through predictable stages of growth and decline that necessitate adaptation by the individual. Development can be thought of as a process in which the key elements are the individual, society and the person's own activity (Fortmeier and Thanning 2002). It takes place in a sequence that is common to everyone, although the pace may vary widely. Developmental achievements are not necessarily permanent: regression to an earlier level can occur.

Although it is possible to identify the average age at which someone might reach a particular developmental stage, there is a wide variation between individuals and across cultures. People develop at different rates, they encounter different environmental opportunities and barriers and their '*development can be understood only in light of the cultural practices and circumstances of their communities*' (author's emphasis, Rogoff 2003, pp. 3–4). Age ranges can be suggested for particular skills to be mastered but these are not absolute and are mainly useful for checking whether development in all skill areas is proceeding at the same pace.

Each stage of development can only proceed normally if the preceding stages have been completed successfully and the conditions for further development are in place. Incomplete development in one area of skill, or in one life stage, will influence subsequent development. Early patterns of development influence the personality structure of the adult but growth and development continue into adulthood and middle age. Maladaptive or incomplete development can be remediated at any age by recapitulating earlier developmental stages (Mosey 1968).

Llorens (1970) based her model of human growth and development on 10 premises:

1. A person develops in parallel the areas of neurophysiological, physical, psychosocial and psychodynamic growth, social language, daily living and sociocultural skills
2. All these areas continue to develop throughout the person's life
3. Mastery of skills to an age-appropriate level in all areas of development is necessary to the achievement of satisfactory coping behaviour and adaptive relationships

4. Such mastery is usually achieved naturally in the course of development
5. Intrinsic factors and external stimulation received within the family environment interact to promote early growth and development
6. The later influences of the extended family, community and social groups assist in the growth process
7. Physical or psychological trauma can interrupt the growth and development process
8. Such interruption will cause a gap in the developmental cycle resulting in a disparity between expected coping behaviour and the skills necessary to achieve it
9. Occupational therapy can provide growth and developmental links to assist in closing the gap between expectation and ability through the skilled application of activities and relationships
10. Occupational therapy can provide growth experiences to prevent the development of maladaptive behaviour and skills related to insufficient nurturance.

Knowledge Base

The developmental frame of reference is based on theories of human development covering all skill areas: physical, sensorimotor, intellectual, language, psychosocial, psychosexual, moral and spiritual development. The knowledge base draws on the work of such developmental theorists as Piaget, Erikson, Kohlberg, Levison, Havighurst and Gesell (Bruce and Borg 1993; Cole and Tufano 2008).

Activity theory contributes an understanding of how people develop skills through four levels, in interaction with the environment (Fortmeier and Thanning 2002):

- **Functions** are the motor and sensory requisites for action, such as muscle tone, perception and sensory-motor coordination.
- **Operations** are the procedures through which functions are translated into action; for example, putting on a shirt is an operation. The more operations a person can perform, the greater will be their range of occupational choices.
- **Activity** includes: general abilities, such as setting goals; theoretical abilities, such as having knowledge and skills in a particular subject, and social abilities, such as collaborating with others.
- **Consciousness** of the world and of one's own place in it enables people to develop a sense of identity and gives them the capacity to assume responsibility for their own lives.

Different aspects of developmental theory may be used with different client groups. For example, the occupational therapist working with children with learning difficulties may draw on knowledge of language, cognitive, emotional, psychosexual, social and sociocultural development. If the child has multiple impairments, the therapist may also draw on knowledge of sensorimotor and perceptual development. The therapist working with adults in an acute psychiatric setting may use theories of personality, emotional, moral, psychosexual, psychosocial, social and sociocultural development.

Function and Dysfunction

Function and dysfunction exist on a continuum. A functioning individual is one who achieves satisfactory coping behaviour and adaptive relationships by developing appropriate skills, abilities and relationships throughout the lifespan. These adaptive behaviours allow the individual to adjust to both internal needs and external demands.

Growth and development can be disrupted or delayed by congenital or acquired disease or injury, or if the conditions for normal growth and development are absent. Dysfunction occurs when the developmental level of the individual, in any area, is unequal to the age-related demands made on them. Some of these expectations are for skills common to all people, such as walking by a certain age, while others are culturally determined, such as social skills. Dysfunction can also occur when the person fails 'to resolve the dilemmas, conflicts, or polarities appropriate for one's stage of life' (Cole and Tufano 2008).

Trauma at any age can interrupt the developmental process and inhibit the development of adaptive skills or cause regression to an earlier developmental level. A major disruption in any one skill area affects all other areas, and the longer the disruption continues the more gaps there will be in the developmental

process. However, people may complete a delayed developmental stage at a later time, when the conditions are right, or may compensate for developmental delay by learning certain higher-level skills without the underpinning of more basic ones (Mosey 1986).

How Change Occurs

Change occurs through learning new skills (Cole and Tufano 2008). As the individual's physical and psychological needs change, and new environmental demands are encountered, the person experiences disequilibrium. This motivates them to learn the skills needed to re-establish a state of equilibrium. When internal or external change happens unexpectedly, or proceeds too quickly, disequilibrium can be experienced as stressful; however, change is not in itself a problem and disequilibrium is a necessary aspect of adaptation (Bruce and Borg 1993).

New skills are acquired through practice in a facilitating environment until competence is achieved. Once a basic skill has been learned, the individual refines and elaborates it through use. During normal development, skills are learned in parallel so that higher-level skills are integrated with lower-level skills in the same area and with other skills areas developing at the same time. If higher-level skills are not integrated with more basic ones, they may be lost when the individual is under stress, causing regression to an earlier level of development.

Client Group

Occupational therapists are concerned with promoting development at all ages; therefore this frame of reference is applicable throughout the lifespan. It can be used with people experiencing any kind of mental health problem, as well as those with delay in physical, emotional or cognitive development.

Goals

The occupational therapist uses activities and relationships to facilitate growth and development. The overall goal of intervention is to increase skills in all areas, with emphasis being placed on the main area of deficit so that the gap is narrowed or closed between expected coping behaviour for the individual's chronological age and actual adaptive ability. Short-term goals are to learn the skills needed for the next stage of development.

Occupational therapy is also concerned with maintaining health and preventing maladaptation through early detection of problems and early intervention. This allows the individual to continue the growth process with a minimum of disruption or maladaptation. Intervention may be particularly effective in helping people adapt to change at times of transition, such as starting a family or retiring (Cole and Tufano 2008).

Assessment and Intervention

The individual's developmental level in the different skill areas is assessed to find where normal development has been disrupted or has ceased. Appropriate assessment methods include interviews, observation, review of records, projective techniques, tests and collaboration with care givers.

It is necessary to meet an individual's needs at their present developmental level if further development is to take place, so intervention takes the person's present level of development as the starting point (Llorens 1970). However, it is also possible to continue development in some skill areas when the development of other areas is blocked. For example, a person with a learning disability may develop good interpersonal skills despite having limited intellectual ability.

Activity theory (Fortmeier and Thanning 2002) tells us that each person has an actual developmental level, which determines what can be performed independently, and a potential developmental level, which is the area in which further learning can take place. The distance between the actual and potential developmental levels is called the zone of proximal development (ZDP). A person can perform tasks in the ZDP with support from others.

Skills are developed most effectively through performing activities (Fortmeier and Thanning 2002) so that basic functions, such as attention and listening, become integrated in performance. It is important for the occupational therapist to take the individual's ZDP as the starting point for selecting therapeutic activities in order to present demands that slightly exceed the person's abilities. If the demands of the activity are too easy, the individual will not learn new skills and will lose interest. If the demands are beyond the individual's ZDP, she or he will become discouraged and defensive.

If development has proceeded unevenly so that one or more skill areas lag behind the others, then

intervention usually starts with the area where development is most delayed. When that area has caught up, attention is transferred to the next most delayed area so that development across the skill areas proceeds relatively evenly. Intervention continues until the individual has attained an age-appropriate level of adaptive skill in all areas, or has attained sufficient skill to be able to function adequately in their expected environment, or has reached what seems to be their highest possible level of achievement.

Intervention techniques include activities, relationships and environments. Activities are analysed and selected for their potential to facilitate the development of particular skills and combined with a suitable type and level of interpersonal interaction to achieve the maximum benefit. The person's human and non-human environments are organized, as far as possible, to provide the appropriate stimulation and support for learning.

Occupational Performance Frame of Reference

The development of a frame of reference focusing on occupation was initiated by Mary Reilly who, early in her career, became interested in the relevance of the central nervous system to human performance. She began to construct a frame of reference that combined knowledge of the neurosciences with theories of intrinsic motivation and social psychology, and with the ideas of Meyer, one of the founders of the occupational therapy profession. This was the occupational behaviour frame of reference, which had a major influence on occupational therapy theory and practice throughout the latter half of the 20th century and was a forerunner of the occupational performance frame of reference.

Following on from Reilly, several occupational therapy theorists began to develop conceptual frameworks to support occupation-focused practice (e.g. Kielhofner and Burke 1980; Reed and Sanderson 1980; Christiansen and Baum 1997). One of the most influential of these has been the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Townsend and Polatajko 2007).

Most occupational therapists today would acknowledge the influence of the occupational performance frame of reference on their practice, even if it is not the only approach they use.

Basic Assumptions About People

People are occupational beings who have evolved to be flexible enough to engage in a wide range of occupations that enable survival in almost any environment on Earth. Wilcock (2006) introduced the idea that the primary role of the human brain is healthy survival, describing it as both an occupational brain and a healing brain. Survival is the primary drive of all animals, and health is necessary for survival. Each person has an intrinsic drive to explore the environment, interact with it and learn how to live successfully within it.

There is an interdependent relationship between people and the environments in which they develop and live (Law et al. 1996). Occupational performance results from the interactions between people, their occupations and their environments. Achieving competent occupational performance is a lifelong process of adaptation to the internal and external demands that occur naturally within the context of person–environment–occupation interactions (Schkade and Schultz 1998). Adaptation is the process through which people are able to use their own resources, and environmental resources, to cope with the challenges of daily living (Cole and Tufano 2008).

People live and occupy themselves in communities that include both human and non-human environments. Five groups of intrinsic factors influence how a person interacts with these environments: neurobehavioural, physiological, cognitive, psychological and spiritual (Cole and Tufano 2008). People are able to adapt to their environments through what they do but environments also shape what people do and who they become, in a two-way process.

Knowledge Base

The discipline of occupational science has contributed much to the occupational performance theory base, from clarifying basic concepts to carrying out research into the relationships between occupations, environments and health. Some of the knowledge base is also drawn from established disciplines, such as biology, sociology, social psychology, neurology and anthropology. Specific areas of knowledge include:

- Occupation and health
- Adaptation
- The components of occupational performance

- Motivation
- Meaning and values
- Volition and engagement
- Occupational choice
- Occupational balance and temporal adaptation
- Environment
- Role and identity
- Social and cultural structures.

The three main components of the occupational performance frame of reference are person, occupation (or occupational performance) and environment. These components interact with each other across time and space as the person attempts to adapt to ever-changing environments through occupation (Law et al. 1996).

This frame of reference integrates an understanding of the structure and functions of the body with awareness of the person. We talk about the health of the body but we use the term *wellbeing* to refer to the state of the person. People are thinking, feeling, spiritual and social beings, who express themselves, transform themselves and relate to the world through occupation.

The occupations that people perform at any stage of their lives are shaped by their own abilities and preferences but also by their environments and opportunities. Occupations develop throughout the lifespan and shape people as much as people shape their occupations.

The environments in which occupations are performed include objects, spaces, people, events, cultural influences, social norms and attitudes (Creek 2003). Cultural influences include values, beliefs, customs and behaviours (Christiansen and Baum 1997). The social environment also includes politics, economy and law.

Wilcock (2006) spoke of being, doing and becoming. *Being* refers to who the person is, their essential nature, which shapes and is shaped by their occupations. *Doing* refers to occupational performance, to the engagement of the person in all the occupations that make up the framework of their everyday life. *Becoming* refers to growth and development, which take place through occupational performance.

Function and Dysfunction

People have the capacity to influence the state of their own health through what they do, and a balance of rest, play and work in daily life is necessary to maintain physical and mental health. People are in a state of function when they have the range of skills and level of competence necessary to cope with their environments and perform a balanced variety of occupations that satisfy their needs and support their health and wellbeing.

Dysfunction occurs when people are unable to perform the occupations they need to do, want to do or are expected to do due to disease, injury or environmental conditions (Law et al. 1994).

How Change Occurs

Human beings have a very large and complex brain that gives them highly developed capacities for abstraction, insight, learning, curiosity and exploratory behaviour (Wilcock 2006). These capacities make people very adaptable and, although much adaptation to specific environments takes place in childhood, people retain the ability to change in response to changing circumstances throughout their lives. Change occurs through various processes:

- learning or re-learning skills to support the performance of a desired range of occupations
- putting in place support to enable the performance of those occupations
- finding alternative occupations to meet personal needs so as to maintain health and life satisfaction.

Client Group

The occupational performance frame of reference has a very wide applicability because it is concerned with what people do in their daily lives, at any age, in any circumstances and in any environment. It can be used in traditional health and social care settings, in other institutions, such as prisons, and in health promotion or community development projects.

Goals

The task of the occupational therapist is to reduce the incapacities resulting from illness and enable occupational performance in the presence of impairment, disability or any other barrier (Reilly 1969). The main process goal of occupational therapy is for the individual to become the agent of therapeutic

change (Schkade and Schultz 1998), therefore it is important to elicit the person's perception of needs and desired level of performance. The outcome goals of intervention are to increase competence in occupational performance and develop skills to support health, wellbeing and life satisfaction.

Assessment and Intervention

The occupational therapist begins by helping the people they are working with to identify the occupations that they expect to do in daily life and the areas of performance with which they are having problems. Examples of assessment techniques include: interviewing, the Canadian Occupational Performance Measure (Law et al. 1994), environmental analysis (Hagedorn 2000), observation, checklists and self-assessment.

When problem areas have been identified, the therapist and the person together identify barriers to and enablers of occupational performance. These may be personal and/or environmental. Intervention is targeted at removing or overcoming barriers or putting in place more effective enablers. This may involve developing skills to a level of competence that supports occupational performance, solving occupational performance problems or adapting environments to facilitate performance.

Within the occupational performance frame of reference, interventions are usually individualized because each person has a unique range of occupations and environments. Effective intervention depends on matching people's performance to the demands of their physical and social environments and their occupations.

Intervention techniques can be categorized as:

- activity used as a therapeutic medium, for example, developing self-confidence and self-esteem through creative activities
- education and training strategies, for example, teaching social skills
- modification of the physical environment, for example, buying a microwave oven to make cooking easier
- modification of the human environment, for example, joining a course at the local college in order to meet people.

SUMMARY

This chapter began by exploring the content of occupational therapy practice under five headings: goals and outcomes; populations served; legitimate tools; core skills; and professional artistry. Occupational therapists work both in statutory health and social care services and in the social field so the content of practice has to reflect this broad scope. The process of intervention was then described, emphasizing that in a person-centred practice it is essentially a complex and iterative process. The chapter ended with descriptions of three frames of reference, chosen to reflect the breadth of knowledge and skills used by occupational therapists in the field of mental health.

Many of the themes introduced in this chapter are discussed in more detail in subsequent chapters.

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5 ASSESSMENT AND OUTCOME MEASUREMENT

ALISON BULLOCK

CHAPTER CONTENTS

INTRODUCTION

Assessment and outcome measurement are integral parts of the occupational therapy process and commence at the point of referral. (It may be helpful to read this chapter in tandem with the description of the occupational therapy process in Ch. 4.) The occupational therapy process begins with the end in mind (Covey 1989), by thinking about the outcome at the beginning of the process. This means it is clear from the outset what the end-point of therapy is. It also makes it possible to make a judgement about whether the outcome has been achieved and to identify if there has been a change in the person's situation. Assessment is measurement of the quality or degree of the various factors in a situation or condition. For occupational therapists in clinical practice, assessment is used to measure the strengths and needs of the person that relate to their referral for occupational therapy.

Outcome measurement involves comparing a person's level of function after intervention with what

they were able to do before. Outcomes are the expected or intended results of intervention. The *desired* outcome is the goal that the individual and therapist want to achieve in their work together. The *actual* outcome is the measurable result of the intervention. Outcome measurement is the evaluation of the extent to which an outcome goal has been reached (Creek 2003), consequently outcome measures are measures of change over time, therefore before beginning intervention, it is necessary to establish the individual's current level of functioning. This chapter will discuss the part that assessment and outcome measurement play in the occupational therapy process including the importance of reliability and validity. It will also consider what is assessed, methods of assessment and different approaches to measuring outcomes.

ASSESSMENT AND OUTCOME MEASUREMENT PROCESS

The assessment and outcome measurement process, as shown in Figure 5-1, is an integral part of the occupational therapy process. Assessment and outcome measurement is not something that is '*done to*' a person. Outcomes are identified collaboratively by the individual and the therapist. Together, they are actively involved in providing information and in interpreting it; they are involved in determining the goals to be attained and expressing them in such a way that they are measurable. During the process of assessment, the therapist's focus of attention shifts between different aspects of the person's performance; skills, tasks, activities and occupations (Creek 2003). There may be long-term outcomes or shorter term, i.e. specific, measurable and realistically achievable steps towards meeting an agreed longer-term goal. These steps should be in a form that is readily understood by the individual involved, the therapist and any others involved. The emphasis is on strengths, promoting engagement and goal achievement. Assessment and outcome measurement takes place in three stages; initial assessment; ongoing assessment and evaluation; and final assessment

Stage 1: Initial Assessment

Initial assessment takes place at the start of the occupational therapy process and can be described as a way of defining the problem to be tackled or identifying the goal to be achieved. It involves collecting and organizing information about the person from a variety of sources in order to identify the challenges they are experiencing, set goals for the outcome and plan interventions effectively. The steps of the initial assessment process described here may not be carried out in the same sequence with every person. The assessment process is shaped by the individual needs and wishes, the context of the intervention, and other constraints. Initial assessments can also be useful for judging whether or not the person will benefit from occupational therapy intervention and rapport building. This is an example of the art and skill of occupational therapy.

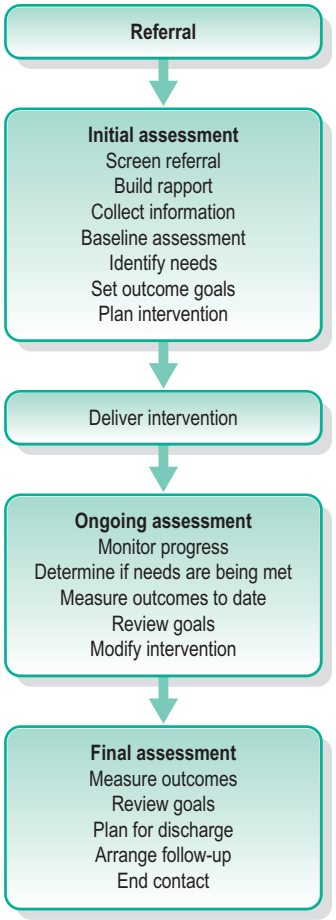

FIGURE 5-1 ■ The assessment and outcome measurement process.

An occupational therapist may be administering a test but the manner in which they do it will convey their values (respect, empathy, trustworthiness and partnership working) to the person they are working with. This not only supports the assessment process but provides a solid foundation for intervention. No one part of the occupational therapy process is unrelated from the other.

Occupational therapy intervention can only begin when assessment clearly indicates the need for it. The outcome of an initial assessment may be a decision not to provide an occupational therapy intervention. An example of this would be a person whose alcohol use is directly affecting their occupational performance who needs to acknowledge the problem to benefit from intervention. Recording the results of investigations is the starting point for interpretation and, as such, is part of intervention planning. The process of organizing information, which should be carried out as far as possible with the active cooperation of the person concerned to produce a list of problems and strengths, agree on goals of intervention and suggest strategies and methods of intervention. These last two aspects of the occupational therapy process are discussed in detail in Ch. 6, which focuses on planning and implementing interventions.

Stage 2: Ongoing Assessment and Evaluation

To monitor change and progress, assessment and evaluation are ongoing. This enables the therapist, working collaboratively to determine if person's needs are being met, obtain further specific information, modify interventions or review planned outcomes. The frequency of these assessments will depend on the type of service and expected length of the intervention. Reviews can include:

- A brief 'sense check' of intervention and progress towards goals. This should take place at every session to ensure that therapy is proceeding effectively as planned
- Once an intervention has been implemented, the therapist again assesses an individual's skills, the effect on tasks and activities and, finally, whether this means that the individual is now better able to perform their usual range of occupations (or desired occupations)
- Ongoing review, which may involve activities such as: observation and discussion; regular completion of tools such as diaries or Likert scales; and repetition of previous standardized or non-standardized assessments.

Stage 3: Final Assessment (and Outcome Review)

This takes place at the end of the intervention. It can be used to:

- measure against the individual's life demands to demonstrate whether outcome goals have been reached
- provide a picture of residual problems
- plan for appropriate discharge and follow-up
- identify reasons why no further progress can be made at this time.

WHAT IS ASSESSED?

It is not possible, or necessary, to learn everything there is to know about a person. An occupational therapist collects and organizes information about the person, working within the context of the referral, the nature of the service offered and the frame of reference being used by the therapist. This section will focus on the occupational therapist's domains of concern; namely occupations, routines and habits, abilities, strengths and interests, roles, volition and motivation, aspirations and expectations, areas of dysfunction, external factors and risk.

Occupations

It is useful to take an occupational history. This is to assess whether the individual's roles and occupations have been disrupted or whether they have developed supportive and helpful habits and routines. Occupations are enacted through activities; for example, the occupation of mothering is expressed through such activities as bathing her child, feeding her child, playing with her child, reading to her child and answering her child's questions. The therapist will seek to discover what activities the individual normally

performs and whether or not these activities support a healthy range of occupations, and equally whether they are supportive of roles that enable the person to feel like they fit or belong in the wider context/world around them.

Occupations exist in a balance that changes throughout the life cycle. A healthy balance is one that allows most of the individual's needs to be satisfied in ways that promote social inclusion and integration. This balance can be disrupted by illness or disability but, equally, an inability to participate in a range of chosen occupations can have a negative impact on health (Creek 2003). The therapist assesses how a person uses their time over the course of days and weeks, whether there are empty times or times when there is too much to do. It is also helpful to find out if the person's time use has changed recently, perhaps with the loss of a major occupation or with the introduction of new demands?

Routines and Habits

Daily activities are organized into routines that support an individual's sense of self and, if performed regularly, become habitual; for example, driving involves a sequence of actions that becomes habitual so that one does not have to think carefully about every stage of the operation. Routines and habits enable the individual to perform everyday tasks without having to remember consciously how to go about them. They are developed to suit the individual's needs at any one period of life; new habits are learned and old ones discarded as circumstances change. The therapist assesses how people organize their time; that is, whether they have useful habits or have to expend a lot of time and energy deciding what to do and working out ways of performing.

Abilities, Strengths and Interests

Abilities, strengths and interests also influence the range of occupations a person adopts and the way these occupations are performed. Ability is the measure of the level of competence with which a skill is performed. In order to function effectively in a desired range of actions, a person must have a variety of skills and be able to perform them competently. When assessing individuals, it should be taken into account that competence is not an absolute concept; norms for competence vary with age and are to some extent socially defined (Mocellin 1988). Competence exists on a continuum and when assessing competence in completion of skills, it is important for the therapist to acknowledge their own bias and thresholds for acceptability and to question these in the context of the individual they are working with.

Strengths are the personal factors that enable a person to function effectively. They include skills, other personal attributes and social networks. The therapist assesses an individual's strengths, so that interventions can be designed to support and build on them as an enabler of change. Interest is the expectation of pleasure in an activity which is aroused by a combination of experience and some degree of novelty. Experience tells us that we have enjoyed something similar in the past and novelty arouses in us the urge to try a new experience. It is important to know what an individual's interests are so that interventions can be designed that are appropriate and support an individual's sense of self. Gaining understanding of an individual's occupational choices and whether these are externally or internally influenced helps to ascertain whether interests are genuine or presumed. For example a person may spend a lot of time watching shopping programmes on television, but it would be wrong to presume this is due to interest; it may be due to an inability to sleep.

Roles

Roles are patterns of activity associated with social position. A role contributes to the individual's sense of social and personal identity and also influences the way in which occupations are performed. A properly integrated role, supported by the skills and habits necessary for its performance, satisfies both society's expectations and the individual's needs. Roles are defined by society and assigned to individuals on the basis of such attributes as age, gender, relationships, possessions, education, job, income and appearance. For example, a person's roles vary in different places: their role at work; being a consumer when shopping and being a parent at home. Each role carries expectations of occupational performance, which the individual who accepts the role attempts to carry out. Therefore, an occupational therapist should consider roles as part of assessment. The range of roles and occupations the person has engaged in over time should be explored, as well as the level of satisfaction these

have provided for them, and what barriers or restrictions to role participation the person has previously experienced.

Volition and Motivation

People have a basic urge to be active, known as volition. They test their own potential and seek to have an impact on their surroundings. The extent to which they act on that urge is known as motivation. The actions they choose are influenced by life experiences. Fidler and Fidler (1978) stated that each person learns their own capacities through doing. Assessment should include exploration of an individual's occupational behaviour and their ability to choose what to do and initiate it. Decisions about what to do may be influenced by the person's internal beliefs, values and interests, but also by their level of competence and external environments and relationships. Developing an understanding of these during the assessment will help the therapist influence change during the intervention phase.

Aspirations and Expectations

Achievement through participation is influenced by an individual's aspirations and expectations. A person who has experienced persistent failure, due to a lack of skill or lack of opportunity to do, may feel incompetent, lacking in control and have little expectation of success or hope for the future. This will influence how a person engages and what in. Successful doing leads to a sense of satisfaction and a sense of competence and therefore builds confidence and aspirations. It is important that interventions match the person's aspirations and expectations, offering a 'just right challenge'. However, the capacity to make realistic plans for the future can be affected by fear of failure or by illness. The assessment process is designed to elicit both what the person would like to achieve and how realistic those aspirations are.

Areas of Dysfunction

Function and dysfunction are not opposites but exist on a continuum. Spencer (1988, p. 437) pointed out that:

> *Temporary or permanent disability takes on a unique meaning for each individual. Age, developmental stage, previous ability, achievements, life-style, family status, self-concept, interests and general responsibilities affect attitudes such as understanding, acceptance, motivation and emotional response …. An accurate analysis of the bio psychosocial context by the therapist is essential to determine the functional implications of the patient's condition.*

During assessment, it is important to take a temporal perspective, considering an individual's past level of functioning and expected future occupations as well as present capabilities, in order to find out whether they have lost skills or never developed competence in certain areas. The ways in which function and dysfunction are conceptualized are determined by the frame of reference the occupational therapist is using. For example, using the adaptive skills model (Reed and Sanderson 1992), dysfunction is seen in terms of lack of mastery of the adaptive skills appropriate to the individual's age and stage of development. Within a cognitive behavioural frame of reference, dysfunction is seen in terms of faulty information processing, irrational thinking and distorted perceptions.

External Factors

Change will also be influenced by external factors such as the physical environment, the goals of the family or carers, social support networks and social expectations. All these factors must be assessed and taken into account when setting or modifying goals and planning what those involved would like the outcome of intervention to be.

Physical Environment

The environment includes both physical factors, such as poor housing or inadequate public transport, and social factors, such as poverty or working in an unsatisfying job. The physical environment is likely to include the person's place of residence, workplace and local or wider community and community locations. Areas to consider in assessment of home environment include: the type and quality of housing; whether it is temporary or permanent accommodation; access to the home; any problems, such as damp or infestation; facilities such as space, heating and garden;

privacy; furnishings and organization of household goods; comfort; where the home is situated; whether it is convenient for transport, shops, libraries and open spaces; distance from the workplace and the character of the neighbourhood. For a work environment, they may include: location in relation to home; transport; access; space, including characteristics of the working space and the total area of the workplace; facilities, such as canteen and health care; noise levels; heating and air conditioning; any hazards, and tools or equipment. Community environments vary considerably, for example rural communities and city communities. Assessment should consider factors such as: the type of neighbourhood; community resources such as shops and leisure facilities; public transport infrastructure; access to healthcare, including GP, dentist and optician; and open spaces. Such assessment will also include consideration of which aspects of the physical environment could be adapted, altered or influenced to encourage an individual's occupational participation, and which are fixed.

Social Environment

The social environment consists of the people who make up the individual's social world, at home, at work and in other areas of life. This includes: neighbours; family; friends; work colleagues; casual contacts, such as shopkeepers and dog walkers; social groups, such as club members, e.g. working men's clubs, and parent toddler groups; and internet contacts (including the person's own avatars and virtual friends and acquaintances). All these people influence and shape how a person feels about themselves through the roles that are assigned to them and the expectations that go with those roles. Alongside this are the relationships that people have with their pets that can also influence how a person perceives themselves and influence meaningful role fulfilment.

Risk Assessment

An element of personal, physical or environmental risk is involved during any occupational engagement to a greater or lesser degree. When assessing each of the areas above, the level of risk should be considered as part of assessment, with the understanding that risk is an integral part of doing and being in daily life. It cannot be eliminated while maintaining healthy occupational participation. Particular risks related to occupational performance can be identified during assessment, for example the risk of someone self-harming if they fail to perform adequately a task or activity that they expected to be competent in or the risk of being knocked over when crossing the road. However, in order to develop or maintain skills or competencies, it is often necessary to withstand and work through risk issues or minimize them through changing/adapting the environment or an individual's thoughts and behaviour. Individual perceptions of risk and tolerance for risk-taking can be a barrier to occupational engagement. Their roles and occupational opportunities may be affected by risky behaviour choices. Others, with professional or personal accountability or responsibility for the person, may have different perceptions of risk or tolerance for risk-taking, which will also create barriers to occupation. Therapeutic risk-taking is a regular component of working with individuals to promote change, and for many people taking the step to engage with services in order to change their lives, is a major risk in itself. (Risk is also discussed in Chs 7, 11, 12, 23, 24 and 25.)

METHODS OF ASSESSMENT

Occupational therapists use a wide range of assessment methods and tools, from interviews to assessment batteries. Some are assessment methods widely used by the different professionals in a multi-disciplinary team: review of records, interviews, observations, proxy reports, and home (environmental) visits (see Table 5-1). Methods more specific to occupational therapy are those that focus on function and involve activity or occupation, such as:

- functional analysis
- activity checklists
- performance scales
- occupation- or activity-focused questionnaires
- projective methods (see Table 5-2).

There are two main methods of assessment: standardized assessments and non-standardized assessments (see Glossary). Both of these methods can also be used to measure the outcomes of interventions.

TABLE 5-1

A Summary of the Assessment Methods Used by all Members of the Multidisciplinary Team

Assessment Method	*Description*
Review of records	Reading a person's case notes to develop an overview of past interventions. Hemphill (1982) recommends using a checklist to ensure that no relevant information is missed. Information gained from the review can be used to plan an initial interview
Interview	An interview is a conversation between the occupational therapist and the person they are working with. How interviews are conducted can vary, for example in duration. A confused person may not be able to engage in a long interview, whereas an acutely distressed person may become calmer with the sustained and undivided attention of the therapist. Interviews can also be: ■ Structured: involving a series of prescribed questions ■ Semi-structured: where there is scope for digression from prescribed questions ■ Unstructured: where there are no set questions and the person being interviewed determines the topics and direction of the conversation As well as talking during the interview, the therapist can observe a person's verbal and non-verbal communication skills, sensory deficits (if any), quality of self-care, mannerisms (if any), posture and facial expression
Observation	Observation involves noting and recording what is seen, e.g. the type, frequency and duration of activities by the client. Much can be learned from general observation, such as the physical appearance of the client (physique, posture, facial expression, mannerisms, gait, grooming and dress). This can give an immediate sense of a person's mental wellbeing Observations can be staged when further information is required about a particular area of functioning, such as cooking a meal or planning an outing, the client can be asked to participate in a task designed to measure that function Individuals can be observed alone or in a group setting. Observing the person in a group can be particularly useful for assessing performance areas which involve interaction with others, such as social skills. Task performance in the presence of others can also be observed. Assessing through observation in group work is particularly useful in assessing performance areas that involve interaction with others, e.g. social skills, including social behaviours and interaction but also allows observation of task performance in the presence of others and the effect that this level of connectedness has on that performance Mosey (1973) described three steps in using observation as a method of assessment: 1. ***Observation***. Noting what the client does without ascribing meaning to it 2. ***Interpretation***. Using observed data to reach conclusions about the reasons for the client's actions 3. ***Validation***. Seeking to confirm the accuracy of interpretations by sharing them with the client or others who know the client well It is important to remember people behave differently when being observed and in unfamiliar environments
Proxy report	Sometimes it may be difficult to elicit information from a person about their occupational history and previous functioning, particularly if they are very unwell and/or lacking insight, or are socially disconnected, for example someone with dementia and behavioural disturbance. With consent, or if it is in the person's best interests if they lack capacity for consent, information can be gained from significant others involved. This is known as proxy report. This can highlight when the relationship and understanding between the person and others in their personal social or care networks forms a barrier to occupational performance or engagement The Routine Task Inventory – Expanded (RTI-E) (Katz 2006) is an example of a tool that uses proxy report. This is because it involves gaining information from the person themselves, the therapist and the person's carer
Home (environment) visit	Visiting a person's home (or other environment) allows the therapist to: ■ Gain an enhanced picture of the person's life demands and role expectations ■ Observe the person's level of functioning in their usual domestic environment ■ Carry out specific assessments which are more valid within a familiar environment ■ Observe the physical environment, including the home and its surroundings ■ Meet family and neighbours in their usual environmental context

TABLE 5-2

A Summary of the Assessment Methods Used Specifically by Occupational Therapists

Assessment Method	*Description*
Functional analysis	Functional analysis is used to assess how people spend their time, their capabilities and identify any problem areas. Over 200 different methods have been devised for collecting data about how an individual functions in daily life (Unsworth 1993). Most of these focus only on activities of daily living (e.g. the Barthel Index and the Bristol ADL Assessment) and most have been devised for use with older people. Examples of these types of assessments used in mental health settings include: ■ Canadian Occupational Performance Measure (Law et al. 1994) ■ Mayers' Lifestyle Questionnaire 2 or 3 (Mayers 1998) ■ Occupational Self Assessment (Baron et al. 2006)
Activity checklists, performance scales and occupation-focused questionnaires	Occupational therapists have always used checklists and questionnaires for assessing skills such as activities of daily living (ADL). Some checklists, questionnaires and performance scales measure directly observable performance, for example: ■ the ability to dress independently, enabling occupational performance to be categorized or graded in simple or more complex ways ■ functions which are more complex and may be more difficult to observe, for example the ability to participate in a mature group (Mosey 1986) Some of the many areas of performance that can be assessed by the use of checklists, questionnaires or performance scales include adaptive skills, sensory integration, past and present life roles, balance of occupations, motivation, interests, locus of control and time structuring. Examples of assessments include: ■ The Bradford Wellbeing Profile (University of Bradford 2008) ■ The Mayers' Lifestyle Questionnaire (Mayers 2004), which was developed to enable people with enduring mental health problems to state their priority needs in terms of quality of life at the beginning of occupational therapy intervention ■ The Interest Checklist (Matsutsuyu 1969), which was developed to assess clients' interests in order to facilitate the selection of therapeutic activities that would evoke and sustain interest throughout the intervention programme ■ The Occupational Questionnaire (Smith et al. 1986), which was developed to enable a person to show their typical way of spending time on a working day or a non-working day. The questionnaire is designed to provide data about the client's habits, balance of activities, feeling of competence, interests and values, and to identify problems in any of these areas
Projective methods	Projective methods were developed as a method of assessing emotions, motivations and values, none of which could be measured with existing tools. Projective tests use standard stimuli that allow people to make their own interpretations. The theory behind them is that the person does not know what is expected (i.e. what would constitute a good performance) and therefore performs spontaneously. Occupational therapists generally use projective methods in two ways: 1. Creation of an object by the person, such as a painting; or presentation of a stimulus by the therapist, such as a poem, followed by a period of discussion in which the person is encouraged to express their feelings about the object freely. This is usually done in a group 2. Presentation of a series of standard activities to the person, assessing how they cope with them Projective methods are an appropriate method of assessment for occupational therapists because they involve doing as well as, or instead of, talking. Most of the projective methods used by occupational therapists involve a phase of creating, which can be structured or unstructured, and a phase of talking about the created object or free-associating about it. The method is used as assessment and as a form of intervention simultaneously, in that therapists help clients to accept projected material as their own and gain insight into how their own perceptions are formed. Examples of projective tests: ■ **The Azima Battery** is a typical projective method developed by an occupational therapist (Azima 1982). This utilizes three tasks: a free pencil drawing, drawings of a person of each gender and a free clay model. These are presented to the client in a standard order and method. The person is given a set period of time to complete each task ■ **The Goodman Battery** was developed from the Azima Battery and differs from it, in that the tasks given are progressively less structured, thus making it possible to assess cognition and ego functioning under decreasingly structured conditions. It was designed for use with young adults and adults experiencing psychiatric disorders. The four tasks in the battery are: copying a mosaic tile, spontaneous drawing, figure drawing and free clay modelling

Standardized Assessment

A standardized assessment is a reliable and valid tool which is standardized for a population. This involves establishing the performance of a similar group of people for comparison. The process is called standardization of results, or 'norm referencing'. Norm-referenced data are collected through a lengthy procedure that involves administering a reliable and valid assessment procedure to a large number of people who are matched for such factors as gender, age, cultural background and possibly disability. The results are presented as a numerical scale, representing the normal range of performance for that group. These can be compared with these typical, or normative, data. There is usually a clear, uniform procedure for using the test. This is called standardization of administration and is usually described in the test's manual; often training is required to learn how to administer the test. The Assessment of Motor Process Skills is a widely used standardized assessment in occupational therapy (Fisher and Bray Jones 2012), which requires occupational therapists to complete a training course before they can use it in their practice.

Non-Standardized Assessment

A non-standardized assessment is a tool that has not been norm referenced and does not required standardized administration. It may or may not have been tested for reliability and validity.

Whether using standardized or non-standardized assessments, the two most important considerations in ensuring accuracy of an assessment results are the assessment's reliability and validity.

Reliability

Reliability refers to consistency; if a tool is reliable its results will not be affected by when it is administered or who administers it. When using assessments or outcome measures occupational therapists want to be sure that the measure has one or more of the following:

1. *Test–retest reliability* involves checking that the same results will be achieved each time the tool is used. An occupational therapist will want to check that this procedure was conducted during a test's development so they can be sure the results of the tool reflect the person's performance and not some other factor, such as the time of day when the tool was conducted.
2. *Intra-rater reliability* involves checking that the same results will be achieved every time the same person uses it. This is important to an occupational therapist because they want to be sure their administration of the tool does not impact on the results, which should indicate the performance of the person being assessed and not their ability to administer the tool.
3. *Inter-rater reliability* involves checking that the same results will be achieved regardless of who administers the tool. This is important because an occupational therapist will want to be sure any results of a tool administered reflect the performance of the person being assessed and not the person administering the tool.

An occupational therapist can find out whether a test or procedure has reliability from its manual and/or from research articles, which have studied the test or procedure.

Validity

Validity refers to whether an assessment measures what it is intended to measure. Validation involves checking this: if we want to know whether a person is able to cook a meal on a gas cooker, there is no point in assessing the person's performance on an electric cooker. There are three main types of validity.

1. *Content or face validity* involves scanning the tool's content to see if it purports to measure what it is supposed to. It is a weak form of validity but a useful technique to use in clinical practice to make a quick judgement about whether a tool is likely to be useful or not.
2. *Criterion-related or concurrent validity* is a process of checking how the tool performs against other assessments (sometimes called gold standard assessments) or other accepted criterion. If research studies show a tool performs well this confirms it is an appropriate means of assessing people.
3. *Construct validity* involves examining, during the development of the tool, how far the assessment truly reflects the theories or hypotheses it is based upon. Again, if a tool has construct validity, it reassures the occupational therapist they are using an appropriate assessment.

If an occupational therapist wants to use an assessment as an outcome measurement as well it should at least be reliable and valid, if not standardized.

Utility

Utility indicates how practical a tool is for use in practice. It is another key issue to be considered alongside reliability and validity when selecting an outcome measure to use to assess a service user. This is because if the tool is cumbersome or time-consuming, for example, it will be difficult to integrate into everyday practice (Bannigan and Watson 2009).

OUTCOME MEASUREMENT

Outcome measurement involves the 'evaluation of the nature and degree of change brought about by intervention, or the extent to which a goal has been reached or an outcome has been achieved' (Creek 2003, p. 56). Change is measured by comparing assessment results before and after intervention; the difference between the two results is the amount of change that has taken place. An outcome measure therefore detects and measures change over time. This may include measuring against the planned or desired outcomes of intervention, but also involves ascertaining the actual outcomes of intervention. Changes measured may be specific, for example being able to make and maintain appropriate eye contact, or broader, for example, gaining employment.

Outcome measurement is tied into the development of a credible evidence base for interventions and their effectiveness. The overall aims of occupational therapy intervention include occupational participation, engagement, competence, satisfaction and balance. The measures occupational therapists choose and use should therefore reflect these aims, whether at a specific skill level or more broadly. The benefits of outcome measurement include:

- evaluation of the effects of occupational therapy intervention
- demonstration of progress
- modification of intervention plans for greater meaning
- elimination of wasteful or ineffective strategies
- planning future service developments
- predicting effects of intervention for the future
- providing evidence to support practice (Clarke et al. 2001).

Fuller (2011) has highlighted the lack of clinically based studies with evidence for the reliability and validity of outcome measures of occupational performance, such as the Canadian Occupational Performance Measure (COPM); Goal Attainment Scaling (GAS); the Occupational Therapy Task Observation Scale (OTTOS) and the Assessment of Communication and Interaction Skills (ACIS). More research is required in this area (see Ch. 9 for a discussion of research and evidence-based practice).

Types of Outcome Measures

Occupational therapists need to be aware of the different approaches to measuring outcomes: individualized; standardized; patient-reported; patient-reported experience; and clinician-reported or -rated outcome measures.

Individualized Outcome Measures

Individualized outcome measures compare a person's performance after intervention with how they performed before intervention, rather than judging performance against a norm. These measures are sensitive to small changes and to those which may be important to the person (Spreadbury and Cook 1995). For example, the Canadian Occupational Performance Measure (COPM) (Law et al. 1994) is designed to detect changes in the individual's own perception of their occupational performance over time and can be used with a wide range of people. Individualized outcome measures used by occupational therapists, include the Binary Individualized Outcome Measure (Spreadbury and Cook 1995); Goal Attainment Scaling (Ottenbacher and Cusick 1993) and the COPM (Law et al. 1994). Some individualized outcome measurement tools, such as the COPM, are scaled; that is, they produce a score on a numerical scale. However, the scale does not represent a normal distribution and cannot be used to compare one person's performance with another's; the person measures themselves against their own previously set goals, aspirations and expectations. The process of using an individualized outcome measure has four stages: goal setting, baseline

assessment, intervention and reassessment. This process can be carried out as many times as is needed for an individual to reach all their important goals.

Standardized Outcome Measures

Standardized outcome measures have been tested for reliability and validity with large groupings of particular populations. Scores for the population are published so that the results achieved from any assessment can be compared with the normal range for that population. For example, the Barthel Index is a standardized assessment of functional independence in personal care and mobility for older people (McDowell and Newell 1996). Standardized outcome measures used by occupational therapists include the Allen Cognitive Level Screen (Allen 1985) and the Assessment of Motor and Process Skills (Fisher and Bray Jones 2012). It is important that standardized assessments are used with the population for whom they are designed and that they are administered following the exact standardized procedures. Some tools require that a therapist is trained and certified before using them, to ensure correct use. If a standardized assessment is modified, used with people other than those it was designed for or administered in a way that deviates from the standardized procedure, the results will be invalid. When using standardized outcome measures, occupational therapists need to ensure they comply with the copyright conditions.

Patient-Reported Outcome Measures (PROMs)

This type of measurement is important in measuring the effectiveness of care from the individual's perspective. Often a Patient-Reported Outcome Measure (PROM) consists of a questionnaire related to the expected or planned goals of intervention. Alternatively, a PROM is a rating scale related to how the person feels at the time about the activities they need and want to do in daily life. PROMS are particularly useful for measuring progress related to subjective, personal change indicated by feelings and emotions, or quality of life. A positive PROM can simply be indicated by a person confirming that an aspect of their occupational performance has improved since participating in an occupational therapy intervention. An example of a specific occupational therapy patient-reported outcome is the Occupational Self-Assessment (OSA) (Baron et al. 2006).

Occupational Self-Assessment. The OSA is a two-part questionnaire used to help people identify their own occupational competence and how meaningful and important competence in particular performance areas is for them. It constitutes a list of 21 occupational performance items and 10 environment items, each of which an individual rates, according to how they perceive their abilities and how valued these activities are to them. Completion of the competency scoring initially allows the person to gain an understanding of the range of items covered in the assessment, before identifying the level of importance of these in relation to each other. The final step is for an individual to identify priorities for change, with or without assistance from the therapist, in order to then set collaborative goals/identify desired outcomes. Repetition of the scale gives an outcome measure of how an individual feels their competence has improved in each of the areas, and whether the individual perception of importance has altered (possibly due to a change in perceived competence over time).

Patient-Reported Experience Measures (PREMs)

This type of measure focuses on the person's experience of the care or service they have received, and again consists of personal opinion, often reported via questionnaires and comparison scales (verbal or written). Rather than measuring the change or improvement in symptoms, function or overall health and quality of life, measurement in this case tends to relate to elements such as the helpfulness of staff, choice, cleanliness, dignity and quality of food. As such, occupational therapists are unlikely to use generic measures that are used across services and professions, because unless the person is clearly focused on their experience of the occupational therapy service they received specifically, experience outcomes can be blurred and shared across services. Photographs of staff may be useful in tying ratings of experience to specific staff members and the service they delivered (and therefore to occupational therapy, if this is what they were delivering). Some services have begun working on incorporating PROMs and PREMs as a single measure (Gibbons and Fitzpatrick 2012). However these are more likely to be valid in measuring overall outcome and experience, providing broad information for service development, rather than on

person-specific change targeted at the smaller personal barriers each individual is experiencing.

Clinician-Reported/Rated Outcome Measures (CLOMs also ClinROs)

In occupational therapy, these are measures that are rated and reported by the occupational therapist or those supporting occupational therapy. Some standardized assessments in occupational therapy are clinician-reported, e.g. the Assessment of Motor and Process Skills (AMPS) (Fisher and Bray Jones 2012) and the Model of Human Occupation Screening Tool (MOHOST) (Parkinson et al. 2006). Non-standardized clinician-reported outcome measures can be problematic, as they have not been adequately tested for reliability and validity. They are subjective, being influenced by the values and beliefs of the person scoring.

Assessment of Motor and Process Skills. AMPS involves observation of specific standardized tasks in areas of personal or instrumental activities of daily living, identified as meaningful by the person being assessed. It allows a measure of overall performance of chosen tasks, but also the quality of an individual's motor and process skills, for example do they demonstrate increased clumsiness, decreased efficiency, need for assistance, increased physical effort or safety concerns/risk. In total, 16 motor and 20 process performance skills are scored and used to influence occupation-focused goal-setting and intervention planning.

Selecting a Measure

The use of outcome measures relates to the measurable element of goal-setting (see Chs 4 and 6 for further discussion on goal-setting), but the choice of measure is dependent on what the individual and their therapist wish to measure. Some outcome measures are simple, in that if, for example, a person has a goal of returning to full-time employment within 6 months, this can be measured by whether they have or have not done so. However the process of achieving something, such as returning to work, is far more complex. Smaller elements may be monitored and measured to indicate progress towards the broader goal.

The process of selecting an outcome measure starts with the initial screening, where the individual and the occupational therapist decide whether occupational therapy is indicated. As the occupational therapy process continues, the therapist should carefully consider the assessments they are using: to identify barriers to occupational performance at the level of skill, task, activity or occupation that are compromising the person's ability to meet their goals. The use of an outcome measure as part of assessment provides the baseline against which to measure later in the occupational therapy process.

A Practice Example

A chef, who has been in an accident which has affected his occupational performance across all domains, might identify his occupational goal as 'to return to work in a restaurant'. He may be aware that there are areas for improvement which need to be worked on prior to that being possible. The occupational therapist helps identify barriers to achieving that goal, e.g. reduced confidence and increased anxiety around others; perceptual disturbance; motor coordination difficulties; reduced motivation to get out of bed; reduced ability to cut vegetables; difficulty monitoring timespans for activity completion; problems turning up at expected times; difficulty keeping a uniform clean and remembering to bring it to work. The chef and occupational therapist collaboratively plan interventions to achieve the chef's occupational goal through achievement of smaller goals. These address the identified barriers through interventions which may include; confidence-building, skills training, perceptual adaptations, memory strategies and other interventions. Priority areas to be worked on first are identified collaboratively.

Different measures may be required to assess, monitor and review these smaller, interim goals. Outcome measures in this example may therefore relate to getting out of bed every day by a certain time, or may perhaps take the form of measuring improvement of skills. For the former, basic checklists and charts may be most useful, and for the latter, a standardized observational outcome measure such as AMPS. Occupational therapists need to be clear in their identification of occupational barriers through assessment. This is because, unless planned interventions target the areas which require change, there is little to be achieved from either continuing or trying to measure the change.

Use of Multiple Measures

The use of multiple outcomes measures may be necessary when more than one goal is set, or when one goal is set but there are several occupational barriers to meeting that goal and interventions are required at different levels to achieve this, for example skill (or body function), task, activity and occupation. The therapist formulates problems at different levels, as: occupational imbalance; occupational performance deficits; activity limitation; task performance problems; or skills deficits.

Measures across all these areas may be used and can be used individually or simultaneously as required, as during the occupational therapy process the therapist shifts the focus of attention from occupation, to activity, to task, to skill and back again. This shift of perspective happens many times during an intervention (Creek 2003). Just as the use of one type of intervention does not have to come before the other in a linear fashion, different measures can be used alongside each other, as long as they are valid, i.e. truly measure what is expected to change. It is not effective to measure range of movement related to dressing, when the main barrier is an ability to make choices.

Outcome-Based Goal-Setting

Having agreed on the areas of function that the individual wants to or needs to improve and the priorities for intervention, the therapist works with the individual to set goals for meeting the identified needs (see Ch. 6). It is important that the desired outcome of the intervention is clearly formulated and recorded in the goals set. They may need to be expressed on different levels, from developing skills, through performing tasks and engaging in activities, to performing occupations and enabling social participation. The relationship between goals and outcomes is described in Chapter 3 and the process of goal-setting is outlined in Chapter 6.

SUMMARY

This chapter has explored the assessment and outcome measurement stages of the occupational therapy process. Assessment is an integral part of skilled intervention, not a series of separate stages, and outcome measurement allows the changes made as a result of this intervention to be made explicit and demonstrable. Consideration of outcome measurement begins during assessment and continues throughout intervention planning and delivery. This should be borne in mind when reading Chapter 6, which is focused on planning and implementing interventions.

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6 PLANNING AND IMPLEMENTING INTERVENTIONS

SONYA McCULLOUGH

CHAPTER CONTENTS

INTRODUCTION

Building on Chapter 4 and Chapter 5, which focused on the assessment stage of the occupational therapy process, this chapter continues with the next stage of the process: planning and implementing interventions. The initial assessment has already been completed and the occupational therapist and service user are ready to identify the individual's needs, skills and priorities in order to set goals for interventions (see Fig. 6-1). (It may be helpful to read this chapter in tandem with Chs 4 and 5.) Just as with the assessment process, the planning and implementation process involves 'art and skill'. Occupational therapists adapt how they use their therapeutic skills with each individual; using theoretical knowledge, as well as their experience, when planning, implementing and evaluating interventions. Depending on the service user's occupational needs, the occupational therapist encourages and motivates

*Sections are taken from Creek and Bullock 2008.

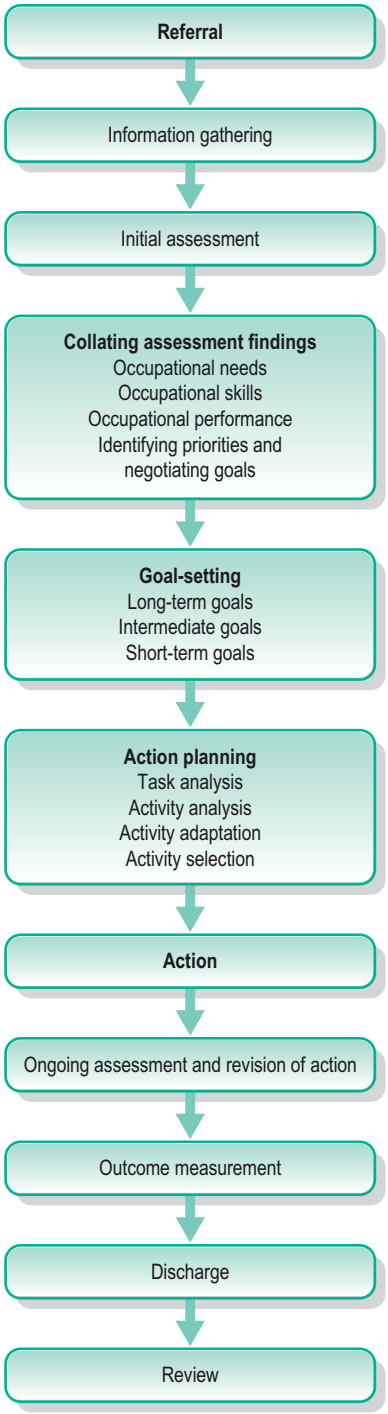

FIGURE 6-1 ■ The process for planning and implementing interventions. *(Adapted from Creek and Bullock 2008, p. 110.)*

the service user to foster engagement using, for example, listening skills, therapeutic use of self, personal qualities and role modelling.

COLLATING THE FINDINGS FROM THE ASSESSMENT PROCESS

The occupational therapist identifies the service user's needs by examining the findings of the assessment to gain a clear understanding of the problems the individual is experiencing. During the assessment process, service users are encouraged to look at their current and future situations. The service user is the one who knows how their mental illness impacts on their life, their abilities and difficulties and what has helped in the past. To analyse the assessment information, the occupational therapist organizes it into strengths, skills (positive aspects) and problems. By discussing the assessment results with the service user, the occupational therapist assists the service user to gain insight into their skills and limitations, which promotes self-discovery and respects their right to direct their own intervention.

Needs, Skills and Occupational Performance

An individual will only require occupational therapy intervention if their occupational performance levels have changed due to mental illness. When an occupational therapist is working with a service user to identify their problems, it is best not to focus on their clinical diagnosis. The mental illness is only one aspect of a person, and they may, or may not, find their diagnostic label helpful. Knowing a diagnosis may mean the therapist 'anticipates' or sets inaccurate expectations of the likely problems relating to the diagnosis; adversely affecting the therapist's ability to see the service user as an individual.

Each person requires a range of skills in order to be able to perform their occupations. Lack of skills or insufficient competence in skills, can lead to the individual being unable to perform activities that will support them to take ownership of their recovery and achieve their personal goals. (There is further information about life skills in Ch. 19.) The occupational therapist uses the assessment findings to establish whether, or not, the individual has achieved an adequate level of competence and skills in the past. The individual's current occupational skill level is determined to identify what skills they will need to learn, or re-gain, to help them to engage in self-care,

productivity and leisure activities. The assessment highlights the skill areas that must be developed if the service user is to fulfil their occupations.

Setting goals for achieving these skills is the next step in the intervention process. Complex problems can be analysed in different ways, using a variety of theoretical perspectives. For example, a service user who has a problem with establishing and sticking to a routine during the day and week could be viewed as having:

- an occupational performance problem: coping with stress when doing new activities
- an activity limitation issue: limited knowledge of local resources to support engagement in meaningful activities
- a task performance problem: confidence to engage in new activities
- a skills deficit: poor problem-solving skills.

Once the therapist and the service user have agreed on how the problem(s) will be addressed, the occupational therapist will record what has been agreed and document the consent to treatment (see Chs 7 and 10 for information about record-keeping and consent, respectively).

Identifying Priorities and Negotiating Goals

The occupational therapist negotiates with the service user to identify which problems they perceive to be the most important. The service user may avoid areas in their lives they feel are too hard or challenging to face. Using the rapport they have built with the service user, knowledge about their past, and present issues, the occupational therapist can use assertive communication skills to support the service user to prioritize the practical issues being experienced. Within the initial stages of therapy, it can be overwhelming for the service user to focus on all of their problems. The occupational therapist supports the individual to focus and facilitates their thinking by:

- asking the service user what is important to them
- exploring further how each problem affects their daily life
- what their family and friends may see as the main problems
- what they see as the main problem
- what would make their current situation more positive; easier to function within and less stressful.

The occupational therapist uses problem-solving skills and creative thinking to support the service user to break down the problems into smaller, more manageable problems to focus on initially. Through this process, the occupational therapist encourages the service user to focus on their skills, strengths and achievements, to make a balanced assessment of their abilities and problems. Occupational therapists need to support the individual to:

- negotiate goals that are realistic and will meet their desired outcomes of intervention
- focus on their recovery goals
- develop an accurate picture of their occupational functioning.

GOAL-SETTING

A goal is a written or spoken statement about particular achievements, plans or tasks that are to be achieved in the future. Setting goals enables the service user to move from vague ideas of what they want, to more concrete aims in order to effectively manage a problem, need or desire. The service user and the occupational therapist work collaboratively; the therapist may provide more support and input at the start. As the process develops, the service user will be encouraged and supported to take more responsibility. Lack of insight or unrealistic goals can be challenged by the therapist focusing on attainable goals and reinforcing the positive outcome that could be achieved. The therapist needs to ensure the goals do not overestimate the individual's potential, as this could lead to frustration, or underestimating the individual, as this will limit the potential for skill development. Goals that are both challenging and achievable provide the service user with the opportunity to develop skills at a higher performance level.

Documenting Goals

Goals are written with the service user, to guide the therapeutic process. Goals are written in language free of jargon, using the service user's language, so they can understand the purpose of the therapeutic interventions. The SMART formulation, i.e. specific, measurable, attainable/achievable, relevant/realistic and timely, is often used to document goals (see Table 6-1).

TABLE 6-1
Two Examples of SMART Goals

Example 1	
Vague goal	Annelies wants to learn to cook a meal her Mum would make
SMART goal	Annelies is going to use the cookery group to plan and prepare a meal that she would have at home with her family within the next week
Example 2	
Vague goal	Vickie wants to take her children to the movies
SMART goal	Vickie is going to take her children to the movies once within 3 months

Goals are written in terms of 'change statements' and indicate timeframes in which they will be achieved. Having a timeframe helps the occupational therapist to monitor change and provides the service user with clear expectations on how they will reach the goal. If there is no timeframe, the service user may become bored or frustrated with therapy sessions and disengage. The service user and therapist monitor progress by assessing change and analysing the outcome of therapy sessions referring to the original goal.

Goals are set according to what therapeutic interventions are achievable in the available time. Not all of the service users' goals may be achievable within the timeframe. For example, when working with a service user experiencing an acute crisis, the timeframe will be short (i.e. days and at most weeks), compared with a service user with a severe mental illness, which could mean up to 3 years (or more) of occupational therapy intervention. Goals are usually set on two or three levels, i.e. long-term goals, intermediate goals and short-term goals. Given the importance of goal-setting, these are now discussed in more detail.

Long-Term Goals

Long-term goals are the overall goals of intervention and the service user is supported to look at long-term goals by focusing on future aspirations, dreams and personal life goals. When working with service users on their long-term goals, the expectation is for the service user to return to previous occupations and explore other activities that support social inclusion; restoring meaningful roles and responsibilities within their local community. The role of the therapist is to support and encourage the service user to work towards achieving their long-term goals, providing opportunities for personal growth, maintaining hope and positive expectations for the future. To assist the service user to find meaning in their life and a positive identity, long-term goals should be focused on the individual building a life beyond their illness, by having more control of their illness and life.

The intervention phase is designed in-line with the service user's long-term goals, which are part of a

CASE STUDY 6-1

Setting Long-Term Goals with James

James, a 28-year-old man, with a diagnosis of schizophrenia, lives alone in a flat. He has a history of using illegal substances and disengaging from services. James has been unemployed for several years, but has worked as a labourer on building sites in the past. He has had several relapses since he was first diagnosed, at the age of 19. James's relapse triggers were difficulties with money or benefits not being paid, being isolated and having difficulties with his neighbours. These things led to non-compliance with medication, which had an impact on his symptoms and made his voices worse, which led to more drug and alcohol use, sometimes resulting in a period of hospitalization. In the community, his routine is chaotic and James is supported by the Assertive Outreach team. James was admitted to a rehabilitation unit after a period on an acute inpatient ward. Assessment was carried out to explore James's strengths and what areas were limiting his ability to engage in occupations. During this current episode of mental illness, James experienced problems with focusing on tasks, difficulties with motivation, maintaining a meaningful routine through engaging in productive and social activities, self-care and personal hygiene. The occupational therapist spent time with James building rapport and finding out what his personal aspirations and dreams are for the future. James spoke about his time working as a labourer on the building sites and how much he enjoyed the work. With support, James wrote down his long-term goal to become a qualified builder by completing the carpentry course at his local college within the next year.

wider programme that may also involve other disciplines. Occupational therapy goals need to be shared with others involved in the service user's care.

Intermediate Goals

Intermediate goals may be clusters of skills to be developed, attitudes to be changed or barriers to be overcome on the way to achieving the long-term goals of therapy. The timeframe for long-term goals may mean it would take several months or years for the service user to achieve the desired outcome. To help the service user to see that their hopes and aspirations are achievable, long-term goals are broken down to intermediate goals. Intermediate goals focus on several skills, such as motivation to engage in activity; developing meaningful routines and roles or modifying their social and physical environment. This allows the service user to gain an awareness of how long-term goals can be achieved. The smaller goals are steps towards the accomplishment of the longer-term goals and developing a sense of personal responsibility.

An episode of an acute phase or relapse of a mental illness can impact on the ability of the service user to focus on their hopes and dreams for the future. The service user will be able to accept responsibility and control of their recovery if goals are based in the 'here and now'. Intermediate goals might focus on engaging in meaningful activity, such as artwork three times during the week; going to their local gym twice a week; going out with a friend or writing in their reflective diary. Three main factors determine what the intermediate goals should be:

1. The service user's wishes
2. Any barriers to performance that need to be overcome, for example, motivation and anxiety in leaving their home environment to engage in daily activities
3. The advantages of learning skills in a developmental sequence so that higher-level skills are built on lower-level skills.

Short-Term Goals

Short-term goals are the small steps on the way to achieving long-term and intermediate goals. The short-term goal is usually to learn a sub-skill, or skill component, of the adaptive skill that is needed for successful occupational performance (Mosey 1986).

CASE STUDY 6-2

Setting Intermediate Goals with James

James is also a keen sportsman and enjoys football. Using James's strong interest in football and his desire to become a builder, the occupational therapist worked with James to set intermediate goals. James agreed to break the longer-term goal of becoming a builder into more manageable goals. James wanted to engage in football in the local community. This was broken down into two goals.

1. James will compile a list of local community football groups over the next 2 weeks.
2. James will attend one of these groups within the next month.

Attending the groups in the community independently will help James develop his confidence and social skills for work. James agreed that he needs to find out more information concerning becoming a builder and regain his building skills. James set a goal to attend the local community college to find out about carpentry courses and apprenticeships and complete the application form. He also planned to engage in voluntary work in his local community that would help him to use his past skills learnt on building sites. Once the goals were agreed by James and the therapist, these were written down and a date was set to review progress in 8 weeks.

Short-term goals are organized into sequence, with the most basic goal to be tackled first. Short-term goals are used to help individuals gain a sub-skill or skill component of an activity, to allow immediate gratification. This will support and focus the service user's motivation on achieving intermediate and long-term goals. To encourage and support motivation during therapeutic intervention, short-term goals need to focus on skills that will be meaningful for the service user and have a positive outcome. The skill component chosen by the service user should be broken down into a sequence of smaller steps that meet the current level of occupational functioning of the individual, to ensure it is manageable and achievable. Short-term goals should be reviewed regularly and can be modified during any point of the process of intervention to meet the occupational needs of

the service user. Once the short-term goals have been agreed, a programme of activities that will lead to their achievement is planned. Knowledge of activity analysis and synthesis enables the therapist to identify, or modify, activities to incorporate all the skills, personal factors and environmental factors that will best bring about change.

Strengthening the Goal-Setting Process

The goal-setting process can be strengthened by supporting service users to:

- explore ways they can motivate themselves to work towards their goals, for example creating celebration and reward rituals to amplify and sustain success
- increase their motivation and ongoing commitment by providing continued support through feedback after sessions
- set goals that are activity related
- maintain motivation by identifying improvements in occupational performance
- regularly re-visit goals to make adjustments or changes to the goals according to their current occupational needs.

Attach measures to the goal, so the service user and the therapist are able to determine when it has been reached. For example, a woman with severe anxiety and social phobia has the overall aim of feeling less anxious among other people. Her immediate goal is to be able to walk into a room with people in it and not to feel anxious. The performance marker she identifies will enable her to tell when the goal has been attained to a standard that is satisfactory for her. For her, the performance marker may be to be able to walk into a room and initiate a conversation with someone within the first 10 minutes.

CASE STUDY 6-3

Setting Short-Term Goals with James

During the 8-week period, James felt his mental illness was impacting on his motivation to carry out tasks and engage in activities. James's first intermediate goal was to engage in meaningful activities during the week, to help structure his week and improve his motivation by attending groups on the ward. James wanted to improve his communication skills, so he set a short-term goal that within the next week he was going to take the role of delegating tasks in the cooking group on the ward. As his motivation grew by attending therapeutic groups on the ward, James became more confident and was able to interact. This contributed towards his goal to attend a community football group independently and engage in voluntary work.

PLANNING INTERVENTIONS

Once goals have been documented, the service user and occupational therapist continue to work collaboratively to develop an intervention plan. The responsibility is shared, so the individual can start taking ownership and control of their recovery. The aim of the intervention plan is to identify meaningful activities that will support and encourage the service user to re-engage in activities to help accomplish their goals. This can involve individual and/or group work and may involve carers, if the service user consents to this, and other professionals when appropriate.

The skill of the therapist is to help the service users identify activities that are at the right level of challenge, to make it possible for them to succeed and reach their full potential. Activities can vary from simple to complex; for example meal preparation can vary from making a sandwich to planning, organizing and preparing a birthday meal for a family member. Within this process, the therapist will think about what skills are required during the performance of the activity, and how activities can be adapted to meet the skill level of the service user. This process is called 'task analysis' and it helps to identify the sequence of steps before carrying out a detailed activity analysis (this is discussed later in the chapter).

The planning of interventions is not a linear process. It is an ongoing process of reassessment, evaluation of outcomes, discharge planning and reviewing and evaluating the overall programme; so it can be modified when necessary. It is essential to communicate with other team members and professionals involved in the service user's care, to keep them informed of the purpose of the occupational therapy intervention and desired outcomes. Once the interventions have been agreed, they will be documented in the care plan, alongside the goals already documented, to articulate what will happen during therapy sessions.

Designing the Programme of Therapeutic Intervention

Activity as a form of therapeutic intervention is central to occupational therapy practice and is used to secure changes in occupational function (Finlay 2004). The intervention programme needs to be managed in partnership between the occupational therapist and the service user. Consideration should be given to the location and time of therapy sessions, and is negotiated between the service user, occupational therapist and other services involved. This takes into account:

- When the service user feels more alert and confident
- The impact of medication
- When energy levels are higher
- Fitting in around other daily routines and roles
- Making sure it does not impact on other activities the service user engages in during the day or week
- Time factors involved, such as setting up and preparing for the therapy session
- Risk management, to reduce the chances of any untoward incidents, while still allowing for positive risk-taking.

The intervention programme needs to be focused and led by the service user's occupational needs and goals, and the format should be chosen accordingly. Group intervention is selected when the occupational therapist is able to identify other service users with similar occupational needs and goals. They must have all agreed they would like to engage in a therapeutic group session to achieve their goals.

Choice of Activity

Negotiating with the individual about what activity they want to engage in, will allow positive choice and sustain engagement to encourage recovery to take place. Many factors influence the occupational therapist's suggestions for the activity to be used in interventions, e.g.

- motivation, interests, meaning of activity to service user
- occupational needs
- abilities and skills
- service users' values
- what is personally or culturally important to the service user
- how it relates to goals
- how it relates to their environment and future life, e.g. recovery orientated
- grading activity to current skill level, working on particular skills using/activity analysis and/or task analysis
- the therapist's knowledge and skills, and the activities that are available
- pragmatic considerations – the possibility of leave being granted according to the Mental Health Act (2007); resources including budget constraints within the department; time, money the service user has available and staffing numbers.

When the service user is unable to identify activities they would like to engage in to help achieve their goals, the therapist will need to be both imaginative and realistic when suggesting activity options. This may include:

- exploring activities the service user has recently engaged in, in their home environment or in the community
- past activities that have been of interest or allowed an experience of personal success
- activities that have motivated or provided a sense of achievement
- suggesting cultural activities
- using the internet, or magazines, as an information sources
- interest checklists
- spiritual experiences, such as scripture, prayer, attending places of worship, accessing online religious resources or singing songs.

The therapist will not always have the experience of, or skills in, a particular activity chosen by the individual. To ensure the activity is successful, the therapist may need to carry out further research or learning, to understand the skills and steps involved in the activity, to help with the activity analysis (this is discussed later in the chapter).

Environment

Consideration of the service user's environment is essential. Occupational therapists need to provide opportunities to engage in self-care, leisure and productive activities in the environment that best meets the service

user's needs to encourage a positive outcome. They also need to consider any environmental constraints related to where the activity will take place (in the service user's home, local community or in hospital). Once this has been established, the next step is to explore what physical adaptations are needed; the type of room; seating; noise; light; how many people the space can accommodate and the social environment. By adjusting the physical environment, or creating the optimum social environment, the service user can be facilitated to achieve independence, safely. When using local non-mental health community facilities, which should be done as often as possible, any community environments selected for intervention need to be welcoming and make the service user feel valued. This helps to develop supportive social relationships and positive social links and networks, which aid in deceasing social isolation. Other factors that influence the extent to which someone engages in an activity are motivation, volition and autonomy.

Motivation (Creek and Bullock 2008, p. 119)

Motivation is 'a drive that directs a person's actions towards meeting needs' (Creek 2010): it has been described as the energy source for action (du Toit 1974). Motivation can be extrinsic or intrinsic. Extrinsic motivation is 'the drive to avoid harm and meet needs' (Creek 2007) and intrinsic motivation is 'the drive to act for the enjoyment of exercising one's capacities, for learning and for taking pleasure in activity' (Creek 2007). Everyone has motivation, or a drive to be active, but people choose to do different things. The capacity to make choices about what to do is called volition.

Volition (Creek and Bullock 2008, pp. 119–120)

Volition is 'the action of consciously willing or resolving something; the making of a definite choice or decision regarding a course of action' (*New Shorter Oxford English Dictionary* 1993). It has been defined for occupational therapists as 'the skill of being able to perceive and work towards a goal through choosing and performing activities that will achieve desired results' (Creek 2007). Some of the factors that affect people's choices of action include:

- **Interests** – the 'individual's preferences for occupations based on the experience of pleasure and satisfaction in participating in those activities' (Kielhofner 1992, p. 157)
- **Personal goals** – the results that the individual wants to achieve by his actions
- **Values** – the individual's 'personally held judgement of what is valuable and important in life' (Creek 2003, p. 60)
- **Awareness of own capacities** – the ability to predict one's own effectiveness in a given situation
- **Meanings** – the significance or importance that an activity has for the person performing it (Creek 1998). These include the personal associations that it has for the individual and wider socio-cultural meanings
- **Nature of the choices available** – this will depend on what the environment can offer but also on the individual's ability to access an activity. For example, there may be a local cinema but a person cannot choose to watch a film if they do not have enough money
- **Knowledge of what activities are available** – the individual can only choose activities that they are aware of
- **Knowledge of how to access different activities** – it is not enough to know that an activity is available, the individual also has to know where it is, how to get there and the conditions for taking part
- **Capacity to see opportunities for action** – some activities are not available all the time, so it may be necessary to know when they can be accessed. For example, it is usually necessary to enrol for adult education classes during a particular week of the year
- **Information on which to base choices** – as can be seen from the last three points, a person needs information about what activities are available, how to access them and when they can be done.

The therapist can create conditions for the service user to exercise volition by suggesting activities that have meaning and value for the service user, giving sufficient information about what is available and providing opportunities for them to practise making real choices. Even if someone is highly motivated and able to choose a course of action, there will be times when they are unable to do what they want due to circumstances. This can mean that their autonomy is compromised.

Autonomy (Creek and Bullock 2008, p. 120)

Autonomy is 'the capacity to think, decide, and act on the basis of such thought and decide freely and independently and without … hindrance' (Gillon 1985/1986, p. 60). The ability to make and enact choices rests on three types of autonomy:

- **Autonomy of thought**: being able to think for oneself, to have preferences and to make decisions
- **Autonomy of will**: having the freedom to decide to do things on the basis of one's deliberations
- **Autonomy of action**: the capacity to act on the basis of reasoning.

Autonomy is not an 'all or nothing' condition; different people have varying levels of autonomy and it can vary for the same person at different times. For example, when someone feels low in mood they can find it more difficult to think clearly or to make decisions. Conditions that may affect a person's autonomy include personal circumstances, environmental barriers and social pressures (Creek 2007). Within the therapeutic environment, the therapist creates conditions that allow the service user to exercise autonomy. However, it is also important to identify barriers within the service user's own environment and to help them find ways of addressing the barriers.

CONTEXT OF THE INTERVENTION

There are many elements that can influence the outcome of an intervention, such as the service user, peer support, a focus on recovery, the occupational therapist's skills, occupation-focused practice and case management. These need to be considered when planning and implementing interventions.

Service User

At the start of occupational therapy intervention, the service user may take a passive role, and want or expect things to be done for them, while others flourish when they are given information, skills and support to manage their mental health and take responsibility for their own recovery process. The individual can be motivated by the occupational therapist not focusing on the service user's illness and symptoms and helping them identify their strengths, dreams and instilling hope for the future. This can be achieved by the therapist supporting the service users to tell their story through the use of creative activities. Engaging in creative activities alongside the individual, the occupational therapist can use this encounter to develop a relationship, experience enjoyment and allow the opportunity for the service user to express their thoughts and feelings in a relaxed and comfortable environment.

A service user referred to an occupational therapist within a mental health team may not have any previous experience of mental health services, or they may have been in contact with services for several months or years. Their past experience of mental health services may influence their expectations of what will be provided and what is expected of them. Service users with a long history of mental illness may have experienced more paternalistic approaches to their care, where mental health teams had lower expectations and assumed service users needed assistance and staff to 'take control'. To overcome this challenge, the occupational therapy interventions will need to emphasize working alongside the service user, sharing responsibility and encouraging active engagement in their recovery. This will allow the service user to see how their personal recovery can be enhanced by them having more active control over their life. There are different ways in which this can be achieved, for example peer support and adopting a recovery focus.

Peer Support

A peer support worker is someone who has lived experiences of mental health problems, who works alongside service users to help facilitate recovery through promoting hope and providing support based on common experiences. Employment of peer support workers in mental health services is rapidly growing in many countries such as the US, Australia, New Zealand and the UK. Peer support can range from informal peer support, service users participating in consumer- or peer-run programmes, and the employment of service users as peer support workers within traditional mental health services (Repper and Carter 2011). Peer support is founded on core values, such as empowerment; taking responsibility for one's own recovery; the need to have opportunities for meaningful life choices, and valuing the lives of people with mental health problems as equals. Peer support encourages a wellness model that focuses on strengths, hope for

the future at all stages of mental distress, and recovery, rather than an illness or medical model. Service users may feel more open to discussing their thoughts or behaviour with peer support workers rather than professionals. As service users may benefit from peer support (McLean et al. 2009; Repper and Carter 2011), this is something that occupational therapists should consider when planning interventions.

Focus on Recovery

Recovery is about discovering – or re-discovering – a sense of personal identity, separate from illness or disability (see Ch. 2). It should be an integral part of planning and implementing interventions. Accessing useful information, peer-led support groups, self-help groups and self-help tools (available as internet-based or hardcopy written resources) can help develop a service user's confidence in negotiating choices and taking increasing personal responsibility through effective self-care, self-management and self-directed care. The service user can be encouraged to narrate their story and be supported in starting their own recovery plan, through using recovery planning tools. Examples of recovery tools that can help guide and support recovery are the Mental Health Recovery Star (http://www.mhpf.org.uk/programmes-and-projects/mental-health-and-recovery/recovery-star) or the Wellness Recovery Action Plan (WRAP) (www.mentalhealthrecovery.com). Family and other supporters are often crucial to recovery and they should be included as partners wherever possible, with the service user's consent. The service user can be supported to move away from mental health services and access local community organizations to help them develop confidence, self-acceptance, self-esteem, reclaiming power and experience the feeling of belonging, cultural, social and community identity.

Occupational therapists need to envisage recovery as a process rather than an end-point to promote the development of hope and optimism. They also need to acknowledge and work with people's strengths, talents, interests, abilities, dreams, aspirations and limitations. To aid an individual's recovery, the occupational therapist can assist in identifying meaningful goals and provide support to best manage their illness through engagement in meaningful activities. One of the areas the occupational therapist can focus on, when supporting the recovery of people with a mental illness, is reducing social isolation. This is done through activity-focused interventions that help move the service user in the direction of fuller participation in their local society, to increase social integration and social inclusion (Lloyd et al. 2008). Barriers to participation in activities that can impact on mental health recovery, can come from internal sources (lack of skills) and external sources (limited peer support, environment, negative social and cultural attitudes, lack of occupational choice and opportunity). Occupational therapists can take a lead role in decreasing exclusion and developing health and mutually beneficial partnerships with organizations in the wider community. This can break down the current barriers and for people with mental health problems to be recognized for their talents.

The Occupational Therapist's Skills

The experience and skill of the therapist also influence which intervention techniques are used. When occupational therapists graduate, they have been taught basic skills and therapeutic interventions within a range of different services. The more skills the occupational therapist has in their repertoire and the more theories they are able to draw on, the better able they will be able to work in a person-centred way and respond to an individual's needs and environmental demands. The stages involved in developing expertise were identified in a study by Benner (1984) (see Box 6-1). During the process of planning and implementing interventions some therapists will base their practice on their practical or technical skills, while others will use theory and models to direct their practice. With experience the therapist will begin to work in a non-linear way through each stage of the therapy process (Creek 2007). The occupational therapist will combine thinking about the situation, problem solving and analysing the activity, negotiating with service users and relevant others to decide what action needs to be taken.

Supervision can support occupational therapists to develop their own skills, to further their learning and support them to develop their professional identity within a team. Supervision should be provided regularly by an occupational therapist with a greater knowledge and experience to help support development, share information and give advice in

BOX 6-1

THE STAGES INVOLVED IN DEVELOPING EXPERTISE

- **Novice** – the novice or beginner will depend on theory to guide their practice and have limited experience within their chosen practice. They will follow rules and find it difficult to take into account individual differences; they will only be able to describe textbook examples or known solutions to problems.
- **Advanced beginner** – the practitioner has started to develop real practice situations to recognize patterns, behaviours and the complexity of a problem or task. Their confidence will start to grow and they will be able to adapt to change, be flexible and creative when understanding a service user's occupational needs, and prioritize issues. They become more adept at predicting multiple outcomes and coping with changing conditions.
- **Competent** – the practitioner will use both situational thinking, prioritizing concerns and procedural aspects are more automated. The therapist will start to see their actions and interventions in terms of long-term goals. Goals determine which aspects of the situation are considered most important and which can be ignored. They are organized and efficient and have a sense of being able to cope. They work comfortably within rules, protocols and standardized procedures.
- **Proficient** – the practitioner will start to pull things together, perceive situations as whole rather than aspects or patterns. Interventions are compared with a range of similar experiences that practitioner has had; anything unusual is immediately noticed and dealt with. They are able to respond flexibly to changes in situations.
- **Expert** – the practitioner will be quick and intuitive, able to criticize and re-evaluate decisions. They have developed the ability to be flexible, organized, broadminded, honest and assertive. They no longer rely on rules, guidelines or models, as they are able to draw on the broad range of their own experience to sum up the situation and focus on the problem. They respond to changes without conscious thought. This can only be gained from practical experience.

(Adapted from Benner 1984.)

recommending further actions and/or alternative perspectives. Continuing professional development is used by occupational therapists to develop and keep their skills and knowledge up-to-date. This is essential to provide safe and best practice for the people they work with (see Chs 7 and 9 for more information about continuing professional development and evidence-based practice, respectively).

Occupation-Focused Services

When planning and implementing interventions, the occupational therapist is occupation-focused. Occupation-focused services aim to enable people to increase participation in activities that help them to gain control and manage their mental illness in their everyday lives (Townsend and Christiansen 2010). The occupational therapist will use activity as the primary intervention for therapy within a variety of settings, including local gyms, libraries, shops, schools, the work environment and hospitals. The main focus needs to be on the service user's occupational needs and how activity can enable them to improve their occupational performance in everyday life. While occupational therapists will be involved in the assessment and planning of activity-focused interventions, implementation of the interventions may be carried out by support workers within services, from the voluntary sector or support workers employed by the team or support workers. Occupational therapists can face challenges when implementing an occupation-focused service into their everyday practice. Pressure to complete paperwork and coordinate the individual's care to meet the standards set by their organization, can limit face-to-face contact with the service user and distract occupational therapists from their core purpose.

Team Working

Occupational therapists can experience different constraints and situations, which influence their practice. This can include the number of therapy staff within the team, time constraints, resources, therapeutic environment, expectations and demands by the team manager and other professionals. It is useful for the therapist to gain an understanding of the role of each member of the team and their specialist skills. This will help the therapist access and make referrals to other professionals within the team for assessment and intervention according to the requirements of the service user.

Understanding the role of occupational therapy within the team, will help the therapist to build confidence and ensure the service is meeting the needs of the service users. Developing the occupational therapy role will take time and energy to ensure the service user's

occupational needs are being met. Occupational therapists can explain their role in a team during case reviews; informal or formal education sessions; presenting case studies, using outcome measures and a strong evidence-base wherever possible. Regular and open communication with managers and the multidisciplinary team and using preceptorship, will help the occupational therapist develop the occupational therapy service.

Occupational therapy interventions can be difficult to implement without the support of other professionals. It can be time consuming and a struggle if the multidisciplinary team are not supporting the occupational therapist to support service users to engage in activities. This can be overcome by the therapist working alongside other team members and developing relationships to encourage team working. Over time, the occupational therapist can influence the team's way of working with service users, by developing a shared vision around the importance of activity to support recovery. They can support other team members to engage in activity with service users by supporting the team to look at their skills and interests and encourage them to use these during an activity intervention. Occupational therapists may need support through supervision or mentors to implement these changes.

Case Management and Care Coordination

An approach to organizing mental health services in the UK is care coordination. This can involve occupational therapists working as a case manager or care coordinator (see Ch. 22). In this role, the occupational therapist puts the service user at the centre of the decision-making process and service provision. Within this role, the occupational therapist takes on the responsibility of overseeing and coordinating services, ensuring access to services and managing the resources required by the service user. They may work directly with the service user to provide therapeutic activity interventions to support social inclusion and help them to take control of their recovery. The role may mean they do not provide direct therapeutic intervention but manage and coordinate other members of the team, such as support workers or other agencies to deliver the intervention. The role also includes monitoring the effectiveness of interventions, appropriateness of community services that are involved and the overall progress and ongoing needs of the service user.

Generic skills are involved when taking on a care coordinating role, such as:

- medication monitoring
- mental state examinations and assessment
- crisis management
- risk management and assessment
- linking service users with community resources
- organizing regular case reviews
- completing case management paperwork.

When working as a care coordinator, occupational therapists may find their focus compromised when trying to deliver occupational-therapy-specific interventions. Research has shown that attempts to balance both a care coordinator and occupational therapist role can result in stress, pressure on time, role blurring and role erosion for the occupational therapist, as well as it potentially having a negative impact on the opportunity to provide occupational therapy for service users (Culverhouse and Bibby 2008). To enable an occupation-focused service, it needs to be valued as part of the essential work of the case manager, not as a luxury. This can be achieved by defining occupational therapy as a separate intervention from care coordinating and other generic tasks. Using outcome measures can help to demonstrate the effectiveness of occupation-focused interventions or to provide evidence of the value of occupational therapy (Parkinson et al. 2009). People with mental health problems experience a range of occupational needs and it is essential that occupational therapists have the time to assess, plan and implement activity interventions to address these needs.

In this section, some of the factors that the occupational therapist takes into account when planning which activities to use to achieve therapeutic goals have been considered. The next step in the process of implementing interventions is to carry out a task analysis to identify the sequence of steps.

TASK ANALYSIS (Creek and Bullock 2008, p. 114)

All activities are made up of steps or tasks that are performed in sequence. Discovering the task sequence of an activity is called 'task analysis'. For example, in making a clay pinch pot, the tasks are:

- Cut an appropriately sized piece of clay
- Wedge the clay

- Shape clay into a ball
- Push thumb into clay
- Pinch the clay to the required thickness all over
- Smooth the inner and outer surfaces
- Add any embellishments or decoration
- Leave to dry out before firing.

Any one of these steps could be analysed into a further series of tasks: for example, there is a sequence of steps involved in wedging a ball of clay. Task analysis is carried out for a purpose, and the extent to which an activity is analysed into smaller and smaller tasks will depend on the purpose of the analysis. If a person has very specific difficulties, it may be necessary to carry out a detailed task analysis to isolate the precise problem. On the other hand, if the therapist is analysing a fairly simple activity in order to teach it to a service user, it may only be necessary to identify the main steps of the activity.

Task analysis may be carried out in order to:

1. Select an appropriate teaching method for an activity, for example, backward chaining (teaching the last stage of the task first, so that the therapist carries out most of the activity and the service user completes it)
2. Select an appropriate activity to meet a therapeutic aim
3. Adapt an activity to meet service user needs by changing or eliminating a step
4. Identify the precise part of an activity a service user is having difficulty performing.

The therapist needs to be cautious about concentrating on a single step in the sequence of actions that make up an activity. The service user should be given opportunities to practise whole activities, rather than single tasks because 'performance does not occur normally in a step by step approach but rather as an integrated continuous flow of behavioural performance. Failure to provide practice in the whole sequence may result in halted, awkward performance' (Reed and Sanderson 1992, p. 174).

ACTIVITY ANALYSIS (Creek and Bullock 2008, pp. 114–115)

Activity analysis is 'a process of dissecting an activity into its component parts and task sequence in order to identify its inherent properties and the skills required for its performance, thus allowing the therapist to evaluate its therapeutic potential' (Creek 2003, p. 49). An activity can be analysed for all its component parts that come within the domain of the occupational therapist. Mosey (1986) called this the generic approach and pointed out that there is no universally accepted framework for doing this. An alternative approach is to study only those components that are relevant to the model or frame of reference being used, for example, activity analysis within a psychodynamic model focuses on the psychological functions and psychosocial interactions involved in performing an activity (Katz 1985).

The format presented here is a generic one that was developed from several different frameworks (Fidler and Fidler 1963; Llorens 1976; Mosey 1986; Hopkins and Tiffany 1988).

Activity analysis also includes any potential for adapting the activity in order to allow for change in the service user. Grading allows the service user to move on to the next goal once a skill has been mastered. Grading may involve a gradual change in the nature of the activity by changing one or two components, or a complete change of activity to allow the opportunity to feel enjoyment and satisfaction. Grading an activity provides the opportunity for service users to increase their motivation and self-efficacy through positive experiences, while engaged in activity. As an example: the goal is to bake a cake for a family member's birthday. This activity can be graded as follows:

1. Start with a baking recipe that only has a few steps. The therapist can select and gather all the ingredients and equipment, and then support and prompt when needed to keep the individual safe.
2. Use the same or similar recipe with only a few steps, encourage the individual to select and gather the ingredients and equipment from the kitchen and encourage problem-solving by limiting support and prompts during the activity.
3. Attempt a birthday cake recipe, including the buying of ingredients from the shop. The individual selects and gathers the equipment. No prompts or support should be required.

Analysing an activity enables the therapist to:

- understand the demands the activity will make on the service user, i.e. the range of skills required for its performance
- assess what needs the activity might satisfy

- determine the extent to which the activity might inhibit undesirable behaviour
- determine whether or not the activity is within the service user's capacity
- discover the skills that the activity can develop in the service user; these may be specific skills, such as threading a needle, or more general transferable skills, such as reading
- provide a basis for adapting and grading activities to achieve particular outcomes.

ACTIVITY ADAPTATION (Creek and Bullock 2008, p. 115)

If the physical or social environments are presenting barriers or restricting the ability of the service user to engage in their chosen activities, the occupational therapist will need to focus on how they can modify or adapt the environment or activity. The environment could include community places, their workplace, home environment or hospital. The therapist and service user together identify those activities that have the greatest potential to achieve the desired outcomes. For example, if the service user's main goal is to improve his general fitness, they may decide that walking is the most appropriate activity to begin with. Alternatively, activity components may be combined into new activities that will better achieve the desired goals. This is called 'activity synthesis'. For example, the service user's secondary goal may be to find a part-time job, so the therapist suggests that he walk to the library every day to look for jobs in the newspapers. An activity may be adjusted or modified to suit the service user's needs; this is called 'activity adaptation'. For example, if the service user is not fit enough to walk to the library and back, he could take the bus for part of the way.

An activity can be adapted in stages so that it becomes progressively more demanding as the service user's skills improve, or less demanding as the individual's function deteriorates. This is called 'activity grading'. For example the service user can walk more of the distance to the library each week as their strength and stamina improve.

Activity sequencing can be used as an alternative or adjunct to activity grading. *Activity sequencing* means 'finding or designing a sequence of different but related activities that will incrementally increase the demands made on the individual as her/his performance improves or decrease the demands as her/his performance deteriorates' (Creek 2003, p. 38). For example, as the service user feels more confident about their fitness, they could join a walking group, or take up swimming, cycling or dancing.

The elements in an activity that have potential for change to enable adaptation and grading are:

- The materials and equipment used (media)
- The environment, including other people involved
- The method of carrying out the activity.

These three dimensions can be manipulated to achieve the desired therapeutic result. For example, the activity of taking the bus can be made easier by using a bus timetable (equipment); going with a friend or family member for support (environment) or going on the bus for two stops (method). Taking the bus can be made more demanding by buying a bus ticket online (equipment), going on the bus independently (environment) or going on a bus trip to a different town (method).

ENGAGEMENT

As well as using the skills of task analysis, activity analysis and activity adaptation in planning and implementing an intervention, the occupational therapist needs to explore, with the person they are working with, barriers and facilitators to engagement. (These are discussed in detail in Ch. 11.)

Barriers to Engagement

Barriers to participation in activities can come from 'internal sources' (mental illness, motivation issues, lack of skills, low self-esteem, low confidence, negative experience in the past) and 'external sources' (limited peer support, environment, negative social and cultural attitudes, inadequate services, stigma, family – over-supportive or no support, negative social culture attitudes to mental illness, lack of occupational choice and opportunity). Due to internal and/or external sources, service users can find it difficult or refuse to engage in a planned activity session. Occupational therapists need to recognize when an individual's illness is hindering the service user's ability to engage in activity, rather than their personal, economic and social resources restricting or when their decision may be reasonable.

Facilitating Engagement

During the implementation process, occupational therapists can experience situations when service users refuse and/or are not willing to engage in the planned activity session. When an occupational therapist faces this challenge, they can use a variety of techniques to facilitate engagement, i.e.

- focus on what is important to the service user; their needs and goals
- rely on the rapport and relationship built-up during the assessment and planning stage of therapy to reinforce the value of occupational therapy and how engaging in the planned activities will support them to achieve their goals
- consider using one of the manifold techniques available, such as not giving up hope, positive reinforcement and education.

CASE STUDY 6-4

Facilitating Engagement

Jody, a 40-year-old woman who has a diagnosis of schizophrenia, lives with her parents who have a traditional view of mental health and see her as having a learning disability. Her parents have low expectations of what she is capable of doing around the house and what she can achieve in her life. Jody's current routines are fixed and restricted and her activities of daily living have always been done for her by her parents. There are barriers impacting on Jody's ability to engage in independent living skills:

- Internal sources: low self-esteem and confidence
- External sources: living environment, limited role within the family home as her parents carry out the entire daily tasks, as they felt she did not have the skills or capability due to her mental illness.

To overcome the barriers and make positive changes for Jody, the occupational therapist worked alongside Jody and her parents. The occupational therapist provided education surrounding recovery and schizophrenia and included the parents when working alongside Jody, to set goals. Through the close working relationship with Jody and her parents, Jody was given the opportunity to make her own choices to develop skills and to take care of herself.

There may be times when an occupational therapist has to work with service users who have been in the mental health system for many years. This can be challenging if the service user has had negative experiences, which means they have, '*done it all before*', '*done it a million times before*', '*been there, done it*'. An occupational therapist can support services users to look at their current difficulties and explore if past skills they have learnt will help overcome their problems or what stops them using these skills. Family members and friends can also add extra encouragement and support, although this may not always be helpful, so it is best to check with the service user who they want involved in their care.

EVALUATING INTERVENTION

Throughout therapeutic interventions, evaluation and assessment is ongoing in order to gauge progress towards agreed goals (see Ch. 5). Modifications can be made to the activity intervention in response to the evaluation process. The documented goals may need to be adapted, changed or new ones written to meet the current occupational needs of the service user. Evaluation is a fluid process and should be used at each stage of therapeutic intervention. Further assessment may be considered by the therapist, if gaps in the occupational needs of the service user are identified. If the needs identified are best met by other services or professionals, referrals to these other agencies should be completed and this should also be documented in the notes.

Case Reviews

As well as ongoing evaluation, occupational therapy case reviews are planned to take place at agreed review dates. They are planned during the goal-setting process and the dates are booked. The review involves the service user and the therapist exploring what changes there have been to occupational performance, what goals have been achieved and what barriers were observed that limited progress. Feedback from family, friends and staff can be helpful to establish how the intervention has impacted on the service user's occupational performance and can be used to reflect on the progress of the service user. If needed, the intervention plan can be re-negotiated with the service user, focusing on new short- and/or long-term goals.

Discharge Planning

Discharge planning begins at the start of intervention, and continues throughout, with the occupational therapist and service user identifying activity interventions that will improve the service user's occupational functioning. If the individual is in hospital, discharge planning will involve supporting the service user to return to their home and local community. Throughout the intervention, reference should be made to discharge, with discussion becoming more explicit as the service user approaches the end-point in the intervention. The way in which an occupational therapy intervention ends is as important as how it begins, if a service user is to gain maximum benefit from the experience. The ending of therapy input should not be unexpected. When therapy interventions have been completed or at the end of occupational therapy involvement, discharge will be explored and planned with the service user. During this process, the occupational therapist and service user will determine together whether the service user has any on-going needs and the therapist will make recommendations and liaise with others in mental health services, such as care coordinators, and/or other agencies.

SUMMARY

Planning and implementing intervention in the occupational therapy process incorporates several stages. The occupational therapist and service user cooperate using the assessment findings to gain insight into the service user's current skills and limitations. Through this knowledge, they establish what skills the service user will need to learn or regain. Goals are documented to help the service user increase ownership of recovery and help to create aspirations, dreams and hopes for the future. Meaningful activities are a powerful therapeutic tool that is used within therapeutic interventions to improve engagement in self-care and productive and leisure activities. Engagement in meaningful activity can support a service user to gain control of their recovery and re-kindle hope. The occupational therapists use their unique perspective of activity analysis and skills assessment to assist in identifying activities to foster motivation, sustain engagement and allow opportunities for skill development. Occupational therapists need to consider how they can support service users to take an active role in their personal recovery, through the use of peer support and recovery tools. Gaining support from team members and managers to balance the role of case management with the use of activity as the main form of therapy, will allow occupational therapists to make a significant contribution to the range of interventions available. Occupation-focused services can provide service users with hope for a better future, through engagement in activity that allows them to develop or regain life skills, to work towards having meaningful and satisfying lives.

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Section 3 ENSURING QUALITY

7 PROFESSIONAL ACCOUNTABILITY

CLARE BEIGHTON ■ BOB COLLINS

CHAPTER CONTENTS

INTRODUCTION

Over the last century occupational therapy has developed into an autonomous healthcare profession (WFOT 2007) whose associated professionals are afforded the privilege to 'exercise judgements for the benefit of others' (Ilott 2008, p. 178). With professional autonomy, however, comes accountability and all occupational therapists are personally accountable for their professional work (COT 2011). They are responsible for their actions, need to be able to justify their decisions, and accept the consequences for any misjudgements (College of Nurses of Ontario, n.d.). Set in the context of trust, this chapter explores what it means for occupational therapists to be professionally accountable in practice.

What is Professional Accountability?

Simply deconstructed, the term accountability is the ability to give an account of something; to describe or document an action or event. Associated dictionary definitions include the term to 'bring to account', meaning to give reason or justify what has been done. Professional accountability can therefore be understood to be the evidence of, and justification for, provision of services under the scrutiny of others. Traditionally, a democratic public has been able to put their trust in professionals with an expectation that they will do their job well for the benefit of others, or at the very least they will not take advantage of, deceive, or exploit others. In her lectures about trust, O'Neill (2002) questions whether modern society is undergoing a crisis of trust in which professionals are no longer deemed to be trustworthy and there is an

expectation for professionals to continually provide evidence of their actions. In the current economic climate, there is growing pressure to show effectiveness, to provide indicators of performance and to reach targets. Failing public trust has also brought about an urge to make services more transparent; for professionals to publish facts and figures and make information widely accessible through media and technology. Where there is greater transparency, however, there is greater risk of a breach or abuse of confidentiality, or misinformation and deception.

The consequence of all this is accumulating public mistrust, which leads to sanctions that make government, professionals and institutions ever more accountable. The increase in stringent measures to scrutinize, control and reach managerial targets has created a culture of bureaucracy, which inhibits the performance of the professional and hinders their ability to do the job itself. 'Professionals … must in the end be free to serve the public rather than their paymasters' (O'Neill 2002, p. 5). For occupational therapists, there are rising expectations to fulfil processes of accountability which jeopardize therapeutic time with those they serve, thus threatening the fundamental philosophy of person-centredness which should underpin practice. This chapter describes some of the accountability processes that impact on the working lives of occupational therapists in mental health practice and explores ways in which they can adhere to demands for performance and audit, but also stay true to the real work of the profession, providing an efficient, effective and acceptable face-to-face intervention in service users' lives.

National Standards

Wherever in the world occupational therapists work; whether it is in healthcare, social care or non-traditional, role-emerging settings (Harrod 2007), they will be subjected to fluctuating and evolving working environments (Creek 2003). However many institutional changes they have to endure they are still expected to continuously provide excellent and effective services. To help them reach those high expectations of care, their duties are based on a set of published guidelines.

The World Federation for Occupational Therapists (WFOT) places responsibility for competent, ethical and professional behaviour on each of its associate country's lead professional organizations. Any authority that has not developed standards for practice in occupational therapy is expected to follow those of the WFOT (2007). Membership countries of the Council for Occupational Therapy in European Countries (COTEC) are all obliged to have a Code of Ethics and Professional Conduct to ensure excellent, safe and equitable services are provided, with the best interests of the public they serve at heart. 'An overall mission of the Code of Ethics is to promote high professional standards and quality in occupational therapy practice based on person-centred or user-oriented principles and social responsibilities' (COTEC 2009, p. 9).

Professional accountability will be illustrated in this chapter, by focusing on the systems used to regulate occupational therapists working in the UK. The Code of Ethics and Professional Conduct, published by the UK College of Occupational Therapists (2010a), is used extensively in this chapter to highlight the professional standards that UK occupational therapists are expected to abide by. This code will be similar to codes of conduct published in other countries (albeit expressed slightly differently, perhaps) For non-UK readers, if the precise detail of the UK code is not applicable, the underlying principles undoubtedly will be. Hence, this chapter is suitable for students and occupational therapists across the globe.

TO WHOM ARE OCCUPATIONAL THERAPISTS ACCOUNTABLE?

The issue of who occupational therapists are accountable to is complex and multifaceted. Ultimately, and most importantly, occupational therapists are accountable to the society they serve. The public have rarely questioned the care they receive from healthcare providers and fundamentally believe that, because they are seeing a professional, they will receive a good service. However, this perception has shifted and a few notorious cases in the UK have epitomized the crisis of trust. On the basis that they were 'trusted' professionals, nobody suspected family doctor Harold Shipman, or the nurse Beverly Allitt, of killing their patients.

These cases prompted more stringent legislation for professional registration in the UK. The legislation intended to protect members of the public and reassure them that appropriate systems were in place to detect and deal with the malicious minority (DH 2004).

Unfortunately, these systems have since failed to protect the public from unacceptable risk and maltreatment, as was the case at Mid Staffordshire NHS Trust. The failings went far beyond a few malevolent individuals and the whole trust fell into a business culture striving for foundation status, instead of a culture that put patients first (Francis 2013). This epitomizes the danger of prioritizing paymasters over individuals and prompted occupational therapists in the UK and beyond, to reconsider their professional responsibilities and revisit relevant ethics and standards guidelines published by their regulating bodies (COT 2013).

Society

In the UK, occupational therapists are now regulated by the Health and Care Professions Council (HCPC). The title 'occupational therapist' is protected by law (COT 2010a) and can only be used by those registered with the HCPC. Originally set up in 2001 as the Health Professions Council, and recently reconfigured as the HCPC, this body keeps a register of health professionals who meet a set of standards for health, training, professional skills and behaviour. In order to register, an accredited course must be completed and standards maintained for continued registration. Occupational therapists are also accountable to wider society via the criminal justice system. If a criminal offence is committed they are subject to criminal justice proceedings and could be tried in a criminal court (COT 2011). Indemnity insurance is used to protect occupational therapists from the personal financial cost of this, but the outcome of proceedings may be that an individual is struck off the HCPC register. The UK Code of Ethics and Professional Conduct, though not legally binding, can be used as evidence in any civil or criminal proceedings as a measure of reasonable and acceptable practice. It would be difficult to put up a defence against allegations of negligence if these standards had not been followed. Similarly, it would be difficult to substantiate a claim of unfair dismissal before an employment tribunal if an employer could establish a persistent failure to meet these standards.

Employers

Occupational therapists are accountable to their employers and must work within the terms and conditions of their employment and job description. If they do not, they could face disciplinary proceedings or dismissal. The UK Department of Health has produced a knowledge and skills framework (KSF) - which staff employed by the NHS are required to work to - in order to regulate service quality (DH 2004). The core dimensions require all staff to demonstrate certain standards in communication, development, safety, improvement, quality and diversity. Professionals employed in posts with higher profiles are expected to take on higher levels of proficiency and responsibility; to handle diverse data and work with complex information, to collaborate and develop working relationships, to work safely, and successfully assess and manage risk. Employers will expect occupational therapists to make critical evaluations of outcomes, be able to reflect and review practice, be able to solve problems, have excellent interpersonal skills in order to relate sensitively to others and have an aptitude to learn and undertake self-improvement (HCPC 2013; Higher Education Academy 2008). Employers will also expect employees to keep up-to-date with mandatory training requirements which may include:

- Fire training
- Moving and handling
- Infection control
- Basic life support
- Conflict resolution
- Safeguarding adults
- Child protection
- Data protection.

Employers produce local policies to ensure employees work within the framework of national legislation and staff training is just one standard by which NHS services are governed to ensure high standards (see Box 7-1).

Any frameworks implemented to improve practice will, in principle, raise standards, but, as discussed in the introduction, there may be a conflict between employers' expectations for undertaking accountability

BOX 7-1
CLINICAL GOVERNANCE

In the UK, the National Health Service (NHS) has developed a regulatory structure called 'clinical governance'. It is defined as 'a framework through which National Health Service organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish' (DH 1998, p. 33). It is an umbrella term that includes working in partnership with service users, carers and the public, to develop and deliver services, manage risk, audit services, ensure services are effective, are based on the best available evidence and ensure that staff are recruited and managed effectively. Healthcare organizations have always had to be financially accountable but with the emergence of clinical governance (DH 1998) came the responsibility for the safety and quality of services. The Health Act (DH 2009) made it a statutory duty to produce an annual Quality Account, which reports to the public about the quality of services delivered. Essence of Care (DH 2010b) aims to support this quality improvement by providing a set of benchmarks to help practitioners identify and share best practice and to develop action plans to remedy poor practice. Although these systems were developed to regulate the NHS many other providers in the UK use them to monitor the quality of their services.

processes (driven by management priorities) and a professional practice in keeping with occupational therapy values and beliefs. In practice, these accountability processes may detract from person-centred working because more time has to be spent in training and governance obligations. (Savage and Moore 2004) which seem only to serve paymasters needs for the purpose of continued commissioning or as defence against a litigious society which no longer has trust in professionals. By maintaining the core values of their profession, occupational therapists should look to training in order to maximize the quality of their service and involve people in the governance process, in order to improve their experience of it (Jones and Stewart 1998).

The Profession

There is an argument that occupational therapists are accountable for what makes their profession unique, particularly in an era where practice is orientated to recovery (Deegan 1988) and more open to influence from the service user movement (WHO 2010). Occupational therapists strive to be person-centred; working 'with' people, rather than 'for' them (Creek 2003). There is a sense in which occupational therapists should uphold what makes the profession unique. In 2006, the UK's College of Occupational Therapists (COT) produced 'Recovering Ordinary Lives', a ten year strategy aiming to reassert the profession's belief that occupation is core to health and wellbeing. 'No Health without Mental Health' (DH 2011) is the UK Government's 10-year mental health strategy. The COT response to this document states 'Occupational Therapy (OT) looks at the person as a whole and takes a personalized approach to recovery; helping patients to get back to work, maintaining social and personal identity, and increasing participation in all areas of life' (Scott 2011). The Code of Ethics and Professional Conduct (COT 2010a) provides occupational therapists with an accountability framework upon which to base professional standards and behaviours, while remaining person-centred and staying true to occupational therapy values. The code is divided into the following sections:

- Service user welfare and autonomy
- Service provision including risk management and record-keeping
- Personal and professional integrity
- Professional competence and lifelong learning
- Developing and using the profession's evidence base.

These headings have been used to structure discussion over the rest of this chapter.

SERVICE USER WELFARE AND AUTONOMY

Once a therapeutic relationship between a member of the public and a professional has been established, the professional takes on responsibility to ensure the wellbeing of that person. First, someone's ability to make decisions, in other words their mental capacity, should be assessed. Capacity should be assumed unless proven otherwise and is considered for each individual situation. If a person is deemed to lack capacity, action should be taken in their best interests and in the least restrictive way (Mental Capacity Act 2005) (see Ch. 10 on Ethics, for a wider discussion

on mental capacity). When someone is referred to an occupational therapist, it is then important to obtain informed consent for assessment and for further interventions. Gaining consent is not a one-off event but an ongoing process and individuals should be aware that they can refuse intervention at any time (COT 2010a). It is not about signing a piece of paper or giving verbal consent on one occasion only but, as in decisions about capacity, gaining consent is considered for each context.

As far as possible, individuals should be able to make informed decisions about the therapeutic activities they want to engage in. Occupational therapists working in mental health may find times when people lack motivation to engage in an activity because they perceive they will not get any satisfaction from it. For some individuals, the thought of engaging in an activity is worse than the experience of actual engagement (Gard et al. 2003) and therefore it is avoided. It can be difficult to ensure that people are given enough information to make choices about activities, particularly if they are feel overwhelmed by psychiatric symptoms (Gaitskell 1998). After all, how can people make informed choices when they have no *experience* to base their choice on?

CASE STUDY 7-1

Informed Choice

An occupational therapist works within a long-stay rehabilitation environment. The people she works with have been living within an institution for many years and may have been 'forced' to attend industrial therapy units. They have never been able to explore other activities they may have enjoyed nor make informed choices about what activities they want to engage in (O'Brien and Bannigan 2008). The occupational therapist needs to offer a wide variety of activities and use her skills to encourage people to sample these, so that they are able to make informed choices in the future. A individual's refusal to participate may not be due to their dislike of the activity. It could, instead, simply be a result of how they are feeling on that day. The occupational therapist needs to be patient and persistent, without being coercive, and keep offering opportunities.

SERVICE PROVISION

The service provided by occupational therapists will always be structured around the occupational therapy process; from referral and assessment, to planning, implementation, review and discharge. Creek (2003) offers a more detailed breakdown of this process - presenting occupational therapy as a complex intervention - but the idea of an ongoing cycle of reflection on the therapeutic process and negotiation with people, remains constant. Occupational therapists have a responsibility to ensure that they provide a fair and equitable service in accordance with the law in their country and the Human Rights Act (1998). Many services use referral criteria to assess the need for occupational therapy and prioritize the workload in order to maximize resources. The reality is that occupational therapists work within finite resources and there may be times when service demand exceeds the capacity to meet it. For example, in a given week - when, perhaps, there are staff shortages due to sickness or study/annual leave - there may be such a large volume of referrals to the service that not everyone can be seen in a timely way. In a different week, even with staff at full capacity, there may be more referrals who meet the high priority criteria and those lower down the priority list may not be seen quickly enough. In each situation, those with lower-priority needs may have to wait longer for therapeutic intervention so it is important that decisions are as fair as possible and can be justified against documented criteria. The Occupational Therapy Referral Priority Checklist (Cratchley et al. 2004) is one such document that can be used to screen referrals. It may also be made available in order for people to make sense of any decisions that affect their access to care. This is a good example of transparent decision-making. Consideration may need to be given as to how transparency is achieved, as care records will only document decisions about individual interventions and not service management decisions. A poster displayed in accessible areas may be an appropriate way of publicizing how referrals are prioritized. However, as suggested in the introduction, efforts to provide transparent information can be counterproductive as it can breed suspicion and mistrust (O'Neill 2002). Rather than providing open access information to the public, it may be better to justify decisions discretely to individuals on a needs basis.

A common dilemma for occupational therapists working in mental health, particularly those who are employed as case managers or care coordinators, is that high priority is often given to service users who are assessed as presenting a high risk. Where significant risk is identified, it may be challenging for therapists to find a way of working with individuals on issues other than risk minimization; issues related to people's occupational needs and quality of life, for example. The following section about risk management suggests possibilities to optimize occupational participation, despite risk.

Risk management

Risk management involves identifying potential hazards or negative incidents and providing adaptive strategies to reduce the likelihood of these occurring, or minimizing harm caused if they do (National Risk Management Programme 2007). Occupational therapists are accountable to the systems designed to ensure that any risks are identified and reduced wherever possible, in keeping with a duty of care to the people they serve and the general public. For example, they have a duty to safeguard children and vulnerable adults with whom they come into contact and need to ensure that abuse is recognized and dealt with effectively. Another important system for those working in mental health in the UK is the Mental Health Act (1983, amended 2007), which is the law designed to assess and treat people in the interest of their own or others' health and safety. Inevitably, despite attempts to manage risk, incidents do occur and both public and staff will at times be exposed to risk. Therefore, many organizations will have systems for recording incidents and near misses and staff should be clear about what to report and when, in order to identify trends and disseminate information so that practice can be changed to improve safety.

The National Patient Safety Agency (2008) published a version of a widely recognized risk management tool for use in the NHS. The five-by-five matrix requires risk to be defined and the seriousness of the outcome ranked on a 5-point scale: negligible, minor, moderate, major or catastrophic. Then, the probability of the incident occurring is established using a 5-point scale: rare, unlikely, possible, likely, probable and almost certain. On the basis of the subsequent colour banding (see Fig. 7-1) and referring to published criteria (National Patient Safety Agency 2008), it is possible to determine what action should be taken if the incident happens, what action can be taken to prevent an incident, and whether risks can be accepted. If the outcome is very serious and it is very probable that the incident will happen, it will need to be given a high priority in terms of allocating resources. This method is used in many professions and industries and could be used to reduce both clinical risks, such as a service user self-harming in an occupational therapy session, and non-clinical risks, such as the spillage of a hazardous substance.

CASE STUDY 7-2

Monitoring Adverse Events to Reduce Risk

A group of occupational therapists working in mental health services for older people had participated in the organization's incident reporting system since its inception. Whenever an incident or near miss occurred, they filled in a report and submitted it to the risk manager. Once a month, they received information that summarized the incidents that had taken place. This was reviewed in the monthly occupational therapy meeting, so that consideration could be given to how risks could be reduced, both in terms of one-off incidents and regarding any emerging trends. Between February and April, there was an increase in the number of incidents reported in the occupational therapy garden. There were four reports of service users stumbling on the way out to the greenhouse, and one report of a service user falling over in the same place. Further examination of the reports revealed that the reason for the falls was a patio slab that had become raised during the hard frost to create an uneven piece of ground. As a result of this analysis, a requisition was put into the works department and the slab was re-laid to make the ground even again. Consequently, there were fewer incidents and near-miss reports in May, and no service users were reported to have stumbled or fallen on the patio. To ensure that this risk did not occur in other parts of the organization, the Risk Management Department circulated a memorandum highlighting the risk and asking managers to check patio areas.

Likelihood by consequence risk matrix

	Likelihood				
Consequence	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
1 Catastrophic					
2 Major					
3 Moderate					
4 Minor					
5 Negligible					

FIGURE 7-1 ■ Likelihood by consequence risk matrix. *(Reprinted with kind permission of National Patient Safety Agency 2008.)*

Positive and Defensive Risk Management

In mental health settings, where there are perceived high levels of risk, professionals might be inclined to spend a great deal of time completing risk assessments to ensure they are not accountable if a risk incident did occur. Worse still is the scenario where all possible risk situations are avoided and a negative cycle of defensive practice occurs. Following any major untoward incident, media hype and closely scrutinised practice can provoke fear among the public and management, which can lead to reduced staff confidence and their becoming more risk averse (Morgan 2000). It is important to find a balance between ensuring safety and providing opportunities for people to engage in occupations that promotes health and wellbeing. A cycle of defensive risk management (National Risk Management Programme 2007) that leads to occupational deprivation (see Ch. 3) may increase risk levels and should be avoided. A risk management approach which engages the person in a collaborative process provides a more positive experience and reduces risk because strategies for risk management are sought and implemented. This can then lead to further collaboration and reduced risk.

Positive Risk-Taking

There are comprehensive clinical risk management tools available for use in specific situations, such as *Clinical Risk Management: A Clinical Tool and Practitioner Handbook* (Morgan 2000), for use in acute services, crisis intervention and longer-term community mental health teams (obtainable from the UK's Centre for Mental Health www.centreformentalhealth.org.uk). This tool encourages a positive approach to risk-taking by identifying how the individual is at risk and how a problem can be tackled (Strong 2001). It promotes risk management as a dynamic process and supports considered risk-taking as a means of producing positive outcomes. Weighing up potential risk with potential benefits and deciding what is an acceptable risk is as important as minimizing harmful consequences of risk; see Fig. 7-2.

An alternative version of the risk matrix, as proposed by the authors in Fig 7-2, emphasizes to practitioners that risk taking can lead to potential benefits and not just harmful consequences. When considering an intervention, if the probability of a risk incident occurring is reduced by positive risk management and the likelihood of there being major therapeutic benefit to the person is increased, then the intervention can be justified, despite the risk. (See Case study 7-3.)

Record-Keeping

Good reporting enhances the collaborative process to produce efficient and effective services (Hammerton et al. 2002) and record-keeping is fundamental to professional practice care. 'The key purpose of records is to facilitate the care and support of the service user' (COT 2010a, p. 19). Care records can include any medium that contains information collected as part of an individual's care provision. Recorded material may be handwritten, electronic,

Likelihood by benefit risk matrix

	Likelihood				
Benefits	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
1 Astronomic					
2 Major					
3 Moderate					
4 Minor					
5 Negligible					

FIGURE 7-2 ■ Likelihood by benefit risk matrix (authors interpretation of Figure 7-1).

auditory or visual, and may include letters, notes, emails, and copies of text messages (COT 2010b). All occupational therapists must follow local and national legislation with regard to record-keeping. In mental health in the UK, the Care Programme Approach (CPA) (DH 2008) provides a framework to assess need, plan care and undertake reviews to ensure needs are being met.

Reports should provide a full, precise and justifiable account of what interventions are planned and delivered (COT 2010b) and, in the UK, teams should adhere to national guidelines. Written notes should be accurate, legible, updated after each contact and contemporaneous; that is, written as soon after the event as possible (COT 2011). Some local policies maintain that best practice is to record notes within 24 hours of an event. Notes should clearly identify the person's name, date of birth, any identifying reference if used (this is the NHS number in the UK) and be chronological, clearly indicating a date and time. It is also good practice for records to be written with the service user in terms they can understand, without any over-complicated terminology or confusing abbreviations (COT 2010b). For example - in the authors' experience - electronic communication has used the term 'lol' which different individuals took to mean 'laugh out loud', 'lots of love' and (more offensively) 'little old lady'. Thus, most occupational therapy services avoid abbreviations altogether, although some will allow them in accordance with local policy that has a list of accepted abbreviations included within the notes.

Records should provide an account of the assessment, the intervention planned, the interventions provided and the arrangements for continuing contact. It is often useful to link interventions to the care plan so it is clearly seen how interventions aim to address the person's needs. Best practice also suggests that people's care records demonstrate that care is based on evidence; this is a particular requirement in insurance-funded health systems (DH 2010a). Also the person's views and any action taken responding to their needs, including any information provided, explanations given or warnings delivered should be recorded. It is useful to base care records on a clear structure, for example 'SOAP' notes use the headings Subjective, Objective, Analysis and Plan to ensure all elements of good record-keeping are included (Borcherding 2000).

In the UK, although there are no laws specifically addressing record-keeping, there are several pieces of related legislation, as follows.

- The Data Protection Act (1998) relates to how records should be kept.
- The Freedom of Information Act (2000) is related to people's right to access their records (unless they include third-party information or disclose information which is harmful to the person).
- The Access to Health Records Act (1990) is for relatives of deceased patients.
- The Human Rights Act (1998) because people have a right to complain about how they are treated and records may be cross-referenced as evidence.

CASE STUDY 7-3

Positive Risk-Taking

A man detained on a mental health ward under the Mental Health Act (1983) had assaulted another patient and was subsequently denied leave. The following week his risk behaviour escalated and there were several other incidents of physical abuse to staff and patients on the ward. Staff became fearful of him and avoid any contact with him, and he continued to be denied leave for fear of unpredictable behaviour in the community. His lack of opportunity to engage in any meaningful activity on and off the ward contributed to a further deterioration of his mental health and the cycle of risk, fear and occupational deprivation continued. During the initial assessment on the ward, the occupational therapist had ascertained that the young man had been a keen rock climber. The occupational therapist discussed this with him and they agreed this would be something to work toward. During the multidisciplinary team meeting, the occupational therapist suggested that she could take him to a local climbing wall. The team thought that this would be unsuitable due to his mental state and unpredictability, but the team agreed this would be a good goal to work towards. A plan was agreed to engage the man in other activities on the ward and take a graded approach to building up escorted leave. Over the next few weeks, the young man's behaviour was less destructive and his escorted leave went well. The occupational therapist undertook the necessary risk assessments and took the decision that the benefits of a focused physical activity in a controlled environment outweighed the potential risk involved. The man was granted leave to go with the occupational therapist to the climbing wall and the activity was a success. Sessions continued on a weekly basis until the man was well enough to go home, where the activity continued with the community team.

Therefore, record-keeping is one of the most important elements of professional accountability, not only to the individual but also to the legal framework, particularly if records are called upon for legal proceedings, in which case a rule of thumb would be 'if it isn't recorded then it didn't happen' (Lynch 2009, p. 50).

> *An adequate medical record can be defined as one that enables you to reconstruct consultation without reference to memory. It doesn't mean that you need to write every detail but when you come back to look at the record you should be able to identify exactly what you would have done and said at the time.*
>
> ***(Hegan 2004, p. 44)***

Keeping records is an expected part of working practice, but staff often complain that the amount of record-keeping they undertake makes it feel like a purely bureaucratic exercise (Moss 2008). As discussed previously, it can seem as if the majority of practitioners' time is spent undertaking accountability processes for the benefit of the organization. However, it should be borne in mind that these processes are in place to benefit and protect the public. Occupational therapists need to keep their person-centred philosophy in mind and make all records relevant and pertinent to individuals' needs. Both formal records and informal notes (for example, those taken during a home visit, in a case discussion or made in a diary) will contain information that should be held safely under conditions of information governance, part of confidentiality policy.

Confidentiality

When members of the public pass personal information to professionals they can expect to do so with confidence that this will be looked after correctly and trust it will not be disclosed to other parties without their consent. Occupational therapists have a responsibility to keep information safe and maintain confidentiality in this way. However, there are exceptions to this rule and the issue can be complex (DH 2003) (see Ch. 10 on Ethics, for a more detailed discussion about confidentiality). Explaining the circumstances of how, when and with whom information may be shared is vital to ensure the rights of the individual are respected and the correct procedures pertaining to risk are followed. Occupational therapists should understand clearly what their responsibilities are and when and how information should be shared with other members of the team, third parties and with the service user's friends and/or family.

CASE STUDY 7-4

Confidentiality

A young man has been admitted to hospital under Section 136 of the Mental Health Act (1983), which allows the police to take an individual from a public place to a place of safety (for assessment) if they believe the person has a mental health problem and is in need of care. He does not want his parents to know the circumstances of his detention and does not consent to the ward sharing any information with his family. His family are informed by the police that he has been taken to hospital and they are now enquiring about his wellbeing. When the family arrive at the hospital, the occupational therapist is asked to deal with the situation. She informs the young man that his parents are in the building and asks if he is willing to see them, and if not, what information he will relay. He is adamant he does not want to see them or want them to know what happened. The occupational therapist informs the parents that the young man is in good hands on the ward but he is not willing to let them know what happened at this time. The occupational therapist apologizes and explains that until their son gives his consent, due to confidentiality policies, they cannot divulge any other information. The occupational therapist suggests that the family contact the ward later in the week to see if the situation has changed and the family are directed to contact the police regarding the situation around the arrest.

PERSONAL AND PROFESSIONAL INTEGRITY

Occupational therapists are expected to demonstrate 'personal integrity, reliability, open-mindedness and loyalty with regard to the consumer and the whole professional field' (COTEC 1996, p. 2) and are accountable for their personal and professional integrity in order to uphold the profession and maintain public trust. Any unlawful behaviour undertaken at work or in personal time could damage public confidence and bring the profession into disrepute (HCPC 2012b). It is hard to separate personal and professional integrity because the core values one holds as a person inform the choices one makes about one's profession. It would be incongruous if someone with no misgivings about harming others were to choose a profession which requires the promotion and protection of others' wellbeing (Stemwedel 2007). There are times when it is necessary or useful to differentiate the boundaries between the personal and the professional, but as discussed here, sometimes these are not easy to define and can be contested. Sometimes, professional duties take priority over personal values (Davys et al. 2006). For example, putting aside personal feelings when providing a service for people with a history of serious offending in a forensic setting, or working in acute mental health settings where the maintenance of professional boundaries is required in order to maintain safety.

Appearance plays an important role for the professional image of occupational therapy. What someone wears provides clues to others as to their professional status and the behaviour people can expect from them

CASE STUDY 7-5

Personal and Professional Boundaries

An occupational therapist is invited by a service user to attend a social function and wonders whether it is acceptable to drink a small quantity of alcohol to normalize the social situation. Practitioners can again refer to professional standards to know what is acceptable. Under 'Substance misuse', the UK Code states that 'you must not undertake any professional activities whatsoever when under the influence of alcohol, drugs or other intoxicating substances' (COT 2010a, p. 24). Therefore, even a small amount of alcohol would not be acceptable.

If an occupational therapist is going to make lunch with someone, it is not usually appropriate for the therapist to eat as well. It may be seen as financial abuse if the person buys and cooks lunch for the occupational therapist, as well as themselves. The person the occupational therapist is working with may find this difficult to understand and be offended by the decision. Also if the individual misinterprets the invitation as anything other than professional, they may be vulnerable to emotional rejection if the situation was not made clear.

them. Therefore, professional conduct while wearing a uniform is important because the public expects continuity between behaviour and 'appearance behaviour' (Davys et al. 2006). In a clinical setting, a uniform not only functions as appropriate work wear for health and safety reasons (DH 2010b), but may also allows the wearer to distinguish between the personal and work role, to feel more professional and be identified as an occupational therapist. However, in mental health practice where the development of therapeutic relationships can be difficult, the use of 'self' is seen as a core skill of the occupational therapist (Taylor et al. 2009). Therapists need to 'adopt an approach which centres on the service user and establish appropriate professional relationships in order to motivate and involve the individual in meaningful occupation' (HCPC 2013, p. 10). Thus, in community-based mental health practice, wearing jeans and a T-shirt or hooded top and adopting a more relaxed demeanour may, at first sight, seem unprofessional but this approach may help the engagement process. In this example, professionalism is more about considering what impact therapist presentation has on the person in their own social context (Davys et al. 2006). When working closely with people in the community and their own homes, occupational therapists also need to consider how their conduct encourages engagement in occupations.

There is a difference between providing social interventions in a person-centred, friendly way, and becoming friends with people. It is acceptable to attend social functions providing the personal and professional are effectively communicated (HCPC 2013). Occupational therapists need to be able to effectively communicate personal and professional integrity in the context of their national standards. If any problems remain, they should use supervision to explore and resolve them.

PROFESSIONAL COMPETENCE AND LIFELONG LEARNING

Once students complete their education and register to practice they have a duty to maintain their professional competence by participating in lifelong learning which the COT sees as central to, and essential for, good practice. 'Lifelong learning should be the continuous pursuit of improvement in understanding, knowledge, skills and reasoning that improves practice to the benefit of those with whom the learner comes into contact' (COT 2010c, p. 3). Lifelong learning spans all levels of personnel including support workers, educators, new graduates, and practitioners and researchers at all levels. The range of learning activities through which professionals develop throughout their career is defined as continuing professional development (CPD). It is a process by which individuals are responsible for their own learning and development and engage in a process of reflection and action, which ensures they maintain their capacity to practice safely and legally. In the UK, the HCPC requires registrants to undertake a variety of learning activities in whatever format suits the learning needs of the individual. Examples of CPD activities are shown in Table 7-1.

The UK's COT (2004) has set up an online Interactive Learning Tool (http://ilod.cot.org.uk) designed to aid CPD. It includes a reflective log to help professionals consider what they have learned and how it can be put into practice (COT 2004). HCPC registrants are also required to keep an up-to-date and accurate record of CPD activities in a portfolio which includes a career history, current job description, a Personal Development Plan and most current Performance Appraisal, reflective logs and a sample of achievements of learning - such as publications, demonstrably improved service user outcomes, or designs for new rehabilitation programmes, for example. Portfolios may also include course certificates and testimonials from colleagues, individuals and their families. The HCPC audits a sample of registered occupational therapists every 4 years and, if selected, the individual must present their professional portfolio along with a report with a summary of practice, a statement about how CPD standards have been met and any supporting evidence (HCPC 2012a). It must demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice, that their CPD has contributed to the quality of their practice and service delivery, and that it benefits the people using their services. Keeping a CPD portfolio is good practice, whether it is expected by a registration body or not.

The notion of professional competence relates only to occupational therapists who are providing services that they are trained and qualified for. Any activity over

TABLE 7-1
Types and Examples of CPD Activities

Types of Activity	*Examples*
Work-based learning	■ Learning by doing ■ Case studies ■ Reflective practice ■ Discussions with colleagues ■ Peer review ■ Secondments ■ Job rotation ■ Journal club ■ In-service training ■ Supervising staff or students ■ Expanding your role ■ Project work/management
Professional activity	■ Involvement in a professional body ■ Lecturing or teaching ■ Mentoring ■ Being an examiner ■ Being a tutor ■ Organizing a journal club or other specialist groups ■ Maintaining or developing specialist skills (e.g. musical skills) ■ Conference presentations ■ Supervising research ■ Being promoted
Formal education	■ Courses ■ Further education ■ Research ■ Attending conferences ■ Writing articles or papers ■ Going to seminars ■ Distance learning ■ Courses accredited by professional body ■ Planning or running a course
Self-directed learning	■ Reading journals/articles ■ Reviewing books or articles ■ Updating knowledge through the internet or TV ■ Keeping a file of your progress
Other	■ Public service ■ Voluntary work ■ Courses

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and above their level of competence should only be undertaken with adequate planning and guidance and occupational therapists have the right to refuse a request to undertake a task beyond their capabilities. Similarly, tasks should not be delegated to other team members without ensuring they are capable and supervised (COT 2010a). Competence also requires professional knowledge and skills to be maintained by an awareness of, and adherence to, up-to-date guidance and legislation.

DEVELOPING AND USING THE EVIDENCE BASE

Occupational therapists must ensure compliance with national and international evidence-based recommendations and implement those that are relevant to the service they deliver. However, national guidance does not cover every intervention and occupational therapists have a professional responsibility to ensure that their work is based on the best available evidence (COT 2010a). Research and development in the field of occupational therapy and mental health is burgeoning worldwide. The Research Centre for Occupation and Mental Health (http://www.yorksj.ac.uk/rcomh/rcomh.aspx) has developed coordinated programmes of research, which aim to provide evidence to support practice (Bannigan 2010). (see Ch. 9 for more information about evidence-based practice). Perhaps not all occupational therapists will want to contribute to the evidence base by carrying out research themselves, but all occupational therapists need to be able to search for evidence, critically appraise it (Public Health Resource Unit 2006), and use it to inform their practice (Naylor 2002). One of the ways that occupational therapists can show that their practice reflects the evidence base is through clinical audit.

CLINICAL AUDIT

> *Audit is a cyclical process of setting standards, checking practice against the standards, identifying areas for change, making those changes and then re-auditing. This enables the continual improvement of services.*
> *(COT 2011)*

Clinical audit follows six stages (Kellett et al. 2001):

- Identify the issue to be audited
- Set the standard (ideally this should be based on rigorous research)

- Measure activity against the set standard
- Identify any necessary changes to practice
- Implement change
- Monitor the effect of the change against the standard.

Clinical audit should not be confused with research (see Ch. 9), It is important to be clear that the aim of audit is simply to establish whether written standards or guidelines have been achieved. For example, an occupational therapist may want to:

- Survey colleagues to see which risk management tools are currently in use (research)
- Complete a research project to establish which risk management tool is most appropriate for use within their setting (research)
- Complete an audit to see whether the risk management tool is being used in accordance with specified standards (audit).

Topics may be identified in a number of ways and audited against a variety of standards. As stated in the introduction, countries without a set of national standards can follow and audit their services against those set by the WFOT. In the UK, the College of Occupational Therapists (2011) has produced a set of standards against which services can be audited. Standards for clinical practice may also be audited against standards produced by the National Institute for Health and Clinical Excellence or against internal audit criteria or other clinical governance activity. Audit may be used, for example, to establish how a service compares with:

- national standards around consent to intervention
- local standards for specific interventions relating to a therapeutic intervention group
- another local service audit of incident and near miss reporting in relation to risk management
- standards set by the organization around record-keeping.

An audit checklist, which relates directly to the standards, can be a useful tool to enable measurement to take place. The standards produced by the COT (2011) come with a checklist, but it is also possible to make one specific to need - such as for an anger management group, as shown in Table 7-2.

For some standards, it will be clear whether the benchmark is met or not. For others, it may be necessary to have a halfway point of 'partially met'. Either way, it is important that the need for change can be easily identifiable. Although clinical audit is well established within health and social care services, it does not always lead to changes in service delivery (Commission for Health Improvement 2003; Kellett et al. 2001; Sealey 1999). It is therefore important for occupational therapists to ensure that they complete the last three stages of the audit cycle by identifying what change needs to take place, implementing the change and re-auditing to monitor the effects of the change. Sealey (1999) considered this issue in detail, identifying 10 reasons why the audit cycle is not completed and offering possible solutions. For example, one of the reasons identified for not completing the loop is a lack of proficiency. Possible solutions are to:

- to find and use people within your organization who have audit skills
- to arrange for training to take place
- to develop a collection of good reference books on audit methods.

Occupational therapists have a responsibility to ensure that they disseminate the lessons learned from their audit activity so that practice can be improved across a wide spectrum of services.

SUMMARY

This chapter has explored professional accountability using the Code of Ethics and Professional Conduct published by the UK's College of Occupational Therapists (COT 2010a). Many European and some worldwide organizations have a similar Code of Ethics and Professional Conduct, so the principles are likely to be widely applicable. Although some of the processes associated with professional accountability can sometimes seem to exist for the benefit of the organizations practitioners work within, there is an ultimate professional responsibility to ensure that service users have the best possible service. This means ensuring that professional accountability is more than a set of merely bureaucratic processes designed to reassure the public but is, additionally, a framework for maintaining practitioners' focus on the person-centred values of occupational therapy.

TABLE 7-2

Audit Checklist for Examining Case Notes

STANDARD	PARTICIPANT											
	1		2		3		4		5		6	
	Y	*N*	*Y*	*N*	*Y*	*N*	*Y*	*N*	*Y*	*N*	*Y*	*N*
All referrals will be seen for an initial interview prior to the commencement of the group to explain the reasons for referral to the group												
All referrals will be seen for an initial interview prior to the commencement of the group to establish when their anger is a problem to them												
All referrals will be seen for an initial interview prior to the commencement of the group to establish what they would like to achieve in relation to improving their anger management												
At the end of each session participants will be given an anger management strategy to practise over the following week												
Each session will include an opportunity for participants to report on how helpful they found the anger management strategy												
At the end of the 6-week course, participants will be given the opportunity to evaluate the group in terms of its effectiveness in meeting their individual goal												

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8 MANAGEMENT AND LEADERSHIP

GABRIELLE RICHARDS

CHAPTER CONTENTS

INTRODUCTION

Many occupational therapists start their careers as practitioners and move into management roles over a period of time. They do not always have specific training in these roles and many develop 'on-the-job' experience. Occupational therapists often make very good managers because of the sound organizational skills and personal attributes they need to have to work as an occupational therapist (Griffin 2001). However, it is important to have an underpinning knowledge of management principles and theory to be a good manager in practice. An understanding of the organization worked in is invaluable as a manager. Getting to grips with its purpose, vision and direction of travel can help managers define the unique contribution occupational therapy makes to realizing an organization's aims. As Braveman (2006) remarked 'learning to observe an organization's culture and values as demonstrated in the daily life of an organization can help you be more effective as a manager' (p. 53). Knowing both the internal and external factors that can influence the environment occupational therapists work in, reinforces their ability to be aware in order to look ahead and manage with confidence.

Alongside management, the importance of leadership in health care has grown in significance in recent years. From the day occupational therapists commence practice, they are faced with many challenges associated with applying the theory of what they have learnt as undergraduates to the rigours of practice (Adamson et al. 1998; Hodgetts et al. 2007; Parker 1991). New graduates perceive there are significant gaps of knowledge and skills, particularly in the areas of communication with other health professionals and the general public, knowledge of the health industry and work place management (Adamson et al. 1998). Alternatively, managers' views indicate that they believe management skills needed for new graduates should include time management and planning for example, but should also include skills related to leadership such as resolving conflict and difficult staff relations while

working effectively in a team (Adamson et al. 2001). It is crucial that not just senior occupational therapists but newly qualified occupational therapists understand the importance of leadership and where possible take on a leadership role for the profession. Having leadership skills, particularly clinical leadership skills, will enhance new practitioners' ability to successfully function within their teams. Learning different skills, styles and behaviours associated with leadership will only add to an individual's effectiveness. Managers, be they occupational therapists or health managers in general, are looking for practitioners who can meet the challenges and have competencies to cope in rapidly changing work environments (Adamson et al. 2001; Morley 2009; Spyby 2012). Sylvia Rodger (2012) proposed that occupational therapists identify themselves as leaders wherever they are and position themselves within organizations or in their professional lives and take on leadership roles no matter how big or small.

This chapter explores the concepts of management and leadership, particularly the differences between the two, before examining what this means for occupational therapists working in mental health settings that exist in modern, ever-changing health and social care systems across the world. Most of the examples are from the UK – a model of leadership competence from a leading mental health trust is presented to illustrate the discussion. The examples illuminate theory but recognize that management and leadership are socially constructed (Chemers 1997) and so are influenced by different cultural contexts. The chapter presents these concepts as a useful toolkit for occupational therapists to use for management and leadership success but if not based in the UK, occupational therapists may need to think about any specific cultural issues that may shape management and leadership practices differently. Some of the examples refer to the mental health occupational therapy literature.

MANAGEMENT

In 1973, Mintzberg posed the question, 'Why do organizations need managers?' and provided some reasons (see Box 8-1), which are still pertinent to organizations today. Many people refer to 'management' as the individuals charged with running the organization and, as such, management presumes a business-oriented focus. A commonly quoted view is that management is about getting things done through others (Drucker 1955; Koontz 1961) but there are different ways of viewing management. Some assert that the aim of management is to support their employees' efforts to be fully productive members of their organizations and citizens of the community in which they operate (managmenthelp.org 2012). Definitions generally refer, in some way, to the process of directing and leading a programme of work in an organization. Managers are the people charged with the responsibility for this process and use many different types of management to achieve this (see Box 8-2).

In health and social care systems, management is seen as accomplishing a series of tasks, often through the effort of others, i.e. it is not oriented around a production line; it is about people conducting the business as well as managing the resources. Skilled managers can accomplish much more through others than they can just through their own efforts (Armstrong 2006). This means there needs to be more understanding of what managers actually do in practice to be effective. This includes the organizational processes of strategic planning, setting objectives, managing resources and deploying the human and financial resources needed to achieve organizational objectives. Traditionally, the term 'management' refers to the activities (and often the group of people) involved in the four general

BOX 8-1

A SUMMARY OF THE REASONS WHY ORGANIZATIONS NEED MANAGERS

1. To ensure the organization serves its basic purpose – the efficient production of goods and services to design and maintain the stability of the operations of the organization
2. To take charge of strategy making and adapt the organization in a controlled way to the changes in its environment
3. To ensure the organization serves the ends of those people who control it
4. To serve as the key informational link between the organization and the environment around
5. To enact formal authority to operate the organization's status system

(Adapted from Mintzberg 1973).

BOX 8-2

A SUMMARY OF THE DIFFERENT TYPES OF MANAGEMENT

- **Change management** is a structured approach for ensuring that changes are thoroughly and smoothly implemented, and that the lasting benefits of change are achieved (MindTools a). It could involve service reconfiguration and redesign, staff changes or disinvestment (budget cuts) for example.
- **Information management** includes the use of both physical and electronic information. Managers need to manage all sources and formats of information for example, paper, electronic, video and audio. Importantly, it is not only about how knowledge and information are gathered but how they process them, digest them and use them to best effect.
- **Knowledge management** is a series of tools and activities to capture the range of information available to an organization. It can be used to enhance efficiency, increase productivity, audit and research and effect change. Knowledge management is a conscious strategy for moving the right knowledge to the right people at the right time to assist sharing and enabling the information to be translated into action to improve the organizational performance (O'Dell and Grayson 1998).
- **Operational management** is having the responsibility for the day-to-day organizing and coordinating of services and resources, liaising with practice staff and other professionals, dealing with the public and managing complaints; anticipating and resolving service delivery issues (see NHS Operational management). In the health service, this role has often been carried out by general managers but people with a professional background, like occupational therapists, also carry out this role.
- **People management** is one of the manager's most important tasks. Managing people often involves planning individuals' work tasks, setting work-loads, carrying out supervision and appraisal processes.
- **Performance management** is about assessing a person's ability to perform to the best of their ability (http://www.citehr.com/performance-management-f60.html). If a person, team or organization is unable to perform adequately, processes should be put in place to monitor and support improvement.
- **Personal management** is about how an individual manages their own work life, goals, time management and careers development. Access to opportunities for mentoring, coaching, shadowing and further training will help develop the competencies to be an effective manager.
- **Personnel management** is not to be confused with people management. Personnel management is traditionally performed by the Human Resources department and includes activities like recruitment processes, screening and interviewing applicants, developing and overseeing employment policies.
- **Professional management** refers to the process of setting the standards expected for the profession in the organization, providing supervision, assessing competence and defining quality.
- **Project management** is the application of knowledge, skills and techniques to execute projects effectively and efficiently (Project Management Institute 2012). It is usually a time-limited activity with an identified beginning, middle and end with an agreed remit, budget, time allocation and an intended agreed outcome.

functions, i.e. planning, organizing resources, leading and controlling and coordinating. All of these four functions occur at all levels in organizations and are highly integrated throughout. Management tasks also involve recording of information, setting performance targets and measuring results. It also assumes that there is a cycle in which management activities are planned, executed and measured through a series of ongoing processes.

Planning

Occupational therapists are used to planning their work for the people for whom they provide services. They carry out assessments, then provide interventions based on those assessments in collaboration with the service user. There is an expectation that the work they do has goals that are specific, measurable (outcome-oriented), achievable and time-related, often referred to as SMART. As Kate Miller described:

> *When I think about what it is that we do as occupational therapists in everyday clinical practice … we apply very certain and definite kind of steps and approaches to our work, it includes listening, gaining an understanding or taking another perspective of the person we are trying to gain an understanding about. We don't make judgements about others and don't force our beliefs on others, we try to engage people in activities and motivate them to improve or regain function. We think outside the box on an everyday basis because we need to make situations and environments work for people so they can continually engage as they want to.*
>
> *(Rodger 2012, p. 176).*

This same discipline can be applied to the planning and development of occupational therapy services. Most organizations, for example, carry out an annual business planning process in order to determine the budgets they have to provide services, set targets and judge performance against the agreed plan. This is different from a strategic plan which might be more long term and visionary. For example, occupational therapy services will usually have an annual working business plan based on the organization's goals and the budgets set for the provision of services. However, they may also have a strategy which includes a high-level mission statement and a plan that includes aims and objectives as to how the overall mission will be achieved. A good example is the UK's College of Occupational Therapists' (2006) strategy, 'Recovering Ordinary Lives – A Vision for the Next Ten Years'. This document clearly describes key messages for the profession and others to work towards improving mental health services. As Recovering Ordinary Lives states: 'the aims of this strategy are twofold: to reassert the importance of occupation to health and wellbeing, and to develop a vision and principles that will guide occupational therapy practice within rapidly changing social and political environments' (COT 2006, p. ix). Several mental health occupational therapy services in the UK have based their strategic plans on COT's (2006) strategy document as a way of framing their own strategy development.

Other types of planning also feed into both annual and strategic plans. Most common are workforce and project planning.

- 'Workforce planning' refers to how an organization estimates its future workforce requirements and calculates the numbers, nature and sources of potential employees who might meet that demand. In other words, it is about getting the right number of people, with the right skills, in the right place and at the right time (Local Government Improvement and Development 2012). Occupational therapy managers will be asked to predict what numbers of staff and what grades they need to meet the work priorities and demands predicted from their business and strategic planning processes. This may also extend to influencing the number of undergraduate places that are commissioned for occupational therapy training in order to meet future workforce demands.
- 'Project planning' is the application of the techniques of planning, implementing and managing the resources available in relation to a specific project. It is usually a time-limited activity with an identified beginning, middle and end with an agreed budget and time allocation and an agreed outcome. Examples of these may be setting up a new service or indeed closing a service. It might also include carrying out a feasibility study or marketing and launching a new product or intervention.

Organizing Resources

Managing resources is about being responsible for a whole range of available resources, i.e. people, finances and physical resources such as buildings and materials. Understanding these resources helps the manager maintain control of the budget allocated for their services. A budget is the sum of money allocated for a particular purpose. Budgets are usually set out on a yearly basis as described in the planning section (above) and serve both a planning and controlling function. Budgets can be a complex mix of information, pay and non-pay, overheads, etc. and appropriate training in budgetary management is advised if occupational therapy managers are to successfully utilize and maintain budgetary control.

Since the 1980s, budgets in mental health services, particularly in the UK, have been held in general management systems, not by individual professional groups (Griffiths 1983). General management was intended to offer active, strategic direction and to devolve responsibility through a clear structure of line management and devolved budgets. As a result, occupational therapy managers over the years have had less direct control of staffing budgets, as these may be held in the integrated services. Therefore the role of the occupational therapy manager is one involving much more influence in relation to making the best use of resources rather than direct responsibility for them. Workforce development is a good example of how occupational therapy expertise is essential in recommending the appropriate

grades of occupational therapists to provide activity within services and how those occupational therapy resources are deployed. An example, from the UK, of organizing resources is the occupational therapy mental health indicative care packages for mental health 'Payment by Results', which set out potential occupational therapy assessment, interventions and outcomes for service users as well as recommended staffing levels for carrying out the activity (DH 2011; Morley et al. 2011).

Leading

Leading is about 'setting the direction of travel' for the organization and realizing its vision through leading teams and individuals and influencing them to follow that direction. As stated previously, this is an important area of development for all grades of occupational therapists. Examples of leadership activity include establishing strategic direction (vision, values, mission and/or goals) and championing methods of organizational performance management to pursue that direction. This is discussed further in the section on Leadership (below).

Controlling and Coordinating

Controlling and coordinating is about the processes and systems designed to manage an organization's structures and data as effectively and efficiently as possible, to reach its goals and objectives. The analysis of data, in particular, in a modern healthcare organization can be complex and detailed. This involves the ongoing collection of feedback, monitoring and adjustment of systems, processes and structures to meet demands. Data that exist can be financial; they can be the findings from research or audit. Data can be used in producing policies and procedures, performance management processes and measures to avoid risks. The key point is to control and coordinate these data to support the delivery of services. For example, Schene et al. (2007) reported that occupational therapists enable people with mental health problems to return to work 3 months earlier, and work for longer hours, than standard mental health interventions. They also proposed that the financial benefits of service users being able to return to work sooner and work for longer hours significantly outweighed the cost of providing occupational therapy interventions. Occupational therapy managers, as well as practitioners on the ground, need to be astute in utilizing information like this to their advantage

LEADERSHIP

There has been a growing interest in recent years about the importance of leadership as well as management skills in the delivery of health and social care. In the UK, Lord Darzi's review of the NHS' 'High Quality Care for All' (DH 2008), described how there needed to be a new emphasis placed on professional staff leading as well as managing the organizations in which they work. There has been a proliferation of literature stressing the significance of good leadership, improving the quality of care as well as being crucial to the effectiveness of individuals and the organizations in which they work (Ovretviet 2009). Braveman (2006) emphasizes it is important to distinguish between the act or process of leading, i.e. leadership, and the individuals who are in the position of guiding others, i.e. leaders. Braveman (2006) proposed the following definition of leadership:

> *Leadership is the process of creating structural change wherein the values, vision and ethics of individuals are integrated into the culture of a community as a means of achieving sustainable change*
>
> ***(p. 84).***

Leaders are the inspiration and directors of the action; they are the people who possess the combination of personality and skills that makes others want to follow their direction.

The Differences Between Leadership and Management

Leadership and management are distinct but complementary concepts (see Table 8-1). The terms have been used interchangeably but recently, there has been growing recognition of the differences between the two and the need to be good leaders as well as effective managers (Bush 2006). Current thinking tends to separate them and recognize that having clarity about how they differ will help individuals to maximize their performance.

TABLE 8-1

A Summary of Different Characteristics of Management and Leadership

Management	*Leadership*
Processes	People
Facts	Feelings
Intellectual	Emotional
Head	Heart
Position power	Persuasive powers
Control	Commitment
Problem-solving	Possibility thinking
Reactive	Proactive
Doing things right	Doing the right things
Rules	Values
Goals	Vision
Lights fire under people	Stokes the fire within people
Written communications	Verbal communications
Standardization	Innovation

(Clemmer 2003).

> *Management is generally seen to involve overseeing day to day operations, accomplishing goals and achieving tasks, while leadership spans a wider remit that includes influencing, and inspiring others, generating ideas and defining a strategy and vision…Managers are not confined to management and leaders are not restricted to leadership. The critical issue is about getting the right balance for the job you do.*
>
> *(Improvement Net 2011)*

It is important to note that one set of characteristics is not better than the other. Both are needed for success and many people will use them interchangeably to be effective in their roles.

Leadership Styles

Within leadership, there are different leadership styles. Kurt Lewin proposed three leadership styles in the 1930s which are still relevant to understanding different approaches to leadership today (Miner 2005), i.e.

1. 'Autocratic leaders' make decisions without consulting their teams. This is considered appropriate when decisions genuinely need to be taken quickly, when there's no need for input, and when team agreement is not necessary for a successful outcome.
2. 'Democratic leaders' allow the team to provide input before making a decision, although the degree of input can vary from leader to leader. This type of style is important when team agreement matters, but it can be quite difficult to manage when there are lots of different perspectives and ideas.
3. 'Laissez-faire leaders' do not interfere; they allow people within the team to make many of the decisions. This works well when the team is highly capable and motivated, and when it does not need close monitoring or supervision. However, this style can arise because the leader is lazy or distracted, and, here, this approach can fail.

An effective leader should be aware of the different styles and know when to use them for different outcomes required. For example, a leader might find an open democratic style on a day-to-day basis is preferable and effective most of the time, whereas during times of sudden increases in workload or deadlines, a more directive or autocratic style might be required. Leadership style can depend on the situation; there are other factors which will also influence which style will be most effective and which one to use. This includes the manager's personality, their values and work experience. It will also be influenced by the employees, individual preferences of how they like, and respond to, various leadership styles and lastly, the organization. The values, philosophy and ethos of an organization will influence leadership styles. Some are based on a spirit of partnership in decision-making, while others operate in a more directive fashion. Given the importance placed on leadership skills, the following model provides a competency framework to conceptualize the components needed for effective leadership (see Fig. 8-1 and Box 8-3). It also encompasses the management skills needed and illustrates their connectedness.

Power

Another important aspect in considering the concept of leadership is power. As Florence Clark (2010, p. 265), the internationally renowned occupational therapy researcher and current president of the American Occupational Therapy Association, stated, 'many of our practitioners are uncomfortable with the word "powerful"'. She proposes that this unease exists because it could be seen as the opposite of caring, it has masculine attributes (in a predominantly

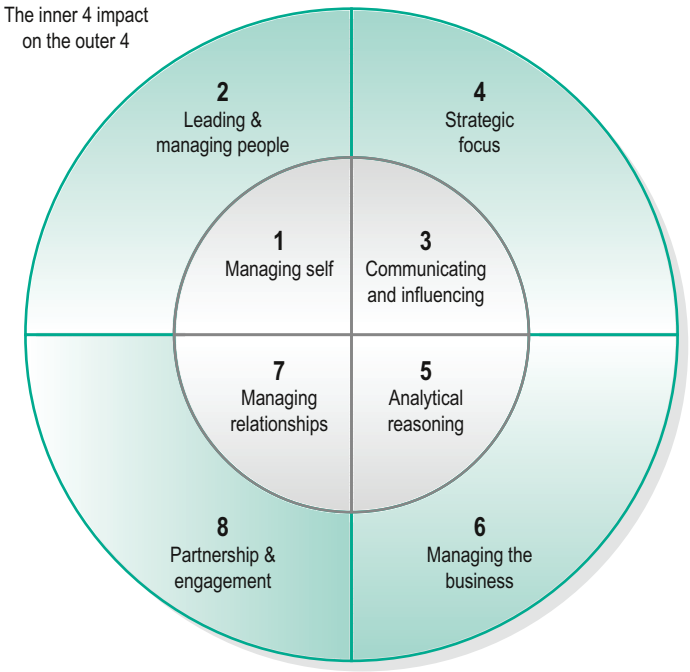

FIGURE 8-1 ■ The South London and Maudsley Leadership Framework. *Copyright 2010 SLaM Partners Ltd. All rights reserved.*

BOX 8-3

A SUMMARY OF THE COMPETENCY DEFINITIONS RELATED TO LEADERSHIP

- **Analytical reasoning:** Analyses data to reach sound decisions and thinks creatively and innovates
- **Communicating and influencing:** Communicates effectively both in person and in writing, gains buy-in from others, fosters open communication
- **Leading and managing people:** Coaches and develops others, empowers teams and leads on change
- **Managing the business:** Drives for results, pursues business opportunities, manages financials, delivers on plans and manages time and priorities
- **Managing relationships:** Builds effective relationships with others, adopts a collaborative approach, manages conflict, and values everyone's contribution
- **Managing self:** Is motivated and self-confident, copes under pressure, acts with integrity and models the organization's values
- **Partnership and engagement:** Understands partners and works with internal and external stakeholders, manages high-stakes interactions
- **Strategic focus:** Develops a compelling vision for the organization, understands its strategic position, designs and implements strategies

female profession) and it is associated with domination. She observed power is neither good nor bad, but how an individual uses or misuses power ultimately colours the perception of power in the views of others (Ulrich 1987). Pollard and Walsh (2000) identified,

> *gender, mental health and occupational therapy are bound in a complex set of connections such as class and culture and the way that these can influence positions of power to define other relationships* ***(p. 430).***

Clouston and Whitcombe (2008) develop the argument stating that because of the medically dominated constructs of the caring professions, and the accepted dominance of this position, occupational therapy will be limited in its power in organizations and will shape how occupational therapy is understood. However, Clark (2010) contends that individuals are the sources of power for the profession and each person plays a vital role in how others see our profession as a whole.

Kotter (1979) proposed that power is a neglected aspect of management in particular, but it also relates to leadership and influence. He proposed that power is a measure of an individual's potential to get others to do what he or she wants them to do as well as to avoid being forced by others to do what he or she does not want to do. Managers regularly acquire and use power. They do so deliberately and consciously as well as intuitively and unconsciously. Power-oriented behaviour has an impact on managerial career progress, on job performance, on organizational effectiveness, and on the personal lives of employees. It involves the combination of power, influence, authority, and organizational politics. Finlay (2000) describes two aspects of power. There is personal power which receives support and trust from colleagues and subordinates, and connection power, which results from personal and professional access to key people and information. Both of these aspects of power will be influenced by the:

- characteristics of the leader
- attitude, needs and other personal attributes of the followers
- the nature of the organization, such as its purpose, structure, the tasks to be performed and
- social, economic and political environment (McGregor 1987).

In essence, it is important to understand the concept of power and how it affects and influences the development of the occupational therapy profession in order to manage and lead successfully. Powerful leaders have an appreciation of their personal attributes, understanding the organizations they work in and grasp the bigger picture of the environment around them. The Kings Fund (2012) Report, into Leadership and Engagement, referred to the need to move from a hierarchy-driven system where power comes from authority to one where managers will need to exert influence, or soft power, across a matrix of organizations. In order to do this, leaders need to deploy a range of leadership styles and behaviours to support the creation of a strong culture of engagement, where power and responsibility are shared within teams, organizations and the wider healthcare system.

Leadership Success

Occupational therapy needs strong leaders to support the profession to flourish (Hankinson 2012). However, leadership success is a complex interaction between many variables. There is no one right style of leadership but it is worth understanding that a range of leadership skills and attributes are as important as management capability. According to Smircich and Morgan (1982), the phenomena of leadership success can be understood in terms of the personal traits of a leader, the situation in which they lead and what they do. Daniel Goleman (1995) popularized the idea of emotional intelligence to help with the understanding of what makes leadership success. He said there are five main elements of emotional intelligence:

1. Self-awareness: if you are self-aware you always know how you feel. Being self-aware in a leadership role means you know your strengths and weaknesses
2. Self-regulation: is about staying in control, not making rushed or emotional decisions
3. Motivation: self-motivated leaders work towards their goals
4. Empathy: leaders with empathy have the ability to put themselves in someone else's situation to help develop others, listen, challenge and give constructive feedback
5. Social skills: leaders with emotional intelligence are good communicators, they are experts at getting their team to support them and be excited about a new mission or project.

Leaders must have a solid understanding of their emotions and how their actions affect the people around them. The better a leader relates to and works with others; the more successful he or she will be (MindTools b).

MANAGEMENT AND LEADERSHIP IN OCCUPATIONAL THERAPY

Having considered management and leadership in general terms, this section considers management and leadership in occupational therapy from an historical perspective, management and leadership today and leadership for the future; all illustrated using management and leadership in the UK (note the comment above about the importance of culture in shaping management and leadership). The section

ends with a case study that presents a day in the diary of an occupational therapy leader in mental health; which brings theory and practice together.

The Historical Perspective

Occupational therapists have always held management roles. For example in the UK, the Chief Occupational Therapist, in 1955, was responsible to the medical superintendent for the development and progress of the whole occupational therapy department. 'While delegating immediate responsibility for the working details to her respective occupational therapists she will act in a supervisory capacity under the direct authority of the medical superintendent and collaborate with the various medical officers in the sections allocated to them' (O'Sullivan 1955, p. 52). Willard and Spackman (1963, p. 17) recommended that management responsibility should be established: 'effective administration is a means of getting things done through people and of making the institution a good place in which to work'.

Over the years, occupational therapy management roles have changed. In the 1970s, District Occupational Therapists had an advisory role, only moving to holding managerial responsibility later in the decade. In the early 1980s, a wider interpretation of management was introduced with the inception of the General Manager role in health organizations. This person was someone who did not necessarily have a health professional qualification. As a result, a wide variety of individually determined management structures proliferated. It is the same today, with General Management integral in organizations. However, there is also a greater number of professional staff, including occupational therapists, carrying out these managerial and operational roles.

In the past, it was more common for occupational therapy managers to have had direct responsibility for holding budgets for services. They were given a predetermined amount to run an occupational therapy service within an organization, based on the annual planning process. This role included being responsible for 'pay costs', i.e. costs incurred by the employment and payment of staff, and 'non-pay costs', i.e. expenses incurred from running the service for example, stationery, equipment, training and travel costs. It could also have included generating income from any activity, for example external training provided, and income from the sale of goods.

Management and Leadership Today

In the ever-evolving healthcare system, occupational therapy managers are finding themselves having to differentiate and understand a variety of management and leadership activity they have to undertake in their roles. In the UK, many occupational therapy manager roles are having less direct operational management responsibilities and are having to use leadership skills, such as influencing to promote and profile the profession. This is particularly the case in mental health. As Methot (2004) observed, many occupational therapists have moved into management roles and abandoned their title of occupational therapist assuming more generic functioning. Rodger (2012) added now, more than ever, whatever their professional role or stages of career development, occupational therapists need to embrace leadership opportunities, no matter how small.

One way to do this at any level of occupational therapy leadership, is to focus on 'our strength in being experts in both understanding occupation and its impact on health and how to use occupation to improve or maintain health and sharing our expertise with others will mark us out as truly a mature profession' (Molineux 2011, p. 95). This could be said of a student or a new therapist learning to find their professional voice as a lone worker in a team of specialists who bring a distinct skill-set to their posts, and occupational therapy consultants leading the way forward in education, clinical expertise and research. All of these levels of practitioner have leadership potential based on personal power – credibility, respect and trust, plus the ability to influence, persuade, debate and negotiate, combined with expert power – knowledge of the profession and the impact on the person (Malby et al. 1998). To paraphrase Rodger (2012, p. 178),

> *[if] we can provide an occupational perspective to address issues of importance to individuals whose performance and participation are limited, as well as to health care organisations and society more generally, [occupational therapy will be more recognised and leadership will be celebrated as part of the profession's territory]*

Leadership for the Future

Finally, there has also been great stock put on the value of marketing occupational therapy services and knowing about political influencing (Craik et al. 1998; Jacobs 1987; Pattison 2006; Morley and Rennison 2011). Generally speaking, marketing is seen to be about advertising and selling goods and services. It is also associated with identifying the particular wants and needs of a target market of customers; in health terms a whole range of stakeholders from service users and their carers to commissioners. Marketing goes on to analyse customers' needs and makes strategic decisions about product design, pricing, promotion and distribution. Some of that marketing strategy for occupational therapy could be, for example, the professional bodies lobbying political parties through to an individual occupational therapist creating new and inventive interventions to support changes in practice and trigger a policy development at a local level.

So what is the future of occupational therapy management and leadership? Modern health care sits with a range of providers not just government-funded organizations. Great stock is placed in the need for the occupational therapy profession to be more entrepreneurial (Foto 1998; Pattison 2006). In the UK for example, there has been the rising development of social enterprises and discussions regarding the potential of occupational therapists to lead and manage them. A social enterprise is a business whose objectives are primarily social, and whose profits are reinvested back into its services or the community (DH 2012). For example students working as volunteers in third-sector social enterprise initiatives (Raine et al. 2010) are profiling the role of occupational therapists in that setting. The American Occupational Therapy Association developed a list of emerging practice areas in which occupational therapists may play a role. Those in mental health included depression, recovery and peer support model, sensory approaches and veterans and wounded warrior's mental health. It follows that with the increase of role emergent placements across the world comes the creation of role emergent posts and occupational therapists that are equipped with confidence, autonomy and independence in service development (Ullah and Klaentschi 2011; Kearsley 2012).

CASE STUDY 8-1

A Day in the Diary of an Occupational Therapy Leader Working in a Mental Health Service

Every day in the life of an occupational therapy manager and leader is different. Here are some examples of the tasks and activities a typical day might look like. (The leadership qualities and skills and types of management that may be deployed in that day are in brackets.)

- Plan and prepare for the day ahead (personal management, self-awareness, self-regulation)
- Read and respond to e-mails (personal management, motivation, information management, operational management)
- Convene and chair a monthly meeting of senior Occupational Therapists across the organization: the function of the meeting includes corporate oversight of occupational therapy and organizational strategy; workforce development; student activity; education and training initiatives; research and development updates. Provide organization-wide information, discuss links to external projects and allocate representation within organization and at external events (knowledge management, operational, change and project management, influencing, personal and connection power)
- One-to-one professional supervision meeting (professional and people management, performance management, coaching, empathy, social skills, personal power)
- Spend time carrying out tasks (operational, project and information management, self-regulation)
- Chair an organization-wide committee: functions include coordinating a complex series of initiatives and projects designed to support the development of social inclusion and recovery-oriented practice (change, knowledge and performance management, influencing, personal and connection power)
- Meet with a service director to develop new occupational therapy roles in mental health triage wards (change, professional and personnel management, influence and personal power)
- Read and respond to e-mails (personal management, information management, operational management, motivation)

SUMMARY

Far from being straightforward and simple, good management and leadership skills also require a great degree of intuition, influencing, pragmatism and political awareness. Today's occupational therapists, from newly qualified practitioners to occupational therapy managers, are constantly challenged to provide the best evidence-based services possible. As outlined in the introduction to this chapter, it is essential for all practitioners to understand the concepts of management and leadership, in order to provide that quality service. This chapter has reviewed the changing nature of occupational therapy management and the growing importance of leadership skills within the modern healthcare system. Understanding the different types and styles of management and leadership will enhance any occupational therapists' ability to perform the various tasks and activities required of them in their job role. Being an excellent professional and moving into management is not enough. Occupational therapists will have to know what the essential components of management are to maximize their effectiveness. While known to be important and growing in significance, leadership does not always come naturally. Having a toolkit of techniques available to an aspiring professional or manager will enhance their performance as a leader. The model presented in this chapter brings together the competencies needed for both those management and leadership roles.

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9 RESEARCH AND EVIDENCE-BASED PRACTICE

KATRINA BANNIGAN

CHAPTER CONTENTS

INTRODUCTION

This chapter focuses on why research (see Glossary) is important to occupational therapists and why it is essential to the delivery of high-quality services. However, research alone is not sufficient to improve the quality of services (Grimshaw and Thomson 1998). Practitioners also need the skills to integrate research findings into practice. This chapter describes these skills.

Ultimately, the purpose of research is to advance knowledge (Wilson and Butterworth 2000). In the context of health and social care, research can be used to gain new knowledge about the most effective interventions to use in practice. 'Research tells us what we should be doing. [Whereas] Clinical audit tells us whether we are doing what we should be doing and how well we are doing it' (Health Quality Improvement Partnership 2009). Clinical audit is an important quality enhancement process but it is not research and will not be discussed further in this chapter (see Ch. 7 for more on clinical audit). For a detailed analysis of the differences between audit, service evaluation and research, see the work of the NRES Ethics Consultation E-Group (2007). Although research and evidence-based practice are

generic skills, used by all practitioners in health and social care settings, this chapter focuses on the issues related to research and evidence-based practice in the field of mental health practice specifically.

The contested nature of evidence-based practice is discussed, because it has been a contentious topic within occupational therapy. The developments in, and challenges for, research and evidence-based practice in occupational therapy and mental health, are therefore considered in relation to this debate. An important development since the last edition of this book is the emphasis on service user and carer involvement in research, so this is also explored in this chapter.

WHY IS RESEARCH IMPORTANT?

Occupational therapists strive to do what is best for their service users but how do practitioners know the best, or most effective, intervention to use? Occupational therapists use different information sources, including anecdotal evidence and research findings to shape their thinking. For example, an occupational therapist may believe that using activities in group settings is an effective way of improving interpersonal skills because they have observed this in their practice, or they may have heard from other leading occupational therapists that group work helps to improve interpersonal skills (e.g. Breines 1995). However, if they were asked for evidence to support their assertion that the use of activities in group work was effective and they used anecdotal information to do so, their assertion would be challenged. The following arguments might be made, for example:

- The occupational therapist was only seeing what they wanted to see
- Their service users *would* say that they thought group work was helpful. They might feel obliged to say so, not wanting to upset their therapist
- Of course, they think the interventions used by leading occupational therapists are effective but surely leading occupational therapists are biased towards their own profession
- How can anyone be sure it was the activity group that was effective and not another intervention occurring around the same time?

These challenges are legitimate because it is acknowledged that human beings are influenced by their assumptions, which biases the way they see the world (Patton 2002). One cannot be certain that an observation is accurate and not merely a reflection of personal bias (Patton 2002). This means that while clinical experience can be valuable in shaping practice, it has its limitations in decision-making about clinical effectiveness:

> *Because patients so often get better or worse on their own, no matter what we do, clinical experience is a poor judge of what does and does not work*
> ***(Doust and Del Mar 2004, p. 474).***

Furthermore, it makes no difference whether the observer is a renowned occupational therapist or a professional colleague; they are likely to carry around the same bias towards seeing the positive relationship between occupation and health. In order to mitigate bias and directly access the service user perspective, practitioners might employ patient satisfaction surveys. However, there are several reasons why these methods are also potentially problematic:

- Respondents often comment on staff (such as individuals' politeness and courtesy), rather than on services
- Respondents often do not want to say anything negative
- The data gathered are dependent on the way the survey is designed and if it is poorly designed, the data collected may be flawed
- Such surveys 'require value judgements from patients about their care based on partial knowledge of their condition and maybe even less about how services are run' (Modernization Agency 2003, p. 1).

It is because of these types of reliability and validity problems that the results of patient satisfaction surveys often lack credibility.

Questions of Effectiveness

If a service user is receiving a number of interventions – perhaps from a range of different professionals at the same time – how can an occupational therapist be certain that their own intervention contributed to the

improvement in interpersonal skills, for example? Or, put another way, how can it be established that it was not another intervention that had produced the effect?

Questions of effectiveness are concerned with researching cause and effect; such as asking whether activity-based group work (cause) led to an increase in interpersonal skills (effect). Randomized controlled trials have developed over time to enable researchers to answer questions about cause and effect and these are now generally used in health and social care settings to evaluate the effectiveness of interventions. Examples of randomized controlled trials conducted in occupational therapy and mental health, include Graff et al. (2006, 2007); Edgelow and Krupa (2011); Lambert et al. (2009).

There are three key features of a randomized controlled trial: a control group, random allocation and blinding. These techniques have been developed to ensure that, if the study has been well-conducted, its results reflect the effectiveness of the intervention and not another confounding factor, the bias of the observer or selection bias, or the play of chance.

The randomized controlled trial is not the only research method that has developed and evolved over time. Methods of ensuing rigour in qualitative research (understood as trustworthiness) have undergone a similar evolution. Qualitative research seeks to develop in-depth understanding of phenomena such as lived experience (phenomenology), or a person's story or narrative about their own recovery journey, for example. Techniques have been developed in qualitative research, to maximize credibility, transferability, dependability and confirmability, to ensure that the findings of a qualitative study reflect the data collected and not the researcher's bias (Polit and Hungler 1995).

Reflecting on the example of occupational therapists' belief in the efficacy of activity-based group work, an overview of published research can be illuminating. A systematic review of activity-based groupwork aimed at helping people with severe and enduring mental health problems in community settings, improve their functional ability and/or reduce their mental health symptoms identified 136 papers (Bullock and Bannigan 2011). Of these, only three papers were relevant and met the inclusion criteria (see Bullock and Bannigan 2011 for more details on the method). Unfortunately, heterogeneity and flaws in quality in the three studies meant it was not possible to make specific inferences for practice from the studies. This means that, at the time this systematic review was published, occupational therapists only had anecdotal information to support their practice in relation to activity-based group work. Although it may have been supported by considerable theory (e.g. Cole 2005), there was no rigorous research to support the assertions that underpin this practice. This is important because activity-based group work is widely used by occupational therapists in mental health settings. The difference between *evidence* and *information*, in the context of evidence-based practice, is summarized in Table 9-1.

TABLE 9-1

The Difference Between Information and Evidence in Supporting Assertions About Practice

***The Basis for Our Assertion:* Occupation Enhances Health**	***Type Of Knowledge Supporting Our Assertion?***
We have seen it with our own eyes (observed)	Information
The client has told us (reported)	Information
We just know what does and does not work (based on intuition or untested tacit knowledge)	Information
We 'Googled it' (quick search of the internet)	Information
We have ideas about the relationship between the two concepts (theory)	(Weak) evidence
Using standardized assessments as outcome measures before and after intervention (careful measurement using reliable and valid measures)	Evidence
Well-conducted recent research (systematic observation using methods and procedures, which ensure the information is valid or trustworthy and not biased by the researcher)	(Strong) evidence

THE DIFFERENCE BETWEEN RESEARCH AND EVERYDAY LIFE

The discussion in this chapter so far highlights the difference between knowledge generated by research and that derived from everyday life (Abbott and Sapsford 1992).

In everyday life, we are free to observe and draw conclusions at will but we know that we often 'see what we want to see'. Research is more systematic than everyday life, drawing on a body of technical expertise or research methodology to ensure conclusions flow logically and cogently from the data and are open to public scrutiny. In this sense, research enables health and social care professionals to be accountable (Kumar 2011). Having a clear audit trail enables a transparency in decision-making that is not present in the use of customary assumption, intuition or tacit knowledge.

As well as having a sound methodological basis and being systematic in its approach, research also requires a certain attitude; a vigilance regarding gaps in arguments and/or weaknesses in the procedures used. Researchers and consumers of research always need to look for possible alternative explanations for the results or findings of a study; asking, for example, if there are any errors in the method. Researchers need to ask themselves '*Are there any other competing explanations for what they have observed?*' When reading research occupational therapists need to ask, '*Is there anything else that could explain what the researchers found?*' A questioning approach not only requires imagination, therefore, but a willingness to be open to other possibilities explaining the results or findings of a study. This means occupational therapists need to think carefully about the research findings they read and be open to the possibility that research may not demonstrate positive outcomes from occupational therapy.

In short, research methods allow us to collect data to generate new knowledge using methods and procedures which ensure the information is valid or trustworthy, and not biased by the researcher. This provides occupational therapists with a way of learning from their experiences which allows them to not be misled by their intuition or biased observations. This was partly the impetus for evidence-based practice. Practitioners in health and social care could no longer rely solely on their intuition or anecdote as sources of knowledge (Doust and Del Mar 2004). They had to start using rigorous, well-conducted research to underpin their clinical reasoning. Much of the new knowledge occupational therapists need in order to work competently post-qualification is gained through research. This is why occupational therapists need to be 'research aware' (see also Ch. 7, where continuing professional development is discussed in more detail in relation to professional accountability).

THEORY AND RESEARCH

Some research is known as 'blue skies research'. This is exploratory in nature with no certainty about how the phenomena being studied may be related, or what the outcome or usefulness of the research will be. While blue skies research has value in health services research, health services research is generally conducted to shape practice and should be relevant and important to service users and practitioners.

Research questions are usually deemed to be important if they have cost implications, and/or involve high numbers of service users, and/or are concerned with increased morbidity and risk of mortality. In some instances, the priorities of service users are used to shape the questions that researchers are funded to research (see Keating et al. 2006; Wright et al. 2007; and http://www.twocanassociates.co.uk/routemap/setting-research-priorities.php). Although practice shapes research questions, the design and approach to data collection is rooted in theory (except in the case of grounded theory, which is used to generate theory).

Theory is needed to operationalize a research study. It is used to define the concepts within the study, understand how they relate to each other, and to understand how best to address the research question. Box 9-1 shows how such operationalization fits into the research process. An example of how operationalization allows for the exploration of underpinning theory is provided in the systematic review of activity-based group work described earlier. In this review, Bullock and Bannigan (2011, p. 257) state:

> *This group work is often activity based (Lloyd, King, & Bassett, 2002), with activity defined as "a series of linked episodes of task performance by an individual which takes place on a specific occasion during a finite period for a particular reason" (Creek, 2003a, p. 49). According to Finlay (2004), "activity groups aim to develop skills and/or encourage social interaction. The term is used in contrast to 'support group' which emphasizes communication and psychotherapy elements" (p. xiiii)*

BOX 9-1
THE RESEARCH PROCESS

IDENTIFY A RESEARCH TOPIC
This should emerge from practice and be important. The topic is used to shape the key terms for the search strategy used to search the literature.

REVIEW LITERATURE
To identify (a) if there is a gap in the knowledge base and (b) how the topic has been researched in the past.

OPERATIONALIZE KEY TERMS
To develop working definitions of the variables (based on the reviewed literature) and an understanding of how terms relate to each other.

FORMULATE RESEARCH QUESTION
This can be expressed as a question, an aim, an issue or a hypothesis.

DESIGN THE STUDY
This involves choosing a research design or approach suitable for answering the question.

FINALIZE RESEARCH PROPOSAL (OR PROTOCOL)
This becomes the blueprint for the study.

SUBMIT ETHICS APPLICATION (IF NEEDED)
If the study involves people a favourable ethical opinion (following ethical review) is required before the study can begin.

COLLECT DATA
Recruiting people to the study and collecting data. No changes must be made to the agreed proposal (protocol) without securing permission for the changes from the ethics committee that gave the favourable opinion.

DATA ANALYSIS
The data collected are analysed using techniques consistent with the research design in order to generate findings or results.

INTERPRET FINDINGS OR RESULTS
Understanding what the findings or results mean in relation to the research question.

WRITE REPORT
For a student, this might mean submitting your dissertation. For someone who has been funded it might mean submitting a report using a template developed by the funding body. It may be a research paper for a journal.

DISSEMINATE FINDINGS
As well as the research report the researcher needs to consider wider dissemination of their work, e.g. conference presentations or information leaflets, so that the people who need to hear about the study's findings or results are informed.

In this statement, the researchers are clearly explaining how the concept 'activity' is understood within their study and how they understand activity is used within group work. Both definitions are supported by references to the literature, drawing on the work of well-known theorists whose work is widely accepted within the profession. Bullock and Bannigan (2011) do not suggest that the definitions are contentious or that there are a number of different ways of defining the terms, which suggests these are fairly standard definitions.

Another example of how theory informs research is Creek's (2003a) exposition on occupational therapy as a complex intervention. The Medical Research Council (2000) described a number of steps involved in evaluating a complex intervention. The first step is 'to explore relevant theory to ensure the best choice of intervention' (Medical Research Council 2000, p. 3) and the second is to 'identify the components of the intervention and the underlying mechanisms by which they will influence outcomes' (p. 3). Creek's (2003a) definition of occupational therapy as a complex intervention provides researchers with a coherently structured description of the components of occupational therapy and how they relate to each other, so that researchers can evaluate the intervention consistently in different studies.

SERVICE USER AND CARER INVOLVEMENT IN RESEARCH

The inclusion of service user commentaries in the fourth edition of this book is indicative of the growth of the service user movement generally and the mental health service user movement in particular. The service user commentary on the research chapter in the previous edition (Ilott 2008) highlighted the following issues:

- The use of language associated with research and evidence-based practice tends to exclude service users

- The research questions which service users generate are rarely the subject of research investigations
- Service users want their experiences to be valued and harnessed within research projects
- Service users want to be involved in research and the ways in which service users can contribute varies enormously from designing studies to leading research programmes
- Service user involvement contributes to better social inclusion and empowerment for service users and carers
- Help for services users and carers may be needed in terms of practical support during the research process
- There is a challenge for occupational therapy, as a research-emergent profession, to learn from others in order to break traditional boundaries of research (such as using new approaches to conducting research) without relinquishing quality standards.

These issues provide a useful structure to explore service user and carer involvement in research.

The Practicalities of Involving Service Users and Carers in Research

There is an expectation that service users and carers will be involved in all kinds of research, including mental health research. The mental health research network in the UK has, as one of its priorities, to give people with experience of mental health problems and their families the opportunity to get involved in studies (Mental Health Research Network 2010).

This is not a purely altruistic gesture because involving service users and carers in research, if done well, improves the quality of research (RCN 2007) (see Box 9-2). The qualification 'if done well' is important here because there is a danger of tokenism; whereby the *appearance* of service user inclusion is created but without an authentic service user voice being heard. Avoiding tokenism requires researchers not only to think, but also to behave, differently. This may include, for example:

- providing practical support and encouragement for service users
- including more time when planning studies
- recognizing that service user researchers' own mental health difficulties may mean they need time away from the study, and that this does not devalue their contribution to the project team
- involving the service users in disseminating the study's findings
- properly acknowledging service users' involvement, including remuneration.

Researchers also need to avoid jargon and use lay persons' language that can be understood by service users and carers, or at the very least have different summaries available for different audiences. Service users are increasingly being involved in mental health research (see Mental Health Research Network 2011), which suggests that service users' experiences are being valued and harnessed within research projects.

Box 9-2 provides an example of a study about occupational therapy in mental health that involved service users. Just as with the taxonomy of participation in research (Hart and Bond 1995) there is a continuum of types of activity for service user involvement, which may take various forms such as co-applicant, reference/steering group member, co-designer, data collector, or data analyst (Mental Health Research Network 2011). While service users are becoming more involved in research, the extent to which service-user-generated research questions are driving research, is unclear. For example few service users are playing a lead role in research programmes; although Dr Diana Rose (Co-Director of the Service User Research Enterprise at King's College in London, UK) is a notable exception, being Europe's first Senior Lecturer in User-led Research.

The Challenges Associated with Service User and Carer Involvement

The technical language associated with research can be a challenge for those unfamiliar with it. This book is written for professionals and students who need to understand this language but – where possible – such technical language has been supported with lay explanations to maximize accessibility.

The existence of this language barrier brings into question researchers' commitment to service user involvement but, as the Service User Commentary (Ilott 2008) noted earlier, in 'breaking traditional

BOX 9-2

AN EXAMPLE OF SERVICE USER INVOLVEMENT IN MENTAL HEALTH RESEARCH

THE EAGER PROJECT

The **E**valuation of the imp**A**ct of the implementation of **G**overnment policy on occupational therapy: using assertive outreach as an **E**xempla**R** (EAGER) Project

In this evaluation of the impact of UK government policy – the National Service Framework for Mental Health (DoH 1999) – on occupational therapy was explored. Assertive outreach was used as an exemplar because, at that time, it was the only policy area in the UK that specified that occupational therapists should be included in teams or that another member of the team needed to be educated to develop the relevant skills. A participatory model of user involvement was adopted to develop an approach to research that was congruent with client-centred practice (Sumsion 2000). A team of service user researchers were recruited to work with the project team on data collection, data analysis, report writing and dissemination. Service users designed the interview schedules, conducted interviews, analysed data and participated in dissemination. As well as gathering qualitative data, a cost analysis and a notes audit using an intervention schedule for occupational therapy were also undertaken.

LESSONS LEARNT

- Involving service users improved the quality of the research. For example, service users brought a different perspective to the interpretation of findings. They found similar issues to the occupational therapist researchers but drew out nuances missed by the occupational therapists. For example, teams without occupational therapists offered a narrow range of group interventions, incongruent with a recovery-orientated service (see Slade 2009), rather than individualized activity provided by occupational therapists. This suggested occupational therapists make a positive contribution to the recovery of people with severe mental health problems.
- Research needs to be planned and conducted over a longer period (Consumers in NHS research support unit 2001; Involve 2003; Steel 2004) because there may be times when service user researchers' mental health problems impact on their ability to work on the study. In this study only one person was continuously involved in the whole process. In keeping with each individuals' recovery journeys people only contributed to the study when they could.
- Incorporating an education programme was beneficial. It ran alongside the study to ensure a lack of research experience did not disadvantage anyone involved in the study.
- Data analysis required prior research knowledge or experience beyond the education programme offered during the study.
- The administration of service users' remuneration was managed through the NHS Trust rather than the university because the processes to facilitate this were already in place.
- It was advantageous to link with a service user consultancy because of their expertise and strength in depth; they were well networked.
- It was important to adopt a flexible approach, for example, data collection was organized over a longer period of time.

ACKNOWLEDGEMENT

The EAGER project was funded as one of the College of Occupational Therapists' urgent research priorities funded projects in 2006. This scheme was a competitive funding round that sought to develop the occupational therapy profession's research capacity. Funding provided the opportunity to develop Dr Katrina Bannigan's research capacity as a principal investigator and Simon Hughes's research skills because his PhD studies were embedded within the project.

boundaries' a balance has to be struck between developing accessible language and maintaining standards.

Occupational Therapy and Service User and Carer Involvement

A key feature of occupational therapy is client-centred practice (Sumsion 2000). Occupational therapists do not stop being occupational therapists when they research so these values should be reflected in their research practice also. The study described in Box 9-2 is an example of occupational therapists conducting research in a way that was congruent with their professional values.

RESEARCH GOVERNANCE AND ETHICS

Occupational therapists operate within a wider health and social care context and must therefore conduct their research in line with local, national and international research governance and ethics

arrangements. Research governance refers to the ways in which organizations ensure that research is conducted to high scientific and ethical standards. These processes are needed to prevent misconduct. Scientific standards refer to methods used to collect, analyse and report data. These are generally monitored through peer review systems, such as research committees at the proposal (protocol) stage and peer review at the journal publication stage, for example (see Box 9-1).

Scientific and ethical standards are closely related because a poorly designed study is inherently unethical. Involving people in a study that cannot answer the question it has been designed to answer is a waste of the time and commitment of the people who agree to participate. Design is a very important part of research because it shapes how the data are collected and analysed. Ethical standards relate to researcher integrity in terms of treating people fairly, being trustworthy and competent, and in ensuring that research participants' best interests are paramount. Ethical procedures protect the people involved in research studies (see Ch. 10 for a more detailed discussion of Ethics).

For a student undertaking a dissertation project complying with research governance and ethics may mean having their work peer reviewed by their supervising tutor and submitting an application to their university's ethics committee. For a practitioner or researcher, compliance may mean adhering to local governance arrangements (such as peer review by a research and development office) and national and/or international systems for conducting research. For example, an occupational therapist conducting a randomized controlled trial is expected to register their protocol with a trials register. Examples of trials registers are the Current Controlled Trials Register (see http://controlled-trials.cm/) or the Iranian Registry of Clinical Trials (see http://www.irct.ir/). There are many others. They would also be expected to use the Consolidated Standards of Reporting Trials (CONSORT) statement (see http://www.consort-statement.org/) to guide accurate writing up of the trial when it is completed, to reduce bias.

Qualitative researchers will often embed review processes into their data collection – such as member checking or investigator triangulation (Polit and Hungler 1995). Research registers are not compulsory for qualitative research although some organizations are starting to keep them. For example the Association for Dance Movement Psychotherapy has developed a research register (see http://www.admt.org.uk/ResearchRegister.html), which includes qualitative research. These examples demonstrate there are variations in how research governance and ethics are managed. Consequently, researchers need to investigate arrangements on a study by study basis. It is wise to check arrangements at the start of any study and avoid making assumptions based on previous research experiences. Research governance and ethical procedures do change over time and vary between organizations, professions and countries even if there is a commonality in their principles and purpose.

DIFFERENT RESEARCH DESIGNS ADDRESS DIFFERENT RESEARCH QUESTIONS

As well as differences in research governance and ethical procedures there are also different approaches to research. Different research designs answer different research questions. This is an important point to bear in mind because it means that different research designs are just *different*; no research method or design is inherently better than another:

> *No single design has precedence over another, rather the design chosen must fit the particular research question … Many different quantitative and qualitative designs exist, each with a specific purpose and with strengths and limitations*
>
> ***(Roberts and DiCenso 1999, p. 4).***

It is important to be aware of the types of questions different research designs or methods are able to answer (see Bannigan 2005, for a summary of these). It is only by knowing the types of questions a research design or method can answer that an occupational therapist can judge whether the correct method has been used in a study or not. This is important because research guides practice. Inappropriate use of research findings may result in an occupational therapist doing more harm than

good (Gray 1997). Occupational therapists are required to provide evidence to support their clinical practice by integrating research findings into their clinical decision-making (Bennett and Bennett 2000). Consequently occupational therapists need to be aware of research and use it in their practice. This is why evidence-based practice is a fundamental feature of health and social care.

EVIDENCE-BASED PRACTICE

Evidence-based practice is one of the most widely discussed topics of the last two decades of health and social care. It emerged in the 1990s and is now a worldwide practice adopted by many practitioners, not just those working in health and social care settings. It developed in direct response to concerns about effectiveness and inequalities in healthcare (WHO 2004) and has evolved rapidly over time.

Today, there is a broader understanding of evidence-based practice. In particular, there is recognition of the complexity of using research findings in practice and of the need to set evidence-based practice in the global context of occupational therapy rather than adopt a narrow, local focus (Whitcombe and Westcott 2006). Originally evidence-based practice was defined as 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients' (Sackett et al. 1996, p. 71) but the scope of evidence-based practice has broadened;

> *Evidence-based practice requires that decisions about health [and social] care are based on the best available, current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources.*
>
> ***(Dawes et al. 2005, p. 4)***

It is recognized that while the best available, current, valid and relevant evidence is important in decision-making it also needs to be considered alongside the service user's values, therapist's expertise and resources. It is a misconception that evidence-based practice is just about research. Research-based knowledge is used in evidence-based practice but not without reference to the wider context of people's lives (Dopson and Fitzgerald 2005a).

The World Federation of Occupational Therapists expects all occupational therapists to be evidence-based practitioners (World Federation of Occupational Therapists 2004). Evidence-based practice is needed because, even if research is well-conducted, it does not automatically mean that its findings will be used in clinical decision-making. Research use is not straightforward. It can take a number of years for valid published research to be adopted by practitioners. This is because it often involves changing behaviour; something which organizations and people, including occupational therapists, often find difficult. Evidence-based practice is a process that involves five steps, as shown in Box 9-3.

The Evidence-Based Practice Process

The process begins with an occupational therapist reflecting on their practice to generate a question important to practice (see Fig. 9-1). The question should identify the intervention, population and outcome of interest. PICO is used as a mnemonic to assist with this, where P = population, I = intervention, C = comparator (if appropriate) and O = outcome (Booth and Madge 1998). For example *Is activity-based group work (I) effective in*

BOX 9-3

THE STEPS INVOLVED IN EVIDENCE-BASED PRACTICE

- **Step 1: Asking the question**: An important question emerges from practice
- **Step 2: Finding the evidence**: The best evidence to answer the question is tracked down with maximum efficiency using a wide-ranging search strategy
- **Step 3: Appraising the evidence**: The evidence identified is critically appraised in terms of its rigour and usefulness in answering the research question
- **Step 4: Using the evidence**: Acting on the evidence. Depending on the outcome of Step 3 this may involve continuing, changing or stopping current practice
- **Step 5: Evaluation**: Evaluating the process and outcomes to assess if evidence-based practice has been achieved.

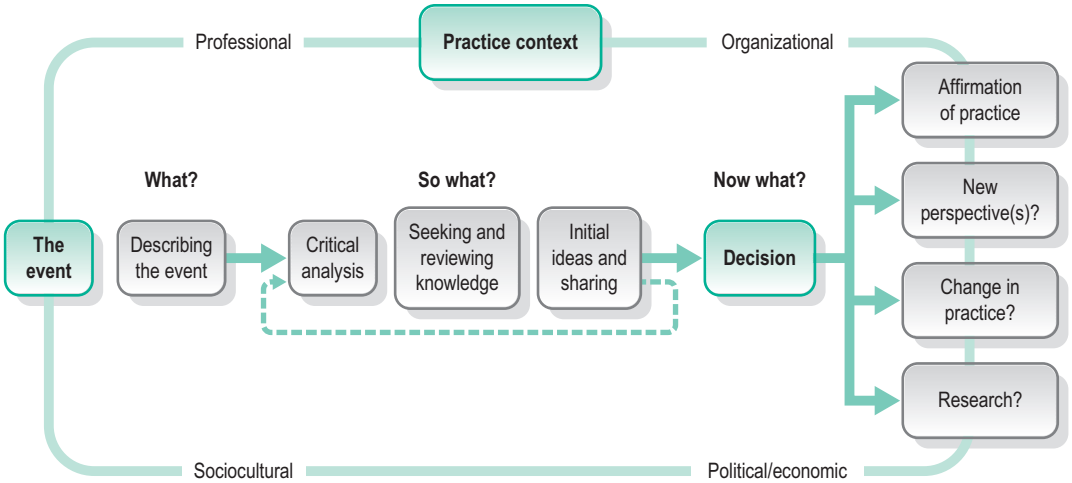

FIGURE 9-1 ■ The Model of Professional Thinking. *Reprinted from Bannigan K, Moores A 2009 A model of professional thinking: integrating reflective practice and evidence-based practice. Canadian Journal of Occupational Therapy 76(5):342–350, with permission from Sage Publishers, http://online.sagepub.com.*

helping people with severe and enduring mental illness in community settings (P) improve their functional ability (O) and/or reduce their mental health symptoms (O)? (Bullock and Bannigan 2011). No comparator was used in this instance but the question could have been formulated thus with a comparator: *Is activity-based group work (I) more effective than psychotherapy (C) in helping people with severe and enduring mental illness in community settings (P) improve their functional ability (O) and/or reduce their mental health symptoms (O)?*

Evidence to answer the question can be accessed from many places so a detailed search strategy, based on the question, needs to be developed to search as quickly and efficiently as possible. As evidence-based practice concerns questions of effectiveness (i.e. questions about cause and effect), and the most appropriate research designs to answer questions of effectiveness are systematic reviews and randomized controlled trials (see Bannigan 2005), it makes sense to search for systematic reviews first (see Box 9-4). If a recent well-conducted systematic review exists there is no need to search further but, if an up-to-date systematic review does not exist, the next step is to search for randomized controlled trials. The hierarchy of evidence (see Box 9-4) helps guide the literature-searching process because it identifies,

BOX 9-4

SUMMARY OF HIERARCHY OF EVIDENCE FOR QUESTIONS OF EFFECTIVENESS

SYSTEMATIC REVIEWS (META-ANALYSES)

Search databases of systematic reviews, e.g. the Cochrane Library (2012) or OT Seeker (2011)

RANDOMIZED CONTROLLED TRIALS

Search databases of primary research, e.g. AMED, CINAHL, Medline or Psyc Info

NON-RANDOMIZED INTERVENTION STUDIES/ OBSERVATIONAL STUDIES/NON-EXPERIMENTAL STUDIES

Search databases of primary research, e.g. AMED, CINAHL, Medline or Psyc Info

EXPERT OPINION/CONSENSUS (E.G. THEORY/ LITERATURE REVIEWS/POLICY)

Search a range of sources, e.g. websites or textbooks.

Note: As a rule of thumb, The Bolam Test may be invoked (in a court of law). It holds that if a professional meets the standard indicated by consensus across a responsible body of similar professionals then this will be accepted (Dimond 2010). This is not just anecdotal practice but an accepted standard of professional practice.

(from Harbour and Miller 2001)

in order of rigour, which are the most effective methods when specifically answering questions of effectiveness. It should be noted that this does not hold true for answering other types of research questions. The challenge in using the hierarchy of evidence is that it is predicated on the assumption that research is well-conducted, but not all research *is* well-conducted, so occupational therapists need to be able to critically appraise any research they read.

Any research identified is critically appraised for its rigour (assessing the method) and usefulness (assessing its relevance to the research question). Once well-conducted and relevant research has been identified, the next step is for the occupational therapist to act on the evidence:

> *The skill in evidence-based practice is neither in finding nor in appraising the evidence but in utilising the findings as part of the clinical reasoning process*
>
> ***(Taylor 1997, p. 472).***

Research utilization is the aspect of evidence-based practice that has developed most in recent years. It is acknowledged to be a more complex activity than was originally thought (Bannigan 2007). The field is developing at such a rate that the terminology frequently changes. For example, *research utilization* was subsequently known as *knowledge transfer*, and is now called *knowledge exchange* (Bannigan 2007). There have been some excellent research-based texts published on research utilization, such as Dopson and Fitzgerald (2005b). The final step involves monitoring how effective the application of evidence-based practice has been, such as by conducting a clinical audit to check the research is being routinely used in practice.

Being an Evidence-Based Practitioner

For occupational therapists to be evidence-based practitioners, they need to routinely access, critique and apply research that is relevant to their clinical practice. A challenge is that evidence-based practice is only one characteristic of good practice. Occupational therapists are also expected to be reflective practitioners. The Model of Professional Thinking (Bannigan and Moores 2009) shows how occupational therapists can integrate evidence-based practice with reflective practice (Fig. 9-1).

Evidence-Based Practice in Occupational Therapy

Evidence-based practice can be difficult to achieve. Barriers to research utilization have been well documented (see Metcalfe et al. 2001). Research suggests 'therapists find that there is insufficient time to implement new ideas, no time to read research, statistical analyses are not understandable, literature is not compiled in one place, literature reports conflicting results and it is not easy to transfer findings into daily practice' (Bannigan 2007, p. 188).

Furthermore, evidence-based practice – particularly the emphasis on quantitative research – has been the subject of considerable criticism in occupational therapy (see Egan et al. 1998; Reagon and Boniface 2010; Tickle-Degnen and Bedell 2005). Taylor (2007) stated 'Qualitative research has, for some time, been seen as the methodology of choice for occupational therapy research' (p. 87). She used three references to support this assertion dating back to 1982, 1989 and 1991. However, she did not present this as the contentious viewpoint it is. Whatever individual occupational therapists think about the value of qualitative research in terms of evidence for the effectiveness of interventions, the reality is that qualitative research will not shape the content of clinical guidelines used to guide population-based decisions. If occupational therapists want their interventions to be included in such clinical guidelines, whether these are developed by government or through the actions of insurance companies, then therapists need to generate 'effectiveness research'. More recently, the research pyramid, an inclusive framework as a means for respecting all sources of knowledge, has been published as an alternative to the hierarchy of evidence (see Tomlin and Borgetto 2011).

Another concern is that evidence-based practice may lead to a standardizing of care (Sackett et al. 1996). This is disquieting for occupational therapists with their interest in creativity (Creek 2003b). However, this concern is based on a misunderstanding of evidence-based practice. It ignores the importance which evidence-based practice places on the interplay between the therapist and the service user. In this

interplay, there is no room for standardization, as is explained in Ch. 6.

It should be noted that there are alternative perspectives to evidence-based practice – such as *values-based practice* and *research-informed practice*. These are introduced here to broaden the chapter's perspective and contribute to the debate surrounding evidence-based practice.

- *Values-based practice* is an adjunct to evidence-based practice and a burgeoning interest in health and social care (McCarthy and Rose 2010). It acknowledges the complexity of professional practice and sees itself as a necessary counterbalance to the dominance of positivist science within evidence-based practice and the consequent devaluing of professional expertise and service users' values. It holds that practice problems cannot be solved by individual, disconnected solutions chosen from a range of evidence-based options and, in contrast, upholds a re-emergence of humanistic values and holistic care. It combines technical ability *and* a human capacity; a blending of the values of both the service user and the practitioner to create a true, as opposed to tokenistic, partnership (Warwick Medical School 2012).
- *Research (or evidence)-informed practice* is widely used in the education and social care sector. It is presented as a more nuanced way to understand the link between research, policy and practice (Biesta 2007). Evidence-informed practice involves following 'best practice standards and making appropriate decisions based on the best available research. When specific research is not available to guide practice, practice standards should be based on the best available information and clearly articulated values that reflect the principles of the practice model. All practice standards should include measurable indicators and be consistently monitored and evaluated' (American Public Human Services Association 2011, p. 3).

Ilott et al.'s (2006) analysis of evidence-based occupational therapy in the global context acknowledged that there are challenges for evidence-based occupational therapy, in that there is a lack of evidence to demonstrate the effectiveness of occupational therapy practice and a dearth of context-sensitive outcome measures. Also, for many countries, the use, and dominance, of English as the language of science, creates an additional barrier to accessing knowledge in countries where English is not the first language.

RESEARCH AND EVIDENCE-BASED PRACTICE IN MENTAL HEALTH OCCUPATIONAL THERAPY

Having considered research and evidence-based practice, this part of the chapter focuses specifically on research and evidence-based practice in the context of mental health practice and occupational therapy.

Evidence for the Impact of Occupational Therapy on Mental Health

How possible is it for the research-aware occupational therapist to base their professional practice on established research findings? A heartening feature of modern practice is that the evidence-base for occupational therapy is growing. In March 2003, OTSeeker was launched. This is a database containing bibliographic information, abstracts and details of systematic reviews relevant to occupational therapy. When the database commenced over 1000 RCTs and systematic reviews were indexed on it. Since then OTSeeker has grown exponentially and in June 2011 there were approximately 7500 records available (Bennett et al. 2011). Steultjens et al. (2005) identified 14 systematic reviews about occupational therapy, though only one was about mental health. Therefore, while it would be wrong to say there is no research to underpin practice in occupational therapy, there are clearly still gaps in the knowledge base. Gaps have been identified in the occupational therapy knowledge base generally (see American Occupational Therapy Association 2007; Bannigan et al. 2008) and specifically in occupational therapy in mental health (see Bannigan and Laver-Fawcett 2011; D'Amico et al. 2010; O'Connell and Farnworth 2007; Rebeiro 1998).

Systematic Reviews in Mental Health Occupational Therapy

The Research Centre for Occupation and Mental Health (RCOMH) has been mapping research in mental health. Updating Steultjens et al.'s (2005) systematic review, RCOMH identified four systematic reviews

relevant to occupational therapy and mental health (Bannigan and Spring 2012). Two of these examined *professional* issues:

- Edwards and Burnard (2003) focused on work-related stress among occupational therapists
- Hunter and Nicol (2002) reviewed recruitment and retention issues within occupational therapy

and two were *clinically* related:

- McGrath and Hayes (2000) looked at cognitive rehabilitation
- Tungpunkom and Nicol (2008) focused on life skills.

The fact that two of the four reviews were about occupational therapists themselves (their stress levels, recruitment and retention) rather than the interventions used by occupational therapists meant there was less evidence about occupational therapy in mental health than there initially appeared to be. Since this work was completed *The American Journal of Occupational Therapy* has published a special issue in 2011 on the effectiveness of occupational therapy services in mental health. This has added three more systematic reviews to the evidence base for occupational therapy in mental health (Arbesman and Logsdon 2011; Bullock and Bannigan 2011; Gibson et al. 2011). Given that systematic reviews are at the top of the hierarchy of evidence for questions of effectiveness (see Box 9-4), this suggests that considerable gaps in the knowledge-base underpinning occupational therapy in mental health persist.

Developing Research Capacity in Mental Health Occupational Therapy

'Research influences practice' (Britnell et al. 2005, p. 13), so a lack of research about effective occupational therapy practice is a concern. Being research aware is essential, but occupational therapists can only be aware of research if studies continue to be conducted. Occupational therapists must become generators of research-based evidence as well as critical consumers of it.

This represents a shift in thinking from the earlier notion that, while all occupational therapists would be research consumers, some would be research participants and only a few would be research leaders (Eakin et al. 1997). In the UK, the College of Occupational Therapists has since declared that 'Occupational therapists have a responsibility to contribute to the continuing development of the profession by utilizing critical evaluation, and *participating* [emphasis added] in audit and research' (COT 2005, p. 17). This goes beyond research awareness as a universal skill and asserts conducting research is every occupational therapist's concern (Bannigan et al. 2007).

Clearly, not every individual occupational therapist needs to develop research proposals or submit grants to conduct research. (Although, if you would like to do this, please do not feel discouraged from doing so.) Occupational therapists can also volunteer to collect data. As more multicentred studies are developed in occupational therapy, more people are needed on the ground to collect data in practice settings. This can only be done if clinicians agree to be involved in studies.

CONCLUSION

Research is required for evidence-based practice (see Box 9-5), and being an evidence-based practitioner is fundamental to being an expert practitioner capable of

BOX 9-5

SOME KEY RESOURCES FOR EVIDENCE-BASED PRACTICE

- **The AGREE Instrument** (A tool designed primarily to assess the methodological quality of clinical practice guidelines)
  http://www.agreetrust.org/
- **The CASP UK website** (Critical appraisal tools)
  http://www.casp-uk.net/
- **DISCERN** (An appraisal tool for consumer health information on treatment choices)
  http://www.discern.org.uk/
- **International Centre for Allied Health Evidence: Critical Appraisal Tools**
  http://www.unisa.edu.au/cahe/Resources/CAT/default.asp
- **OTcats** (Occupational therapy critically appraised topics)
  www.otcats
- **OTSeeker** (A database that contains abstracts of systematic reviews and randomized controlled trials relevant to occupational therapy)
  http://www.otseeker.com/
- **Research Centre for Occupation and Mental Health** (Provides a monthly bulletin with useful appraisals of latest evidence)
  www.yorksj.ac.uk/RCOMH

working with service users to deliver high quality interventions. Although evidence-based practice has been on the agenda since the early 1990s, occupational therapy is still a long way short of a body of evidence of the scale needed to clearly demonstrate the effectiveness of therapists' interventions in mental health practice.

Occupational therapists should be concerned not simply with how good an occupational therapist they are, but with how good an occupational therapist they can be. The service users we work with would benefit greatly if more occupational therapists chose to read research, become research aware, conduct research and contribute to the evidence base. This is not necessarily easy to do but, as Martin Amis (1996) said, working hard gives you muscles for working hard.

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SERVICE USER COMMENTARY

INTRODUCTION

This chapter discusses the importance of research to occupational therapists and their reliance on evidence-based practice. The author asserts that research and evidence-based practice is a contentious issue in occupational therapy and mental health and needs to be scrutinized. I agree because there are various facets to knowledge production. It is not only health and social care professionals who conduct research, but also an ever-growing body of service user/survivor researchers. This includes people who are dissatisfied with research conducted *on them* who want their voice heard so that research can inform practice which meets their needs, and it also includes users/survivors who are professional researchers themselves. For example, see the work of Rose (2009).

In this commentary, I give examples from my own experiences as a service user/survivor of occupational therapy and also draw on my experience as a user researcher, studying at post-graduate level and beyond. I will also examine power issues and bias in mental health research.

QUESTIONS OF EFFECTIVENESS

Occupational therapy researchers have to evaluate how their intervention (cause) contributes towards developing service users' skills (effect) and improving their mental health. This is a particular challenge when it is acknowledged that the service user in question may have input from a range of professionals.

Even though an occupational therapist may feel that group activities are working effectively, how does he or she know whether this is best practice, or what meaning it carries for individual service users in relation to the wider context of their lives? This is why there should be more than one choice of activity within inpatient settings. An example I can give is a relaxation session that took place in a male side ward at a liaison psychiatry unit. The occupational therapist assumed we were all benefitting from this experience, but as someone who had suffered past abuse, lying down on a male bed smelling of men's body odour, was a frightening experience. It resulted in me leaving the session and upsetting the status quo, just when other service users were beginning to relax to the occupational therapist's soothing words and background music. The occupational therapist only saw what she wanted to see. One needs to look beyond that and consider the reasons why service users are in hospital, and why some may want separate activity groups. Occupational therapists, therefore, need to be reflexive researchers. They need to critically reflect on their own biases, assumptions and predispositions.

WHY RESEARCH?

Scientific randomized controlled trials are seen as the 'gold standard' in healthcare research, even within mental health research. Such trials may answer cause and effect questions but people are complex and cannot be studied simply by using methods from the natural sciences. Quantitative research asks 'closed' questions. Qualitative research methods, such as observation, interviews and narratives, can be much more effective in accessing the voices of mental health service users. One may discover more from an interview than a questionnaire because service users have feelings, thoughts and ideas. Therefore, by asking us what we think works most effectively, you will understand why someone does not want to use a group session, or the reason why they are against taking their medication (e.g. weight gain).

RESEARCH IN PRACTICE

All research is biased to some extent and may be heavily influenced by the values and norms of the researcher. The randomized controlled trial is only one way to conduct research, though it still dominates and gets most of the research funding. Stating that there is a *hierarchy* of evidence negates the influence of user/survivor researchers. It is rather presumptuous when there are a variety of ways of gathering research evidence. It is only during the past two decades that people thought about asking service users what they actually wanted from services. Now, in most academic research, when researching mental health, the researcher has to provide evidence of service user involvement. Discovering 'what works' for service users requires their involvement from the outset, as equal partners.

POWER IN RESEARCH

Among many marginalized groups, research has historically been research *on* people rather than *with* them. User/survivor research is still seen as less important than academic research and still has to fight to get even a small amount of funding, unlike the large sums that medical research obtains from drug companies, the government and other organizations.

Furthermore, assuming that mental health service users are a homogeneous group is not only ignorant but excludes certain individuals. Service users come from all walks of life, all ethnicities, classes and academic abilities. Also, there are certain powerless groups in society that have been ignored, marginalized and discriminated against in research, for decades. Foucault (1967), for example, describes how mental health service users were defined as insane and hidden from the rest of society – locked away in asylums. Rose (2009) describes how mental health service users (deemed mad) are also locked out of the dialogue about mental illness.

Furthermore, research about mental health is invariably about men not women, and most research about black and minority ethnic populations tends to be about black men, to the detriment of black women, who are doubly discriminated against – with the exception of some South-east

Asian women. This has led some user/survivor researchers, particularly women, to promote a feminist perspective (Essien 2003).

CONCLUSIONS

User/survivor research is now established and has its own theories of knowledge production (epistemology) and different ways of exploring the social world (methodology) (Rose 2009). Surely, a way to address the comparatively low profile of the user/survivor presence in academic research is to accommodate user/survivor studies in systematic reviews. As one service user told me when I conducted some research: 'I was asking questions that the professionals involved with them would never think to ask because they had not been service users'!

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Section 4 THE CONTEXT OF OCCUPATIONAL THERAPY

10 ETHICS

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CHAPTER CONTENTS

INTRODUCTION

This chapter explores healthcare ethics in relation to occupational therapy in psychosocial settings. The matters discussed may appear routine but these unremarkable aspects of practice run the risk of going unnoticed because interest is often focused on the unusual and random moral occurrences of healthcare (Wright St Clair and Seedhouse 2005). The latter often attract a significant amount of publicity, debate and discussion and there is a danger that ethics is only associated with complex and extraordinary situations. There are many competing ethical theories and philosophies in healthcare, this chapter will consider 'normative ethics', which explores what is morally right and wrong and the application of ethical principles to occupational therapy practice.

WHAT IS ETHICS?

The word ethics originates from the Greek word *ethos,* which means a person's character or natural disposition (Leathard and McLaren 2007). Ethics is not merely concerned with dilemmas, it is about how individuals make sense of the world they live in, based on their beliefs, values and experiences, which influence the moral judgements we make (Hendrick 2004). However, respecting the values of others which often differ from our own is vital and is essential for collaborative, person-centred practice. Ethics is not just about dilemmas but these may arise when a situation occurs and there appears to be no acceptable resolution. Options may be limited to selecting between unsatisfactory choices. However at some point,

a moral judgement has to be made, which will be influenced by the values and beliefs of those making the decision.

THEORIES ABOUT ETHICS

Different philosophical schools of thought have developed theories to explain how moral judgements are made. It is not within the scope and remit of this chapter to critically explore philosophical theory in detail. However, it is important that occupational therapists have some basic understanding of the three main theories of ethics as each offer a different perspective. Their relevance to contemporary practice is often the centre of much discussion, so none of the theories should be used uncritically.

Virtue Theory

Originating from the work of Aristotle (384–322BC) who suggested individuals possessing particular character traits, for example compassion, honesty and courage, will conduct themselves in a virtuous way, this theory has been developed further over time but the central tenet remains; a virtuous person is a person of good moral character and does good for others. One of the main criticisms of a virtue-centred approach is that it is vague and provides no guidance for practitioners to follow when they have to make difficult decisions (Begley 2005). Conversely, Hursthouse (1999) suggests that virtue ethics can provide guidance on how to act in a given situation because each virtue generates rules and standards about how to behave. Gallagher and Hodge (2012) note there is no definitive list of which virtues are significant. Sieghart (1985) identified that the altruistic component of professional identity develops in parallel with the development of the knowledge for practice. Professional identity is rooted in the ethical ethos of that profession. However, one of the difficulties with this contention is that, if occupational therapy students are supposed to acquire specific ethical values through their professional education, whether they actually acquire this is questionable. This is because of the indiscriminate way in which the ethos of the profession is taught and assessed (Terry 2007).

Consequentialism (Utilitarianism)

Jeremy Bentham (1748–1832) and John Stuart Mill (1806–1873) suggested that good or bad actions are determined by their foreseeable consequences. Decisions are made on the basis of the greatest good for the greatest number and, if only undesirable choices are available, the least undesirable should be implemented. It is based on the pursuit of happiness and pleasure. However, this theory fails to take into account the needs of individuals who are in the minority, that some consequences are not foreseeable and happiness and pleasure are subjective experiences. Within occupational therapy education and practice, there is great emphasis placed upon considering the person as an individual, whereas this particular theory does not focus on individual need but may be useful when considering how finite resources are distributed.

Deontology

Deontology was developed by the philosopher, Immanuel Kant. It is a duty-based theory, where the emphasis is placed upon the nature of the actions rather than the consequences. Certain duties are mandatory, for example not to lie. A duty-based ethicist would claim telling a lie to an individual, even where this may have better consequences, is morally wrong to do so, because lying is unacceptable. There is no rationale for identifying an individual's duties to another or guidance on how to resolve situations when duties conflict. This approach does not consider personal feelings or consequences for an individual or group which, again, is not compatible with the core values of occupational therapy practice. However, within healthcare roles it is helpful to have some sense of what duties are required of each professional group, many of which can be found in professional codes.

ETHICAL PRINCIPLES

By contrast, Beauchamp and Childress (2009) present a principled approach to bioethics, outlining a framework of four principles: autonomy, beneficence, non-maleficence and justice. It is suggested that these are the basic values which underpin common morality and these also form the foundation of many professional codes. Application of the principles facilitates the identification of, and reflection on, moral problems. In practice, these principles become prima facie

duties, which professionals are required to uphold, such as respecting confidentiality. However, if there is conflict between principles, for example respecting autonomy and beneficence, it is assumed that the dilemma can be addressed through careful consideration (Reamer 1995). Beauchamp and Childress (2009) acknowledge no theory or framework can provide absolutes but identify their guidance at least provides a basis for discussion. This approach to resolving ethical dilemmas has been widely adopted in the health literature and has proved popular with members of the medical and nursing professions. As with the ethical theories (above), there are criticisms of this stance. Wright St Clair and Seedhouse (2005) suggest that this view is overly simplistic; it is not sufficiently adequate to facilitate the resolution of ethical dilemmas due to the lack of detail and absence of an underpinning theoretical basis and does not provide specific guidance for moral behaviour. Therefore, it cannot guarantee ethical practice but provides a useful starting point for occupational therapists to reflect upon their decision-making process. This is illustrated by considering the principles as features of being an ethical practitioner.

BEING AN ETHICAL PRACTITIONER USING A PRINCIPLED APPROACH

As there is an ethical dimension to most of what takes place at work (Hendrick 2004), professionals working in psychosocial practice need to be able to recognize these matters and consider the implications for the individual, their families and carers. It is important to remember that healthcare ethics is not the concern of one professional group or discipline but is a matter which should be approached from a multidisciplinary perspective (Campbell et al. 2007). Occupational therapists, as members of the multidisciplinary team, are well placed to contribute to such discussions regarding ethical matters. However, conflict may occur as a result of different professional groups having diverse values, beliefs and approaches to practice. Each of the four principles, set in the context of ethics as a multidisciplinary concern, are considered in turn.

Ethical Principle: Respect for Autonomy

Autonomy refers to a person's ability to make his/her own decisions based on their own values and beliefs (Beauchamp and Childress 2009). An autonomous person is someone who can evaluate and consider information, whose decisions and action reflect their goals, has the mental capacity to make decisions and the freedom to act upon choices (Tschudin 2006). If an individual has limited autonomy, it does not necessarily indicate that they are unable to make any autonomous decisions independently (Hendrick 2004). For example, an individual may not be able to consider the most effective intervention options available to them but could exercise some choice over daily occupations, e.g. what to eat and what clothing to wear. However, it is important that autonomy is not reduced to just facilitating choices.

In some cultures, individual autonomy is not acknowledged, for example where a husband makes most of the decisions, and some individuals prefer to involve families in the decision-making process (Arnason et al. 2011). The concept of autonomy is still applicable but needs to be respected in-keeping with an individual's culture. However, respecting cultural diversity does not mean an individual cannot make their own choices should they choose to do so (Arnason et al. 2011). Occupational therapists should promote the individual as an autonomous person, allowing them to consider their own ideas, principles and wishes and how these inform their plans, how they want to live their life now and in the future (Wright St Clair and Seedhouse 2005). In relation to ethical practice, a consideration of autonomy is fundamental, for example when obtaining consent.

Consent

According to the Oxford English Dictionary Online (2012), consent can be defined as 'voluntary agreement to or acquiescence in what another proposes or desires; compliance, concurrence, permission'. One of the basic ways in which autonomy is respected is by obtaining consent to assessment or intervention. It is universally accepted that obtaining consent is a legal requirement to ensure that individuals understand the consequences of what they are being offered and to protect the professional from criminal charges (Hendrick 2004), such as battery or trespass. Busy hospital environments may not be conducive to an individual giving informed consent and, visiting individuals in their home environment can be just as challenging (Moreno et al. 1998). Communication plays a vital role in an individual providing consent and this

involves the occupational therapist in listening and supporting the individual concerned; not merely conveying information (Arnason et al. 2011).

Securing Consent. Consent is only legally valid when the person is acting voluntarily. Occupational therapists are obliged to ensure they clarify their role, identify what they can offer and listen to the individual's concerns. Sufficient time should be given to allow an individual to consider all the details before making a decision and information should be conveyed in a way that they can understand, for example when seeking consent from an individual with a learning difficulty, pictorial cues may be required (DoH 2001a). However, when challenging behaviour is an issue, an individual may be unable to provide consent to the intervention, which is problematic, especially if the aim of the intervention is to prevent harm to the individual or another. It is imperative that all team members work within the ethical and legal boundaries of the countries where they practice and adhere to The Human Rights Act (1998), to ensure that their interventions are in-keeping with legislation and that individuals' needs are at the centre of their care.

To provide consent for interventions, an individual must have mental capacity. Mental capacity can be defined as having the ability to make decisions, based on understanding facts at the same time as considering the various options and the effects of different interventions (Hendrick 2004). There is always a risk of assumptions being made about a vulnerable person's mental capacity without it being assessed. For example, older adults, especially those with dementia, may not always be given the opportunity to exercise their autonomy and are prone to having decisions made for them because of their age (Hendrick 2004).

An occupational therapist needs to be able to differentiate between confusion, irrational decisions and mental capacity (see Box 10-1). Capacity can fluctuate and may be impaired by other factors such as medication, vitamin deficiency or infection. Loss of capacity can be temporary and therefore should be assessed for each intervention. There are also different levels of capacity. Some individuals may not be able to make decisions independently regarding more complex issues but can make decisions regarding everyday matters. Poor practice can occur when an individual is deemed lacking capacity and consequently, is not consulted regarding any matter, irrespective of how simple it may be. In the UK, occupational therapists have a duty to ensure that they assess mental capacity, under the Mental Capacity Act (2005) and a code of practice has developed to help practitioners with this (Carr 2011). (See Ch. 24, for a discussion of mental capacity in relation to older people.)

BOX 10-1

ETHICAL ISSUES RELATED TO DIOGENES SYNDROME

'Diogenes syndrome' (Clark 1980; Pavlou and Lacks 2006; Pickens et al 2006) is a term used to refer to older adults who live in the community and present with extreme self-neglect. Consequently, occupational therapists may encounter a range of ethical dilemmas when supporting older adults to live at home. Difficulties may include loss of housing, marginalization within the community and hoarding behaviour, which may give rise to increased risks from fire and tripping hazards (McDermott et al. 2009). Unsanitary living conditions may promote illness and infection, either exacerbating existing health problems or creating new ones. An ethical dilemma may occur when an individual has mental capacity to make decisions but may lack insight into the problems their current living conditions present.

Occupational therapists, like other health and social care staff, will strive to respect autonomy and support an individual to make decisions which reflect their values and beliefs. An occupational therapist should avoid, at all costs, making judgements about an individual's living conditions and avoid imposing their standards on to others. To embark upon a cleaning process, against the older person's wishes, conflicts with respecting autonomy. It also may result in the breakdown of the therapeutic relationship, when perhaps energy and resources should be focused on establishing trust and trying to develop an understanding of the issues which have given rise to the situation in the first place (McDermott et al. 2009).

This principled approach does not take into consideration the impact that poor levels of self-care and environmental neglect can have on those who live around them or own the properties where individuals reside (McDermott et al. 2009). Occupational therapists need to recognize when an individual's choices are not conducive to their health and wellbeing and have consequences for the wider community. Positive solutions when working with an older adult in this situation, may take a long time to achieve. Additional resources may be required, for example agencies to cleanse the environment and alternative temporary accommodation (McDermott et al. 2009). Ongoing support may be needed to enable an older person to maintain their self-care skills, their environment and participate in other occupations, which would provide structure, routine and social contact.

Recording Consent. Implied consent is the weakest form of consent because it is indicated by the individual's behaviour, such as turning up for an appointment or nodding their head (Hendrick 2004). Verbal consent is commonly used in practice but is not reliable because it is difficult to prove at a later date, unless documented. It is good practice for services to have consent forms for individuals to sign in order to provide written consent, after consideration and discussion regarding what is being proposed. If forms are not available, occupational therapists should always document when consent has been obtained or if consent has been withheld/withdrawn, outlining the reasons for the decision taken by the individual. This decision should always be respected; it is unethical to coerce or persuade an individual to consent to assessment or interventions. Any person has the right to exercise their choices.

Restrictive Practice

A challenge for occupational therapists working in psychosocial services, particularly forensic mental health settings, is the practice of restraint. Restraint involves keeping someone under control or within limits and is applied in health and social care settings, to restrict freewill for the individual's safety or that of others. Organizations and services use a range of terminology, e.g. 'control' and 'restraint', so it can be confusing as to what actually constitutes restrictive practice. Wolverson (2004) suggests these generic terms encompass a broad range of interventions, all of which seek to reduce an individual's autonomy and encourage paternalism. The practice of restraint conflicts with the principle of respecting autonomy and can produce feelings of unease in professionals but it is required in a minority of situations, in order to protect the individual or those around them.

It is important to recognize that many interventions and practices may not be recognized as restrictive but may have this impact (Wolverson 2004). Horsburgh (2003) asserts that some types of restraint can take more subtle forms, for example denying access to equipment, which could promote independent living. Restraining an individual involves suppressing their freedom. This can be achieved in many ways, including using medication, seclusion, locking doors and surveillance technology (Hughes 2009) (see also Box 10-2). Other practices include using baffle locks in care homes for individuals with dementia, to complete physical restriction, to holding a person's hand to prevent them from lashing out at another (DoH 2002). However, it needs to be recognized that when restraint is not indicated this becomes abuse and is immoral (Hughes 2010).

Another challenge is the lack of specific guidance on when restraint may be appropriate or when it should be carried out. Good practice suggests there must be a clear rationale for implementing restraining techniques when working with individuals, for example with dementia, and that restraint should not be permitted in order to make carrying out care tasks easier (Mental Capacity Act 2005). In addition, the restraint used must be in proportion to the situation and that every attempt at using alternative strategies must be explored. Again, the concept of proportion lacks clarity and in reality is subjective; further guidance on this deeply emotive issue is required in order to protect individuals from practice which can be degrading and de-humanizing (Nuffield Council on Bioethics 2009).

Ethical Principles: Beneficence and Non-Maleficence

The principle of beneficence refers to the duty 'to do good' and is often discussed alongside non-maleficence, which is concerned with minimizing harm. Professionals are required to look after those in their care and protect and promote their wellbeing. Part of this process includes making sure the risks of an intervention provided do not outweigh the benefits of what is being offered, although it cannot be assumed that all interventions will produce benefit.

In 2001, the Department of Health published 'Valuing People', a policy framework, which set out to address the social exclusion experienced by individuals with a learning disability. Four key principles are highlighted: 'legal and civil rights, independence, choice and inclusion' (DoH 2001b, p. 26). However, with increased rights comes an increase in responsibilities and individuals need to be educated about the importance of this. For example, if an individual is residing in a group home, there may be an expectation that activities of daily living should be shared, however, if this perspective has not been made explicit to a person, then this may not happen, which may affect other residents, possibly resulting in conflict impacting upon

BOX 10-2

ETHICAL ISSUES ASSOCIATED WITH ASSISTIVE TECHNOLOGY AND TELECARE

Assistive technology and Telecare refers to a broad range of equipment and systems, including environmental controls, sensors, falls detectors and communication aids, which may help to facilitate independent living for a range of individuals who, for example, may have a learning disability or dementia.

There is an increasing body of evidence identifying that a proportion of vulnerable individuals benefit from increased safety and independence, as a result of assistive technology; furthermore, it provides reassurance for families and carers (Loader et al. 2009; McCreadie and Tinker 2005). However, some concerns have been highlighted with individuals with dementia, especially in relation to privacy and stigma and the use of tracking devices. Potentially, there is a conflict with respecting autonomy, as individuals may feel under scrutiny and their sense of welfare diminished (Morris 2004). However, Welsh et al. (2003) identify that it is perhaps the method in which some devices are implemented, rather than the device itself that is harmful and the need for clearer guidance regarding best practice is required. Interestingly, Welsh et al. (2003) suggest that agitation and 'wandering' behaviour in individuals in 24-hour care facilities may be the result of 'cabin fever' and that individuals should have access to outside space. This may be an aspect of intervention that occupational therapists could develop as part of a person's care plan and could encompass previously enjoyed occupations, for example walking or sitting in a garden, as opposed to being confined indoors.

Every effort must be made to explain what technology is being proposed to the person, this may include showing pictures or photographs, obtaining consent and arranging for the individual to try the technology in their home or a demonstration centre (Perry et al. 2009). The individual's ability to understand needs to be clarified by asking simple questions in order to protect their interests. Furthermore, the risks associated with the application of assistive devices and equipment interventions warrants serious deliberation. Assistive technology is becoming increasingly sophisticated but can still malfunction, so it should not be used to replace contact with carers and the delays in staff responding to alerts or technological problems need to be taken into account (Perry et al. 2009).

If an individual lacks the mental capacity to consent to such technology being installed in their home, decisions should be made following consultation with family and friends to establish the individual's views on privacy. Decisions should reflect the person's best interests, as outlined in the Mental Capacity Act (2005), together with the consequences of not having the devices for carers (Nuffield Council on Bioethics 2009).

wellbeing. Occupational therapists need to ensure that individuals are aware of their roles and have the skills to meet their responsibilities when supporting independent living programmes.

Ethical Principles: Justice

From a global perspective justice is a difficult concept to consider because of the huge inequalities that exist between Western society and the rest of the world. From a simplistic perspective, justice equates to fairness, however, Seedhouse (2009) identifies that the concept of justice is impossible to define but should be considered in relation to the notion of need. However, need is subjective, and in many circumstances, not all needs *can* be met. For example consider Telecare technologies. Eccles (2010) identifies that to utilize some of these systems, broadband or a telephone landline are required; these services can be expensive and availability and efficiency vary worldwide, which may result in some individuals either being unable to afford or access what is on offer. It is difficult to resolve such social injustice in order to achieve fairness, when social divisions exist.

The notion of 'occupational justice' is based upon the belief that all individuals should have the opportunity to participate in occupations of their choice, irrespective of their ability, socioeconomic status or where they live (Townend and Wilcock 2000, 2004). For example individuals with psychosocial issues or learning difficulties may encounter limited opportunities and barriers to paid employment or voluntary work. This can also impact upon accessing leisure facilities, though leisure remains a Western concept and is not relevant to some societies due to their political and economic circumstances (Whalley-Hammell 2006).

Townend and Wilcock (2000, 2004) assert that occupational justice is an essential consideration, as occupational injustice can have grave consequences on health and wellbeing. 'Occupational injustice' can manifest itself in many ways, for example an individual with a learning disability may experience occupational deprivation if they do not have a person-centred plan, and interventions then reflect the interests of others, rather than their own. 'Occupational alienation' may occur if an individual with psychosis is denied access

to more challenging occupations and roles because staff working with the individual have low expectations of what they consider the person can achieve. 'Occupational imbalance' arises when too much time and energy are channelled into one occupation; in developed countries, this is often work and as a consequence, less time is spent participating in other valued occupations and roles, which can seriously impact on physical health, mental health and quality of life. (See Ch. 3 for a detailed examination of occupational justice and associated concepts.)

ETHICAL PRACTICE AND OCCUPATIONAL THERAPY

This section will consider what these ethical principles mean for occupational therapy practitioners, by considering confidentiality, confidentiality in relation to information technology, communication, autonomy and occupational therapy practice, occupational therapy and restrictive practice and approaches to restraint. (Research ethics is not discussed here because it is covered in Ch. 9.)

Confidentiality

In health and social care settings, 'confidentiality refers to one of the most important and well-established legal and moral obligations in healthcare ethics' (Hendrick 2004, p. 115). Confidentiality does not stand as a single ethical principle but is connected to several of the bioethical principles outlined by Beauchamp and Childress (2009); it demonstrates a respect for autonomy and those professionals, in receipt of service user information, act beneficently by doing no harm. Upholding confidentiality protects patients' privacy and maintains public confidence in professions, and conveys employing organizations are trustworthy. Furthermore, confidentiality is central to developing a trusting professional relationship. Occupational therapists are in a privileged position, working with vulnerable people with psychosocial difficulties.

Ensuring confidentiality is an obligation clearly identified in all professional codes, for example, 'You are obliged to safeguard confidential information relating to service users at all times' (COT 2010, p. 11). Maintaining confidentiality is also identified as a duty in contracts of employment and is covered by statute law, for example in the UK, the Data Protection Act 1998 and worldwide, the Human Rights Act 1998, and as a duty of care in the law of negligence (Dimond 2010). This means occupational therapists should not inform relatives about an individual's diagnosis without first obtaining their permission. This can cause conflict if others are affected by an individual's behaviour, which may occur as a result of poor mental wellbeing.

There is no general legal duty to report crime to the police, however, you must not obstruct police investigations and confidentiality cannot be used as a defence in a court of law (Simpson 2000). However, there may be circumstances where it is justified to breach confidentiality, for example if the information is considered to be in the public interest, or injury or harm to the individual or another may result as a result of non-disclosure (DH 2010; Dimond 2010). Any request by a court of law to disclose information must be respected (Bourke and Wessely 2008) and it is an occupational therapist's responsibility to be aware of their organization's policies and procedures regarding this matter (COT 2010).

If a situation occurs and an occupational therapist is unclear of the legal position regarding confidentiality, it is advisable to seek advice. For example in the UK, the local Caldicott Guardian, whose responsibility to oversee how identifiable information is managed by health organizations, may be able to help with this (Dimond 2010).

There are many challenges in the clinical setting, which may inhibit an occupational therapist's ability to ensure confidentiality. The delivery of services in the UK has become increasingly complex, involving large numbers of professionals and teams, presenting more opportunities for confidentiality to be inadvertently compromised. An observational study conducted in Canada recorded breaches of confidentiality that occurred in hospital lifts and found that allied health professionals were the second highest group that compromised this (Vigod et al. 2003). Although a small study, it highlights some professional groups' lack of awareness of their environment and the impact this can have upon maintaining confidentiality. Other environmental constraints may give rise to an unintentional breach of confidentiality. The following

were highlighted by Cross and Sim (2000) in their study of hospital-based physiotherapy, i.e.

- Working in areas where only curtains may separate one person from another, e.g. on a ward, this can lead to private conversations being heard
- Lack of facilities, e.g. private rooms for discussions with patients
- Departmental layout, e.g. waiting areas near to offices and therapy rooms, running the risk of private conversations with individuals being overheard by others
- Group work – accidental disclosure through group discussions
- Lack of time – may lead to conversations in inappropriate places, e.g. lifts and corridors
- Making/taking telephone/mobile phone calls in earshot of others
- Leaving records/notes/computer screens unattended
- Taking notes home
- Gossiping about service users or colleagues
- During home visits, e.g. neighbour's enquiries.

It is imperative that occupational therapists consider their environment and how this may impact upon their practice.

Confidentiality and Information Technology

The introduction of a variety of information technology systems used to gather, communicate and store data between professions, services and other agencies, presents more challenges in safeguarding confidential information, e.g. using social networking sites as a method of communicating. There is a risk of breaching confidentiality if the conversation turns to your daily work. The American Medical Association conducted a study of 78 US medical schools and more than 50% confirmed cases of students posting unprofessional messages on the internet (BBC 2009). Staff should ensure that their behaviour does not erode public trust and confidence in the profession to which they belong and refrain from discussing professional matters in public forums where the information can be easily accessed, if they wish to avoid sanctions being imposed on their ability to practice their chosen profession.

Occupational therapists have a duty to ensure that they are up-to-date in their use and management of new technology systems within the workplace and are conversant with any codes of practice within their organization or provided by their government.

Communication, Autonomy and Occupational Therapy Practice

The underpinning ethical value of occupational therapy practice is restoring and maintaining wellbeing through activity and participation (Dige 2009). Reflection upon Beauchamp and Childress's (2009) principles may provide some guidance when working with an individual, for example supporting a person to make autonomous decisions regarding participation. However, a therapist still needs to understand how this may be best achieved in the context of the individual's psychosocial health issues.

Individuals cannot make decisions about their care unless they receive sufficient information to allow them to make an informed choice. Occupational therapists should use language that is familiar and jargon-free. It is imperative that they listen to what individuals have to say and respect this (Rumbold 1999). Communication should be honest; it is unacceptable to lie or deceive. The therapeutic relationship should be based on mutual respect and openness; this includes being sensitive and respectful of differences in culture (Farsides 2002). Individuals are vulnerable and may be greatly influenced by what is claimed by occupational therapists, however, they will not engage or cooperate with services if they do not trust the occupational therapist they are working with.

Occupational therapists cannot force interventions or services upon individuals, even if they think it is in their best interests. Time and energy should be spent on developing a therapeutic relationship, in order to facilitate active participation in the decision-making process, while encouraging trust and negotiation. For example, occupational therapists will need to identify and prioritize risks collaboratively with individuals but not focus on these exclusively; a balance should be struck between highlighting what the person can achieve independently, together with areas of risk to be considered and how these may be positively addressed.

Occupational Therapy and Restrictive Practice

Challenging behaviour can result in occupational therapists being confronted with ethical dilemmas which are complex, with no easy resolution. Occupational therapy students, in the UK, are not formally trained in the strategies for dealing with challenging behaviour, unlike their nursing peers (Stubbs and Dickens 2008). The evidence base for the effectiveness of physical interventions is limited (Sailas and Fenton 2000). As a consequence, careful consideration should be given as to when such measures should be implemented.

Practising restraint conflicts with respecting autonomy, duty of care and best interests and also does not sit well with the underlying professional philosophy, which emphasizes person-centred practice and collaborative working. The use of restraint could give rise to therapeutic relationships breaking down and lack of future engagement. Furthermore, the very act of being restrained could lead to an emotional and physical reaction, putting the individual at greater risk of being restrained in the future and also the prospect that physical harm may result (Commission for Social Care Inspection 2007; Nuffield Council on Bioethics 2009).

Approaches to Restraint

A comprehensive assessment will help to highlight potential triggers to disturbed or violent behaviour and enable staff to consider the possible reasons for this. A team management plan devised collaboratively with the individual, carer and family, may highlight how such issues may be addressed and hopefully eliminate escalation.

Despite limited evidence on its efficacy, Muralidharan and Fenton (2006) suggest greater emphasis should be placed on de-escalation techniques to diffuse potentially difficult situations. De-escalation produces less counterproductive consequences than the use of medication and physical techniques (Stubbs and Dickens 2008). However, the National Institute for Clinical Excellence (NICE 2005) highlights that if de-escalation fails to diffuse a situation, physical interventions may be utilized.

The use of advance directives has been suggested as one way of enabling individuals to state what they would like to see happen to them should they become disturbed or violent. This would enable individual autonomy to be respected and recognizes that they have the greatest knowledge of their own behaviour. However, it has been argued that advance directives involve individuals making judgements regarding their future mental wellbeing and that some would be unable to fulfil this requirement (Olsen 2003).

If restraint is to be considered, then discussions about this should be conducted with the individual, family and carers, so that informed decisions regarding the options available are thoroughly evaluated (Hughes 2009).

Occupational therapists working in environments where violent or disturbed behaviour may arise must make themselves familiar with information, guidance and training, produced at local and national levels. In addition, the need for good supervision and psychological support following incidents should not be under-estimated; working with challenging behaviour can have a profound psychological effect on practitioners and so they need to be supported. Ethical dilemmas may occur as a result of conflict in relation to respecting autonomy but the risk of ensuing harm either to the individual, or another, may outweigh the ethical principle of autonomy.

FRAMEWORKS TO SUPPORT ETHICAL DECISION-MAKING

Ethics is not merely about applying codes (see Box 10-3) and principles in order to resolve ethical dilemmas. Ethics cannot be compartmentalized from everyday practice or cast aside for others to respond to. This is because ‘ethics is like oxygen; it is part of everything we do’ (Seedhouse 2002, p. 253). Theories, models and frameworks provide structure but they do not create ethical practitioners. The responsibility for sustaining ethical practice should come from within the individual, rather than being pronounced by an external body (Sarkar and Adshead 2003).

There are models and frameworks that have been developed to guide professionals through the myriad of questions which pose challenges to those trying to seek resolution of an ethical dilemma (see Useful resources).

BOX 10-3

PROFESSIONAL CODES OF ETHICS AND CONDUCT

Codes of ethics (codes) produced by professional bodies are deemed important documents that represent the values of the professions, and cannot be violated without sanction (Freud and Krug 2002). Codes offer some guidance on a range of matters, including professionalism, minimum standards of practice, ethics and etiquette. Over the years, these documents have been revised to reflect changes in legislation and practice and therefore, provide a broad spectrum of guidance for practitioners to refer to, as opposed to specific and detailed regulation. According to Tschudin (2006, p. 79), the functions of the professional codes of conduct are:

- 'to inform the professions of the standard of professional conduct required of them in the exercise of their professional accountability and practice'
- 'to inform the public, other professions and employers of the standard of professional conduct that they can expect of a registered practitioner'.

In the UK, the College of Occupational Therapists has revised its Code of Ethics and Professional Conduct (COT 2010). In this updated version, COT defines and incorporates the terms 'you must' and 'you should'. These terms emphasize how an occupational therapist is expected to behave or perform in a given situation, highlighting the obligatory nature of the tasks to be carried out. It must be remembered, while codes have a place in providing basic behavioural guidance, they cannot offer any answers to facilitate the resolution of ethical dilemmas because of the unique, dynamic and complex nature of the individual's circumstances.

These can help to inform moral reasoning but the decision-making still remains the responsibility of those individuals involved in the process. To support the development of their own ethical practice, occupational therapists perhaps should consider using The Capable Practitioner Framework (Sainsbury Centre for Mental Health 2001). It includes the values and attitudes, such as being honest, non-judgemental and being committed to equal opportunities for all persons, characteristics expected of all ethical practitioners working in psychosocial practice. This framework also highlights the inherent difficulties services may experience in measuring how values are applied in practice.

It has been argued that professional codes should be used as a framework for guidance but cannot be expected to resolve complex ethical dilemmas (Terry 2007). Consequently, some practitioners may not find it easy to recognize an ethical dilemma when it presents itself and as a result of the general nature of the codes, feel unable to address ethical issues with skill or confidence. Codes are generally not legally binding; however, they are the principal document used as the foundation by which accusations of professional transgression and incompetence are measured. Beauchamp and Childress (2009, p. 7) assert that some of the 'codes appear to oversimplify moral requirements, make them indefensibly rigid, or claim more completeness and authority than they are entitled to claim'. Consequently, professionals may be led to believe that they meet all the appropriate conditions if they adhere to what is outlined in the code but then fail to consider other factors, which may have a bearing on the issues that confront them. Adhering to a code may be another way of upholding standards but it cannot make a clinician an ethical practitioner. Occupational therapists need to apply their professional reasoning, and engage in collaborative working and reflective practice when considering conflicting/competing demands, and codes allow for this.

SUMMARY

The nature of professional roles and relationships is changing as the psychosocial needs of a diverse population become increasingly more complex. It is imperative that occupational therapists recognize and respond to the ethical dimensions of their day-to-day practice. However, a basic awareness of ethical theory and professional membership is not sufficient when contemplating complex ethical issues (Terry 2007). Greater emphasis should be placed upon working together with service users, carers and families. Inter-professional discussions should be conducted in a collaborative and transparent manner, ensuring all concerned are consulted and listened to, and that any decisions made are achieved through sound ethical reasoning, having taken into account the broad range of opinions presented.

This chapter provides a basic overview of a number of ethical theories and approaches which have been instrumental in how some professional groups consider ethical practice. Moreover, it highlights some of the day-to-day practice issues where occupational therapists

may encounter ethical dilemmas. Unfortunately, there are no easy answers; ethics is not formulaic and cannot be reduced to ticking boxes. Occupational therapists should endeavour to be receptive to the ethical aspects of their daily work and this would facilitate them being open to the views of others, constructing new ways of thinking about familiar situations and developing a deeper understanding of moral reasoning and the ethical complexities of day-to-day psychosocial practice.

USEFUL RESOURCES

These resources were developed for practitioners in the UK but they are web-based, so may be useful to those working outside the UK (as long as they are not used without consideration to local cultural issues).

The Mental Health Foundation (2010) identified that a significant proportion of health and social care professionals are not complying with the requirements of the Mental Capacity Act (2005) when undertaking assessments of mental capacity. Data from The Assessment of Mental Capacity Audit Tool (AMCAT) highlighted this issue and it is designed to assist staff to consider their skill and knowledge and learn from recent capacity assessments they have undertaken. AMCAT offers a quick, free, confidential report and provides suggestions for future capacity assessments. Available at: http://www.amcat.org.uk/

Department of Constitutional Affairs (2007) has published a code of practice which provides guidance for individuals who may be working with a person who is unable to make decisions; it outlines a very clear process and highlights roles and responsibilities. Available at: http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf

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11 PERSPECTIVES ON USING AND PROVIDING SERVICES

ANNE-LAURE DONSKOY ■ ROSEMARIE STEVENS ■ WENDY BRYANT

CHAPTER CONTENTS

INTRODUCTION

Occupation is fundamental to everyday life (Krupa et al. 2009) and is a pre-requisite for recovery, survival and addressing long-term issues (Kelly et al. 2010). Therefore, maximizing the accessibility of occupational therapy is an important part of professional practice. This requires careful thought about what obstructs or enables people's access to, and use of, services.

Access is often considered in terms of physical environment issues, for example services being located far from where people live, but social and occupational perspectives on mental health offer a broader view. The social model of disability, for example, highlights attitudes as a primary barrier and cause of disability (French and Swain 2008; Oliver and Barnes 2012; Tew 2005). Similarly, from an occupational perspective, access to activities to promote health and wellbeing requires awareness of not only what people seek to do, but who they are and what they hope to achieve (Tew 2005; Wilcock 2006). How can a person's hopes be supported or constrained within a programme or service? To understand barriers and facilitators, therefore, it is necessary to listen to the experiences of people who have delivered and received occupational therapy services.

This chapter is co-written by two people who have used mental health services (ALD, RS) and an occupational therapist (WB). Direct experience of occupational therapy as a mental health service user is an important source of information, knowledge and understanding for practitioners. All three authors have been involved in research into the experiences of service users receiving occupational therapy. They have drawn on this, as well as on their own and other service

users' stories as illustrations for this chapter. These stories indicate the shared and individual aspects of their experiences as authors. They offer critical reflection on occupational therapy, drawing on a social perspective and highlighting the importance of the social environment in which therapy takes place.

Initially, the authors consider the barriers to accessing occupational therapy; examining who has access to occupational therapy services and who is excluded, and why this happens in different settings. The experience of occupational therapy, from service user perspectives, is explored in relation to its meaningfulness. Recovery is considered, along with the realities of survival and the dangers of promoting activity for its own sake. The value of occupation has been appreciated widely, beyond occupational therapy services, and the relationship between occupational therapy and other occupation-focused services is considered. The significance of carers and care-giving is also discussed. Finally, collaborative work exploring the service user's experience of occupational therapy is highlighted as being important in overcoming the barriers and enabling engagement in occupational therapy.

ACCESSING OCCUPATIONAL THERAPY: A SOCIAL PERSPECTIVE

From a service user perspective, to access occupational therapy, the individual needs to know that it exists. Information should be available in different formats, and include details of what is provided. However, even when a person knows that occupational therapy is available and could be beneficial, other factors may prevent access. From a social perspective, there are many barriers to accessing and using mental health services. Tew (2005) suggests there are three elements to developing a social perspective on mental health:

1. Recognizing a continuum of mental distress, resisting a rigid distinction between what is considered normal and what is not
2. Engaging in an honest way with complex and complicated experiences, resisting pressures to focus on just one aspect, such as anger
3. Listening carefully to what people say about their experiences and respecting the meanings they attach to those experiences.

The first element suggests that if eligibility for occupational therapy is restricted to those with particular symptoms or behaviours, others will be denied access. One service user, in a study of occupational therapy in an acute admissions unit, felt excluded when they were told occupational therapy was targeted exclusively to skill acquisition rather than meaningful occupation:

> *They said it was for people who need to learn and they said … I didn't need to be here, there, doing it, which I thought was a bit unfair.*
>
> *(Bryant et al. 2011a)*

The third element indicates the importance of understanding the different reasons which service users might have, for wanting to engage in particular occupations. Exploration of these personal meanings extends beyond discussing needs and aspirations. It includes the meanings that arise through participation in occupational therapy.

Organizational Barriers to Occupational Therapy

Organizations are required to define the referral criteria for their services so resources can be targeted efficiently and effectively. This process can impact on therapists' choices about provision, and hence the choice offered to service users. Adopting narrowly defined outcomes in this 'defining and targeting' process can exclude people who are more challenging to engage, where positive outcomes will require more time and resources.

People's access difficulties can be understood from different perspectives, including psychological, occupational and social perspectives. For example, a psychological perspective might understand resistance to occupational engagement in terms of a person's motivation or volition (Creek 2010) (although an individual may have genuine reasons for not wanting to engage in an occupation – such as cultural, ethical or practical reasons), whereas an occupational perspective collaboratively identifies meaningful and purposeful activities, tasks and skills (Craik et al. 2010). Both these perspectives focus on why individuals and groups engage (or do not engage) with occupations. They are enhanced by a social perspective on mental health, which emphasizes how the social environment can restrict or facilitate participation (Tew 2005). For

example, collaboratively identifying meaningful and purposeful activities requires effective communication between people, which is a social process (Tew 2005).

Positive Risk Management

From a medicalized healthcare perspective, everyday practice decisions are often based on diagnostic categories and assessed levels of risk or disruption to everyday life, perhaps linked also to service users' status under legislation such as the UK Mental Health Act (1983, 2007). The restrictions which this legislation places on people impacts on all aspects of their lives.

Organizational structures can facilitate access even if a service user is in crisis if the service is able to deal with risk in a rational but creative way. For example, close observation and monitoring, which might otherwise be intrusive, could be appropriate and offer the person who is suicidal a social structure to support them. Similarly, the capacity of organizations to manage reasonable risk is a crucial factor in service users' recovery (Langan 2010). Being risk averse undermines opportunities for service users, whether in groups or individually, to explore, develop and take control of their own recovery. Positive risk management is underpinned by a social perspective on mental health (Ramon 2005) and an awareness of human rights (Dimond 2010); emphasizing that people should be treated equally and fairly as an equal member of society (UN 2006).

Inpatient and day hospital settings have intrinsic access constraints due to the sheer number of people moving around buildings. The everyday logistics and procedures which keep a service functioning often reflect organizational priorities over and above individual needs (Rogers and Pilgrim 2003). For example, the passes and keys issued to staff on closed wards not only restrict everyone's movements, but they also reinforce the feeling of unnaturalness of the situation and of relationships, especially for service users. In general, the unequal power relationship between staff and service users impacts negatively on the service user's overall experience.

From a service user perspective, occupational therapy is often limited to working hours, during the week, with little or no service provision at weekends and evenings (Notley et al. 2012). At those times, access to other hospital resources, such as kitchens and art rooms, may also be denied; limiting the opportunities for service users to progress with their occupations and start to translate the skills acquired in therapy to less supervised, more real-world settings (Townsend 1996). Le Granse et al. (2006) found the following example from a study of occupational therapy in the Netherlands, Belgium and Germany:

> *The occupational therapist encourages the client to make his own cup of coffee.*
> *On the ward, however, he is not allowed to do that himself.*
> *The client wants to go to the cinema, but he can't because the night nurse locks the doors around 22.00 hours.*
>
> ***(Le Granse et al. 2006, p. 151)***

Access to Community Occupational Therapy

In community settings, from a service user perspective, access to occupational therapy may depend on the availability of transport, and on being able to meet transport costs. This introduces a paradox, whereby low attendance (for these logistical reasons) may even lead to much needed services being scrapped on the basis that they are not financially viable. Service users may also be denied access to community resources due to differing referral criteria and risk assessment policies, reflecting different organizational priorities. Occupational therapists may have little or no control over these issues. Individual service users will have even less control over them. Ownership of occupation and commitment to the occupational therapy process cannot begin to take place when the service user's agency, in terms of being empowered to make choices, is effectively thwarted from the start. The issue of access does not just apply to the first point of contact with occupational therapy, but at every stage. Overcoming barriers can be achieved by sharing and negotiating the meaning of occupational therapy as it unfolds.

NEGOTIATING MEANING

To service users an occupational therapy assessment may have profound, unanticipated implications for the assessed person's sense of identity. The individual may interpret the assessment as a judgement, wondering

'What is the OT seeing that leads them to think I need occupational therapy?'

How first encounters are handled is vitally important. To use the old adage, there may not be a second chance for an occupational therapist to make a good first impression, as one occupational therapy service user's experience highlights:

> *This member of staff showed me around and I saw this guy doing mosaic on glass. I love working with colours and that grabbed my attention. I asked if I could do that too but the member of staff said 'no' I could not do it because this other person was already doing it and so I was shown to a table where these women were doing some sewing. Now I hate sewing, it just isn't me but she was adamant it would be a good activity for me. That was the end of my interest in OT. In fact I never went back to the unit. There was no explanation as to why only one person was allowed to work on this particular activity I was interested in (was it an issue of supervision?); they did not try to find me a similar activity, they just went for the simplest and easiest solution for them. This was not about my needs in the end but about theirs. The effect was that they had lost me, and any potential connection with me, even before I signed up to OT'.*

In this situation, there is no sense of the staff member relating to the service user as an individual. It may be said that 'occupational therapists need a high level of empathy and to have a sense that tunes in to our needs and feelings even when we can't speak' (College of Occupational Therapists 2006, p. 12).

'Tuning in'

Where occupational therapy does 'tune in', it can resonate at the core of the person's sense of identity, providing a life-changing experience, as one service user's account of woodworking testifies;

> *I argued and argued to be allowed to use my grandfather's carpentry and marquetry tools; this was met with counter-arguments about health and safety rules which seemed more important to them. In the end common sense prevailed. This experience allowed me to connect with a part of my family history in ways I had never known before. The aim was also a challenge to myself, to be able to create an object from a simple lump of wood; it still takes pride of place at home. I do believe my grandfather would have been proud and that was important to me at that point in time.*

Another service user's experience of pottery makes a similar point:

> *I had never done it before. I enjoyed it. When I was discharged I looked for more opportunities to do pottery and found an organization with a rarely used pottery which I used. I ended up teaching pottery to others and would now like to work in this field. It helped me find an activity, to reach my potential and to, in turn, empower other people.*
>
> *(College of Occupational Therapists 2006, p. 9)*

Overall, the therapy process and the context must be, or become, meaningful to the service user. Under the pressures and constraints of everyday practice, missing the opportunity to 'tune into' the service user can have serious, ongoing, implications – as a service user explains:

> *I spent the first 18 months of an eight year spell in OT glued to a corner of the room by the window. There were the very few odd days when I was desperate for someone to come and take me away from my spot but mostly I would have liked to just stay there until the end of time. Being there, in that spot, was what I had to do to remain alive. In time, I came to realize that one person, a secretary (note, not the OTs who spent most of their time in the office), would come and talk to me after the session had ended, while I was plucking up the courage to go home. She never judged me. She realized how paralysed and disconnected I was. She was the one who told me I was entitled to lunch but even then I would never have been able to get it myself. Gently she encouraged me and, month by month, bit by bit, I slowly found the courage to make a cup of coffee in public and to finally grab the packed sandwich on offer on the trolley. Years later, when I read my medical notes, my spell by the window was described as 'refuses to engage'. More to the point I was unable*

to 'engage' and they did not try to 'engage' with me either. And yet, had not the secretary known how to 'engage' with me, just using patience and her humanity?'

Exploring the Purpose of Occupations

Service users can sometimes struggle to see the purpose of occupational therapy;

> *Many of us had had very good experiences of occupational therapy whilst in hospital but felt that, despite this, we didn't always know what it was, what it provided, or what we could expect from it. We also felt that access often depended on knowing about it first. If we knew that it existed, then we were much more likely to get access to it than those of us who had little or no knowledge of it.*
>
> *(College of Occupational Therapists 2006, p. 15)*

In hospital settings, occupational therapy may be experienced as a place just to pass the time or do activities which sometimes appear meaningless (Craik et al. 2010). In a story which appeared earlier, the opportunity for the service user to 'do some sewing' was deeply uninspiring, even though others seemed to be enjoying it. It was not the way she saw herself. It is therefore not surprising that some people will question their own identity in relation to a suggestion by an occupational therapist that they engage in an occupation which has not been negotiated first. For example:

> *It was not relevant to me: baking fairy cakes and cooking English meals and playing the drums were not relevant to me … I felt my life was passing me by.*
>
> *(College of Occupational Therapists 2006, p. 20)*

The therapeutic intention, to help someone acquire cooking skills, gets lost. A more positive example of tuning in to the service user is given by Le Granse et al.:

> *The occupational therapist discovers that the client is interested in classical music. She encourages the client to borrow a couple of CDs at the public library. The client, however, is afraid to travel by bus to go to the public library. The occupational therapist and the client therefore decide to go together, until the client feels free and is ready to travel alone to get his CDs.*
>
> *(Le Granse et al. 2006, p. 150)*

RECOVERY AND OCCUPATIONAL THERAPY

'Recovery' is a concept that has emerged from the service user and survivor literature (Anthony 1995) but a number of service users are now extremely wary of the term, as it has been taken over by mental health professionals and abused by them (Carson et al. 2010). In effect, the medical model still drives the clinical view of recovery, seeing it mostly as a means of returning to a former state of health (Turner-Crowson 2002).

Anthony's definition of recovery is well known, although it is often truncated in the literature to fit a vision of goal-defined outcomes that can be measured and reported. In fact, Anthony sees recovery as:

> *a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. … Recovery from mental illness involves much more than recovery from the illness itself. People with mental illness may have to recover from the stigma they have incorporated into their very being; from the iatrogenic effects of treatment settings; from lack of recent opportunities for self-determination; from the negative side effects of unemployment; and from crushed dreams. Recovery is often a complex, time-consuming process. Recovery is what people with disabilities do. Treatment, case management, and rehabilitation are what helpers do to facilitate recovery.*
>
> *(Anthony 1995, p. 7)*

Recovery is a personal and unique journey (Chamberlin 1978; Deegan 2001); 'what works for one person may not work for another' (Ásmundsdóttir 2009, p. 116). This requires the therapist to have a sense of the bigger picture in order to engage with the service user's whole narrative, and to avoid focusing over-exclusively on their presenting (or past) behaviour or

symptoms, or on the need for caseload throughput. One service user's experience of reading their own case notes underlined the discrepancy between how they had felt and how they had been perceived:

> *On looking through my medical notes it became clear that staff were disturbed and angered by what they considered to be my ambiguous attitude to their offers of help – I was not "able to make use of the facilities they offered". If they had taken the trouble to engage with me, listen to my story and take it seriously, they would have understood that in the past I had been traumatized by physically intrusive, painful and distressing medical interventions by doctors as they attempted to 'help' me. As a result I was fearful of offers of help from health workers. This created a fluctuation between asking for help and rejecting help.*

Recovery thus needs to be supported and reviewed regularly together with the service user. It requires that the assessment and care-planning processes have the service user at the centre from the outset:

> *We need to be sure when we start occupational therapy that it will suit us as individuals; it has to have a diverse approach in order to achieve this. If we are to engage with it, it is important that we do things that we want to do. These are often things that we are good at or enjoy.*
>
> *(College of Occupational Therapists 2006, p. 7)*

Openness about purposes, assessment and care-planning is essential to promote a collaborative approach from the very beginning. Assessment tools can help the occupational therapist. One tool which has a service-user-centred approach is the Occupational Performance History Interview (OPHI-II) (Ennals and Fossey 2009). It offers a contextualized and authentic way to respond to people's life stories. This and other tools are explored in more detail in Ch. 5.

Survival: The Art of Staying Alive

Without survival, there can be no recovery. This simple fact may be so obvious as to be overlooked in professional literature and therapists' training. For many service users, survival is a hard struggle that dominates their everyday life. The notion of 'meeting basic needs' encompasses more than the tasks of day-to-day living that enable survival. It is also about just being. To facilitate this, the therapist must keep an open and resolutely fresh mind, avoid making assumptions about what represents a step forward for the service user, and keep their sense of humanity alive. Wilcock's doing–being–becoming–belonging synthesis highlights the significance of thinking about occupation not just in terms of doing, but recognizing the importance of being (Wilcock 2006).

It is important not to underestimate the value of an individuals' occupational engagement at what might appear to be a basic level. Watching television, smoking and sleeping may be regarded by staff as time wasted, despite the fact many people in their everyday lives engage in these occupations unquestioned. For service users in the early stages of recovery or living with long-term problems, filling time in these ways can be helpful:

> *We wanted them to provide distraction from the feelings that we experience*
>
> *(College of Occupational Therapists 2006, p. 8)*

Boredom may be regarded as a negative feeling with a potentially positive outcome, if it creates a space for people to explore what they might do. However, in acute settings – where little or no choice of activity is on offer outside of working hours – boredom can be a distressing experience (Bejerholm 2010), and needs to be alleviated.

Using occupational therapy to 'structure time, relax and relieve boredom' (Lim et al. 2007, p. 27) can be problematic for therapists who do not want their role to be devalued, or do not wish to be seen merely as providers of entertainment. Nevertheless, giving a person a reason to get up in the morning and engage in stimulating thinking are also motivators for occupation. It was better to be doing something rather than nothing, according to a service user in a forensic setting:

> *You feel good with yourself knowing that you've done something for the day, instead of just doing nothing … even if you don't like the lesson. But you're doing it … not because you have to, it's because you want to.*
>
> *(Craik et al. 2010, p. 342)*

A MORAL OBLIGATION TO BE ACTIVE?

Becoming more active is widely acknowledged as a sign of 'recovery', and developing new interests can be a sign of 'growth'. However, this emphasis on 'being active', can also feel paternalistic, if not moralistic, to service users, reflecting a moral belief in the benefits of activity for its own sake (Friedman 2012). It echoes the history of moral treatment, which stressed the corrective benefits of 'activity' (Peloquin 1989). There is also a danger that 'being active' might only be an outward sign of compliance with staff and have motivations unconnected with any therapeutic purpose. Two participants in a study in forensic settings, where good behaviour determines release, stated that attending occupational therapy was about appearance:

> *You go to the right groups … for 2 years … You've got to do all that before they let you go … you've got to appear to be keen … because you'll never get out of this place, you know you've got to get motivated and all that.*
>
> ***(Craik et al. 2010, p. 342)***

Activity and Service Pressures

Pressurizing service users into being active can reflect a need to demonstrate that services are effective. Cost-effectiveness is increasingly a primary concern and the language of health and social care policy is often based on economic models, such as the UK's Payment by Results agenda (Lee et al. 2011). It can seem to the service user that services are primarily focused on the (cost) effectiveness of an intervention rather than the present and future quality of their life.

An individual needs time to adjust to the occupational therapy setting; to find a space to explore their thoughts and needs if they are to move from survival to recovery. It takes time to nurture the human mind, taking into account its fragility as well as its potential. Clinical (and cost) effectiveness must be balanced with a recognition of the individual's rights and needs to take control of their own occupations (World Federation of Occupational Therapists 2006), and should not override the need for a therapeutic relationship within which meaning can be negotiated:

> *Gaining power and control came through meaningful choices and resources that put these choices into practice. Accurate information and access to services that were in accordance with the participants' beliefs was important, as well as the availability of different services to choose from.*
>
> ***(Ásmundsdóttir 2009, p. 118)***

In the experience of one of the authors (WB), negotiation and discussion between the occupational therapist and the service user before any activity can begin embodies the art of occupational therapy:

> *My work with one woman was focused on self-care as she lived alone and struggled to find the energy for things such as washing, dressing and preparing food. I was standing with her while she made a hot drink one day when it became clear that her heart just was not in it. Unless I, or someone else stood by her, she just could not summon up enough strength to do it. We talked about it when she was preparing a meal in a later session. The meal was a pie which she briefly placed under a grill to warm through. I suspected that she would have eaten the pie cold had I not been there. There was pressure for her to return to her solitary life but we agreed that she needed more time to regain a sense of purpose in her life. She was open to the challenge of living in supported housing with others, in order to get more intensive support, so rehousing became our focus. With more time and support, she could take ownership of her self-care at her own pace.*

In this situation, there were stages of observation, sharing perceptions and negotiation. It was necessary for Wendy to tune into the woman's experiences. The problem was not with the occupation – cooking a pie – for the individual had chosen to do that. It was not about her safety in doing so nor was it due to a lack of knowledge or skills. The overriding issue was her sense of hopelessness about her future. Trying to perform for the therapist made this sense of hopelessness more obvious to her, and to the therapist. When sensitively discussed, new goals and resources could be identified.

Enabling someone to address their own needs may involve a prolonged phase of preparation, building trust and hope. If services remain focused solely on the prescribed outcomes, the bigger (more truthful) picture of needs may remain obscured.

Long-Term Issues

People with disabilities, including mental health problems, are now increasingly under pressure to 'move on' out of services, whether they feel ready or not. This can have adverse effects on their recovery. People need varying amounts of time, in order to gather enough strength to make progress (Bejerholm 2010). Occupational therapy should move with the person, in a timely and appropriate way, responding to changing situations. The foundations of engaging with the service user in that process may have to be re-laid each day in order to bring coherence, purpose and meaning to the intervention:

> *When I worked as a social care occupational therapist, I met Louisa, who had lived alone for many years, most recently in a ground floor flat. Several problems were raised: Louisa struggled to stand up because of swelling and pain in her joints. I organized for her to have assistive equipment for the toilet, chair and bed. Her support worker was concerned about Louisa arguing with her neighbours, which seemed to be happening more often. For most of her life she had paranoid beliefs about people and the problem was that Louisa's kitchen wall cupboards, on a party wall between her and her neighbours, had become very cluttered and disorganized. When she opened the doors, items fell out and she thumped the party wall in frustration, blaming her neighbours. In consultation with the owners (a housing association) we arranged for the cupboards to be relocated onto another wall and lowered, so it was easier for her to organize the contents.*
>
> ***(WB)***

This practical approach to Louisa's difficulties may appear simple in retrospect, but careful and focused negotiation was needed. Often, this requires close collaboration with others involved, such as carers. Enabling someone to maintain their skills, preventing and slowing deterioration or loss, is an important part of the work – perhaps the most important of all even, as it could be what keeps them alive.

Occupation as Therapy Versus Occupational Therapy

Occupations are part of life, and people engage in them without any involvement from occupational therapists. Many service users will recall how relatives, friends and others enabled them to engage in activities, or when they independently used occupation as a focus for their own recovery.

The distinction between professional services provided by occupational therapists and other services, which also have an occupational focus, might not always be obvious or important to service users. This challenges occupational therapists to demonstrate the value of their professional reasoning regarding occupation, and how they harness occupation as a therapeutic medium. The earlier story of a service users' positive experience of input from a secretary underlines that many people outside the occupational therapy profession have intuitive skills regarding the use of occupation.

Some mental health support workers may also work with an occupational focus but, without specific training, the success of their occupation-focused interventions will depend on the personal skills of the individual worker, and perhaps their willingness to work collaboratively with an occupational therapist. This is frequently a fruitful partnership:

> *I worked with a support worker to enable a woman to clear up her home, which was filled with so many of her possessions that the hallway and living room were barely accessible. She had raised her only child alone and her anxiety to provide adequate clothing and toys for her had been overwhelming. Her limited income meant that whenever she could, she bought items which she considered to be a bargain and an investment for the future. Her daughter was now an adult and financially independent. Her financial contribution to the household budget meant her mother no longer had to worry so much about money. Instead, she became preoccupied with how to clear her possessions and was very interested in developing a practical graded approach to this*

with the support worker. She was also intrigued by the new opportunity to challenge some of her beliefs which had made her feel anxious throughout her life. We explored these in occupational therapy sessions alongside the practical sessions with the support worker. The work went well and soon she was able to face another challenge, to redecorate the house, something she had not had time for before.

(WB)

Reliability and continuity of care are essential for supporting the service user in this type of work, but can be compromised when services are limited by eligibility criteria, waiting lists and the low number of support workers in some areas.

CARERS AND OCCUPATIONAL THERAPY

'Carers' are family members, partners or friends who provide unpaid support to people who experience illness, disability or frailty.

(Hancock and Jarvis (1994), in Small et al. 2010)

Caring within the family is reported in the literature as often 'burdensome' for the care-giver (Chaffey and Fossey 2004; Wane et al. 2009). Fox (2009, p. 26) describes how carers may experience stigma by association, and feel undervalued:

Carers continue to experience the 'courtesy stigma' associated with caring for the mental health needs of their relative (Goffman 1963) and the negative perception of their role persists in the minds of many practitioners.

(Hogman and Pearson 1995; Jones 2002)

Carers are usually reported as facilitators of care, help and support (Josephsson et al. 2000). However, carers may have difficulty helping because of their own personal circumstances, or a lack of understanding or a negative attitude towards their relative's mental health. There may be a lack of support or education available to them or they may be over-involved and become over-protective (Chaffey and Fossey 2004; Small et al. 2010; Fox 2009; Wane et al. 2009) In contrast, they may be the best and most knowledgeable source of support, as one service user reports:

My Mother is my 'carer', and I have always had a good relationship with her, but it seems that professionals saw her support of me as evidence of her 'collusion' with my 'resistance to treatment'. My Mother did what she thought was right for me. And in the end when professionals gave up, my Mother did not. She was the one I could always rely on. I was her daughter not a patient.

Service users and their carers are often entwined in an intricate relationship. They may be tightly knit allies or bitter enemies; sometimes apparently both at the same time. For practitioners working with this dynamic, the complex nature of the relationship must be acknowledged. It is important not to idealize a relationship or to become judgemental. Some service users, for various reasons, do not want their relatives involved in their care and this should also be respected.

Carers and Care-Giving Issues

'Caregiver interventions need to acknowledge the multiplicity of ways in which relatives create understanding … and its occupational consequences' (Josephsson et al. 2000, p. 64). Small et al. (2010) highlight the differences in perspectives that can arise when carers have a poor understanding of the condition:

There is little shared understanding of mental illness and care giving between carers and professionals. For carers, good care tends to involve controlling the behaviour of people with schizophrenia while, for professionals, it tends to involve giving people with schizophrenia more say in their care, even though this increases the burden of care on carers.

(Small et al. 2010, p. 25)

Furthermore, it has been suggested that:

the views of carers and health and social care professionals are at odds with each other, therefore, and, to resolve these differences, professionals must engage with carers rather than criticise them for not conforming to professional assumptions.

(Small et al. 2010, p. 25)

Well-informed carers can constructively challenge practitioners' assumptions about how to proceed. For less well-informed carers, occupational therapists could provide information in a number of areas – such as how to navigate mental health services, understanding jargon, and regarding issues of access and eligibility criteria as part of the assessment process. This knowledge enables carers to help the service user. Knowing what to do and how to minimize risk is important for carers who may be exposed to difficult situations without support.

Focusing on everyday occupations can be a bridge to engaging carers in collaborative working:

> *I was interested to meet with the husband of one of the women I worked with, on a home visit from the hospital, as it seemed there were tensions in the marriage. He was surprised when I wanted to see the kitchen, so I explained that she had said cooking was important to her. The kitchen was large, but many drawers and cupboards were padlocked. When I asked about this, fears about her suicide attempts were shared and we discussed the challenges they had faced together. Going into the kitchen enabled the challenges to be explored and possible solutions to be identified. This included negotiating the removal of padlocks and increased support for her husband during this time. Structuring time apart into their daily lives was also important, to reduce the tension between them.*
>
> ***(WB)***

A careful and sensitive assessment was the key to understanding the dynamic of the relationship between the husband and wife and finding a way of working with it.

Carers who look after a person with long-term support needs may require support themselves. Their lives can become disrupted and their sense of identity challenged. Chaffey and Fossey's (2004) study of women carers showed that:

> *Life trajectories and occupations were altered to incorporate caring. The pursuit of their interests, in addition to care-related occupations, appears important for carers to sustain satisfying lives.*
>
> ***(Chaffey and Fossey 2004, p. 199).***

Clearly, carers' lives are likely to encompass many other roles beyond their 'carer role'. Lloyd and Stirling (2011) suggest that carers strive to create new selves and relationships that are meaningful and affirming. Service users' and carers' needs are often interconnected. For example, enabling a service user to establish routines and regular activities as part of their recovery (Dun and Fossey 2002) may also liberate their carers to pursue their own life goals and occupational choices in addition to their caring responsibilities. Occupational therapists can helpfully explore these occupational issues directly with carers, and assist them to become or remain involved in occupations that have personal meaning; creating opportunities for time away from their caring role (Chaffey and Fossey 2004).

USER-LED SERVICES

User-led initiatives are to be found primarily in the voluntary or non-statutory sector. They might be specifically commissioned or a user-led project may already be part of an organization's activities.

Peer support is particularly valued within a recovery-oriented approach, 'Peer services, if done well, can provide hope, role modelling and simple safe strategies for recovery' (Mead 2006, p. 8). Peer support workers have direct personal experience of mental health problems themselves, and of working towards their own recovery. This expertise can be invaluable; providing practical and emotional support to other service users. Occupational therapy involvement with peer support services enables an occupational focus to be sustained beyond the one-to-one work between therapist and service user.

There are, however, potential tensions for peer support workers, particularly if role distinctions become blurred. For instance peer support workers may be asked to take on medical duties normally performed by a nurse, for example, because they are perceived as a cheaper option (Soloman 2004; Walker and Bryant 2012). They may also be in danger, when employed within statutory mental health services, of being manipulated into coercing service users to comply with treatments (Mead and MacNeil 2006) and of being subsumed into the dominant medicalized culture, thus forgetting their identity and roots as survivors:

> *Although peer programs would like to think we act differently than other providers, we often run into the same quandaries around 'managing' difficult, frightening behaviors. Often the focus of both peer centers and traditional services is on relaxing, 'calming down,' and avoiding conflict or stressful situations.*
> ***(Mead et al. 2001, p. 10)***

Mead et al. (2001) propose that 'peer support training can help develop our ability to sit with discomfort while we explore the dynamics of our relationships' (p. 11), thus valuing recovery over traditional models of response.

An example of user-led services comes from Club Houses which have occupation at the core of their mission statement to support social inclusion and participation in everyday life (http://www.iccd.org/mission.html). The Swedish model differs from the US model, in that it has a stronger recovery orientation with a specific focus on agency and self-determination. It has benefitted from funding from the Empowering Adults with Mental Illness for Learning and Social Inclusion (EMPAD) project which emphasizes 'learning opportunities and labour market integration of people with mental illness' (http://www.empad-project.eu/index.html). The thrust of the EMPAD course is learning through doing and through listening to other people's stories. At the Fontänhuset (Fountain House) Club House in Stockholm, there are programmes with practical outcomes, for instance learning to cook in a professional kitchen attached to a professional café or learning information technology and communication skills in a professionally set up newsroom leading to the production of a successful magazine. Users are referred by health and social care services, or they self-refer (see: http://www.fountainhouse.org/category/tags/training).

Peer support and user-led services, when developed collaboratively, highlight those aspects of services which service users find particularly helpful. This is an essential step towards overcoming the barriers to engagement in occupational therapy.

Appreciating the Experience of Occupational Therapy

This chapter is the product of a collaborative partnership between service users and an occupational therapist. To identify the barriers to occupational therapy, we have shared and explored stories from our own experiences and from that of others alongside relevant literature. Service users sharing their experiences in focus groups, has generated many of the quotations used in this chapter (see College of Occupational Therapists 2006; Craik et al. 2010). Involving service users in the evaluation and development of services can be a powerful stimulus for discussion about the value of occupation and occupational therapy because overcoming the everyday impact of barriers to an individual's occupational engagement is an essential part of personal recovery. User involvement is widely sought, and supported in policy and legislation. Debate about principles (such as whether people can represent others) sometimes overshadows the importance of developing practical strategies to help people. With an occupational perspective, user involvement in projects can be individualized and inclusive, drawing on a sophisticated and flexible appreciation of each individual's capabilities and wishes (Bryant et al. 2011b; Involve 2012).

CONCLUSION

This chapter has explored themes of access, negotiation, meaning-making, purpose and inclusion, acknowledging the social dimension of these issues and recognizing that an occupational perspective offers practical and relevant insights. To overcome barriers and facilitate engagement with occupational therapy, it is necessary for occupational therapists and service users to communicate effectively, but also to appreciate that occupation itself is a means of sharing experiences and exploring what enables people to survive and recover from mental health problems.

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12 DEVELOPING THE STUDENT PRACTITIONER

ANNE LAWSON-PORTER

CHAPTER CONTENTS

INTRODUCTION

This chapter outlines the context in which contemporary practice occurs from political, professional and educational perspectives; exploring the influence that each perspective has on the learning and practice of pre-registration students. The apparent mismatch of expectations between regulatory, academic and practitioner partners will be discussed, indicating the challenges in educating practitioners for the future.

Concepts of competence will be analysed, considering how a student practitioner becomes competent and eligible for registration as an occupational therapist. The role of emerging placements in facilitating student practitioner development will be examined.

The chapter ends by identifying the value of exposing students to the perceived risks of role-emerging placements, along with some strategies for academics, placement educators and students to mitigate risk and support success in role-emerging areas.

WHAT ARE PRE-REGISTRATION STUDENTS PREPARING FOR?

Occupational therapy involves autonomous and evidence-based practice, requiring practitioners to be knowledgeable, skilful and professional. Their expertise is focused on what people need or choose to do to support their health and sense of wellbeing. In addition, practitioners need to be able to think creatively to find and evaluate solutions for health, social and societal issues. Enabling people to achieve health and wellbeing requires consideration of the person's occupational needs and wishes, in the contexts of their

lives. In parallel, occupational therapy is defined by the varied contexts for practice which are influenced by global, national and local social issues, including politics, policies and resources such as finances.

A Changing World

Occupational therapy takes place within unpredictable and evolving circumstances from local to global levels. The contexts are varied and partly determined by the specific circumstances of the country, region or locale in which the therapists are employed. For example, in some places occupational therapists may work in well-established areas such as paediatrics, orthopaedics or return-to-work programmes, where healthcare is funded largely through personal health insurance or the state. Intervention is specifically focused and clear evidence-based outcomes are expected. In parts of Eastern Europe, where occupational therapy is still emerging, occupational therapists might have to demonstrate their value and define their practice in order to develop legitimate opportunities to establish themselves and their services. In other parts of the world, for example in parts of the UK, what seemed established practice is changing, as NHS services are contracted out to other providers within the private and voluntary sectors. Leicester and O'Hara (2009, p. 16) describe this phenomenon as 'redesigning the plane while we are on it'.

Consequently, while occupational therapists share the same professional philosophy, not all occupational therapists are necessarily focused on doing the same things. To prepare for practice, it is important to develop and maintain awareness of how occupational therapy is shaped by the political, professional and educational contexts. Although mental health problems can create a specific need for occupational therapy, awareness of the contexts for practice can enhance understanding of the reasoning behind the different actions and roles taken by therapists.

The Political Context

Promoting mental health and wellbeing has been recognized as vitally important for the global population (see Ch. 2), challenging the historic tendency to separate and specialize health services for people with mental health problems and learning disabilities. Being aware of mental health issues and being responsive to them is a requirement of every health and social care context. The World Health Organization's (WHO) *Report on Disability* (WHO 2010a) estimated that the number of disabled people worldwide was around 15% of the world's population. This number, including children with disabilities, continues to grow. Population demand for health and social care services is high, with an expectation that services will continue to be provided where they already exist. Technological advances in treatment and drugs are expensive, and difficult moral decisions are being made about *who* can receive *what* treatment, which itself leads to inequalities in access to and provision of healthcare. Austerity measures have an additional impact, with people affected not only by poverty from a reduced income, but also poverty of opportunity as a consequence (see Chs 13, 29).

The political vision to address these challenges has been articulated by organizations such as the World Health Organization (WHO). Using political visions to inform preparations for practice is not about ignoring realities, but supporting professional development. For example, the WHO report *Primary Health Care: now more than ever* (WHO 2008) indicated the need for reliable and responsive healthcare systems which are individualized and participatory, clearly placing the user of services in the centre. There are four main principles which are important for understanding the political context for occupational therapy:

- Universal coverage, ensuring that preventative health services are available to all and free at the point of access
- People-centred services, with community-based, accessible healthcare delivery points
- Public health policies, acknowledging that much of what affects populations lies outside immediate healthcare needs, for example, community opportunities, poverty, housing, employment
- Leadership, to guide and steer changes towards greater efficiency and effectiveness.

These four principles could suggest the increasing demand for services is a positive indication of a shared and increased awareness of the central importance of health. A subsequent WHO report on *Health Systems Financing* (WHO 2010b) picked up on the universal coverage principle. The impact of rising population

expectations, rising costs, expensive treatments, demographic challenges and the increase in chronic disease was acknowledged. It was also suggested that efficiencies could be made, based on an estimate that health services globally wasted between 20% and 40% of healthcare spending.

To prepare for practice in this political context, education of student practitioners should navigate the tension between the vision of a right to universal healthcare and the reality of resource-limited service provision. It is the context within which occupational therapists work, impacting on current practice and future development, with many legitimate opportunities for occupational therapists to consider. It is also the context that students need to learn about, understand, reflect on and act upon, as it will affect the way in which their professional career may develop.

Thibeault (2006) suggests that academic institutions have a responsibility to '*be at the forefront of the action…wake up their students and communities …and plan strategies to bring about rapid change*' (p. 161). In developing Thibeault's point of view, it should be the responsibility of *all* occupational therapists to ensure that they make themselves aware of the political context, seeking to understand how it impacts on occupational therapy and proactively contributing to professional development.

The Professional Context

Although occupation has been recognized as a determinant of health and wellbeing throughout human history, like many other health disciplines, occupational therapy did not emerge as a profession until the 20th century (see Ch. 1). Since then, the profession has evolved to address changing health and social care demands with therapeutic occupation, working with individuals, their families and carers and increasingly, with communities. As well as agreeing standards of professional behaviour, occupational therapy has developed a shared knowledge base to inform and support practice. These elements of the professional context are a focus of practice placements for students.

Occupational science, with its focus on understanding the nature of occupations and the challenges to participation in occupations, has helped to broaden where the profession sees its potential influence and legitimate involvement (see Ch. 3). This has led to the idea of role-emerging or non-traditional settings for situated learning on placement.

Emerging Roles

There are clear examples of where occupational therapy has extended beyond traditional services in hospitals and clinics (notably Kronenberg et al. 2005; Lorenzo et al. 2006). Reflecting their setting, many of these examples take a broad view on health, not using diagnostic categories to distinguish between people. Instead, needs are defined in terms of occupational injustice and/or social exclusion. Preparing for professional practice in these settings requires a focus on occupational theories, learning and exploring how to interpret and apply relevant ideas in practice in a creative way.

This expansion into non-clinical settings has been helpful in creating opportunities for the profession. However, it challenges practicing occupational therapists to critically reflect on what students and graduates are being prepared for. Within mental health services, the dominant paradigm is concerned with solving health problems through treatment, therapy or other forms of institutional support. The service user is often a passive consumer of services (see Ch. 11). In contrast, the health improvement paradigm aims at prevention, engagement and participation through social inclusion, offering the service user a more active role. The two paradigms are not mutually exclusive, but the current dominant paradigm is being subtly changed as governments recognize that prevention of ill-health may be cheaper than cure (WHO 2010b).

So we have a challenge in educating students: ensuring that they are competent to work within the dominant paradigm, delivering targeted and highly focused services; while also preparing them to work in other settings which may demand a more flexible approach.

The Educational Context

To practice as a professional, it is necessary to have achieved competence in agreed areas. Debate continues about the vision for the profession and the education of students to achieve it. The process of agreeing on the scope and focus of professional practice is ongoing. The movement towards standardized occupational therapy education began in America and developed as the profession grew in response to the needs of

First World War casualties (Colman 1992) (see Ch. 1). The movement to regulate and structure education for occupational therapists has been adopted worldwide (Hocking and Ness 2002; TUNING 2009; College of Occupational Therapists, (COT) 2009). Ensuring that standards of education are set and met is important for occupational therapy as a profession. It is also the responsibility of the educational institutions, such as universities, who provide the learning environment. They have to organize the approval of occupational therapy pre-registration education programmes, involving funders, professional bodies, educational representatives and others who are responsible for registering and regulating practitioners.

Consequently, world regulatory bodies, such as the Health and Care Professions Council in the UK, have developed Standards for Education and Training (SETs) (Health Professions Council 2009) that supersede professional body standards. The SETs are used to validate educational curricula for a number of health professional programmes, including occupational therapy. On successful completion of a validated programme, British graduates are considered to have attained the HCPC Standards of Proficiency (SOP), which are really statements of competence, and they are eligible to apply for registration to practice.

The TUNING Process

In Europe, a system to harmonize educational structures and outcomes across Europe known as the TUNING process, was initiated as a result of the Bologna Accord in 1999. Its aim was to create a set of subject-specific and generic statements of competence at undergraduate, post-graduate and doctoral levels, which would result in comparable degrees across European higher-education institutions. One of the intended outcomes of this process is to support academic and student mobility and employment mobility across Europe. The Council of Occupational Therapists in European Countries (COTEC) and the European Network of Occupational Therapy in Higher Education (ENOTHE) worked together to produce the TUNING competences for occupational therapy. Like other agreed standards for occupational therapy education, the TUNING competences are intended to be points of reference to aid curriculum design rather than prescriptive statements. Occupational therapy was among the first subject areas that created the first- and second-level TUNING points of reference; a process that started in 2002, leading to publication in 2009 (TUNING 2009).

In addition to the above, there are also professional requirements for educational programmes, often expressed as standards for education and/or curriculum guidance, such as the World Federation Revised Minimum Standards for Education (Hocking and Ness 2002) or the Curriculum Guidance for Pre-registration Education (COT 2009). These documents express the intended outcomes of educational programmes either as learning outcomes or as a graduate profile – essentially additional statements of competence. It would be unfair to give the impression that there are vast numbers of competences to be achieved as some are reiterated and referenced across documents, although the number of profession-specific competences for TUNING alone is currently around 36.

Meeting Requirements

The growth in the number of regulators may have led some programmes in occupational therapy to become more focused on attainment of the required competences and less focused on the continuous *process* of ensuring that graduates are motivated to think and reason critically, although university-based programmes will have relevant internal standards to meet. Lederer (2007) considers developed capacity for critical thinking to be an important outcome of education, although his research was limited to students. The quality of professional practice is linked to the capacity for critical thought. The unquestioning use of evidence-based protocols (used in many medical situations such as medication prescription) or other guidelines for practice are not an indicator of competent practice. In contrast, mental health services require the judicious and reasoned use of the available evidence to meet a particular individual's specific and contextual needs.

Another issue to be considered is that some standards or competency documents were written at a certain point in time and may no longer address current trends. It takes time to review, revise and approve occupational therapy programmes, a process which does not always keep pace with the changing context for practice. This puts increased responsibility on

academics and practitioners to ensure that curricula are sufficiently adaptable and proactive so that evolving opportunities for occupational therapists can be taken up. It could be argued that prescriptive competences, such as those produced by some organizations like HCPC and the TUNING process, may preclude the ability of academic institutions to be responsive to contextual changes in the desire to be seen to be addressing the regulatory requirements.

There is an ongoing challenge to ensure that occupational therapy education programmes have sufficient flexibility to educate graduates to be fit for today's purpose, yet equipped with the ability to think critically to prepare them for tomorrow's challenges. The increasing interest in Masters' level pre-registration education, delivered as accelerated programmes, suggests one response.

PREPARATION FOR PRACTICE

General requirements for the length and outline of an occupational therapy programme are detailed in the World Federation Minimum Standards for the Education of Occupational Therapists (Hocking and Ness 2002). Initially, these standards were the result of identifying the key components of existing programmes in the 1950s, to produce guidelines for any country wishing to develop an occupational therapy programme. Regular revision over the last six decades has reflected developments in education, as well as in the practice of occupational therapy in health and social care environments.

The minimum standards have to be achieved by an occupational therapy programme for it to be recognized by the World Federation of Occupational Therapists. The current requirements indicate that a programme should be a minimum of '3000 hours, spaced over 90 weeks, and extended over three years' (p. 16). It acknowledges that some programmes are 4 years long, but there is evidence that accelerated courses exist for holders of a first degree and also work-based learning programmes, where the programmes may be considerably shorter than the 3000 hours; 90 weeks minimum. There is some debate about whether it is more important to achieve the required input of hours or to achieve the required outcomes of education, irrespective of the length of a programme, to become a competent graduate.

In terms of the proportions of a programme that should be dedicated to certain topics, the minimum standards identify that one-sixth of the time should be spent on basic sciences, half of the programme should be allocated to the theory and application of occupational therapy and one-third of the programme to placement learning (which should equate to a minimum of 1000 hours).

All occupational therapy programmes of education have two distinct areas of interest:

- Developing the professional knowledge, professional skills and critical thinking abilities of students
- Ensuring that the above is integrated into placement learning to produce a competent practitioner.

How these elements are delivered is the responsibility of the educational programme to decide, however the delivery should be congruent with the specific educational strategy and programme philosophy. Different learning and teaching methods are used globally, between educational institutions and within individual programmes. Tutor-centred approaches include didactic teaching methods, such as lectures. Student-centred approaches include problem- and enquiry-based learning in seminars, which aim to develop research, critical thinking and problem-solving skills. Appreciative enquiry aims to build positively on what has worked well in the past to seek solutions to issues, using learning and creativity (Rubin et al. 2011). Student-centred approaches are perceived to develop deep learning more readily, thereby creating competent, independent and critical learners and practitioners. They also acknowledge that many students come to occupational therapy education with relevant personal and work experiences, which can form the basis for their professional development. These varied approaches to learning reflect different interpretations of what is involved in being and becoming a competent practitioner.

Developing Competence

Short (1985) recognized the vital importance of how the term *competence* is interpreted in education. Different interpretations of competence are concerned with what people can do (performance and behaviours), what they know (knowledge and skills) and

how they are (a state of being). It can be difficult to make judgements about whether competence has been achieved in any of these interpretations. For example, performance and behaviours may be more quantifiable and observable than a state of being, which could be judged in a more qualitative and subjective way.

Short's critical analysis will be used to structure further exploration of the development of competence within occupational therapy education.

Competence in Performance and Behaviours

Competence in this context refers to the demonstrable ability to do something correctly or to a sufficient standard. Acts of this kind are often independent of an ongoing purpose or intent. For example, students may know what to do when an office telephone rings in a placement setting. They may have been instructed to pick up the phone, give a greeting, take a message and/or pass the caller to another person. They are either able to do this or not. The ability to achieve isolated tasks, such as this, is essential in indicating a baseline level of communication skills and professional conduct.

However, it is rare that student therapists perform purely isolated tasks that have no relation to what follows. They are expected to deal with more complex levels of behaviour and performance, which require them to exercise judgement and make decisions. For example, referring back to the telephone call, if the student decides to pass the call on to a more appropriate person, then they have to understand the issue to be passed on and to decide who the most appropriate person is to deal with it. The student also has to have the skill to communicate effectively and courteously with the caller and, if taking a message, know how to detail accurately what the message is.

Replicated, learned acts of purely doing something are uncommon in occupational therapy by the very nature of working with individuals and organizations. Occupational therapy requires more than a technical approach to doing things, although technical skills may still be required.

Competence in Using Knowledge and Skills by Thinking and Reasoning

Creek (2009), in an unpublished lecture ('The art of occupational therapy'), identifies the different types of knowledge used by occupational therapists (see also Ch. 3). There are *universal theories* that inform the student about such things as basic sciences, medical and mental health conditions, professional frames of reference and social policy, which can be learned through such things as lectures and private study. There is also *contextual knowledge*, which is gained when students work with people in their own context. For example, the student will have to seek knowledge about a particular individual's health condition and circumstance. Creek also identifies *practical knowledge* where students learn not just *what* to do but *how* to do something, such as how to make an individual feel welcome and how to communicate to facilitate a person's engagement in an activity (Creek 2007).

Short's (1985) explanation of competence in knowledge and skills complements Creek's view. The application of knowledge and skill, whether universal, contextual or practical, is purposeful. It requires critical thinking to make judgements and choices about the most appropriate and pertinent course of action, for and with a person.

To develop the capacity for critical thinking and decision-making, students need firm foundations for professional practice. In particular, they need to develop competency in using universal knowledge about the philosophy of occupational therapy and theories that inform practice and approaches to intervention. Practical knowledge will enable students to feel secure and grounded. They will be able to explain their interventions in the context of their professional knowledge and skills, and an individual's needs. Being able to clearly explain to others about the nature and intention of occupational therapy should be a focus of learning in every educational setting, including placement settings. Therefore educators and practitioners should make sure that every student can explain how occupational therapy can address identified individual, group and community issues. Occupational therapists need to be able to persuasively explain their practice and vision in every new encounter to each new person who needs occupational therapy, as well as for initiatives in settings where occupational therapy has been previously unknown.

Learning how to explain the practice and vision of occupational therapy requires awareness of the underlying professional reasoning, which takes different forms (Schell and Schell 2008). Practice educators can facilitate learning through sharing their

own reasoning, modelling and encouraging the application of professional reasoning to and in practice. Professional reasoning is important in developing individualized interventions, which are informed by evidence. It is necessary to ensure that protocols are not applied indiscriminately to all individuals. Evidence-based practice is not about providing a specific recipe for intervention in every case (see Ch. 9).

The Art of Being a Competent Practitioner

Short's (1985) fourth concept of competence is defined as a 'state of being' (p. 5), implying the quality of a person. This state of being competent includes such subjective elements as their values and attitudes. This particular concept is difficult to define and also difficult to measure, having a fundamentally holistic nature, linked to therapeutic use of self. The qualities of a competent therapist are expressed not just by what they do and what they know, but how they go about their work. We know when we encounter competence in a person, and it is this state of being competent that educational programmes and placement educators strive to develop in their students.

Understanding this concept of competence as professional artistry has been explored by Creek (2009), using the Dreyfuss and Dreyfuss model of skill acquisition (Benner 1982). This offers insight into the expert practitioner who tacitly knows what to do, based on a synthesis of understanding, experience and expertise. From the outside, this expert way of working can look accidental or coincidental, but is probably more accurately described as alchemy – the magical power of changing something that is common into something of value. This power is a synthesis of different elements of competence, uniquely adjusted for each situation and thus appearing to have a magical quality.

This degree of expert practice is of course difficult to achieve within the timescale of pre-registration programmes, especially when opportunities to apply and rehearse knowledge and skills in practice are time-limited. Yet, professional artistry is an important part of developing confident practice in less familiar and more unpredictable situations (Fish 1998). The role of placement or practice learning is crucial in the development of both professional competence and artistry; it is where the art of occupational therapy develops through the application of professional knowledge and skills. Future graduates will need to be competent to continue to work in the prevailing settings of health and social care and also in other employment contexts which continue to emerge as the result of policy changes.

To achieve this, students will need to be exposed to varied placement experiences where occupational therapy has a legitimate role. This involves balancing established placement settings such as acute inpatient units, with other settings, such as those which use therapeutic horticulture with many different groups of people. These alternative settings require development by practitioners and educators, in partnership with relevant organizations. The next section develops this theme further.

SITUATED LEARNING AND THE SIGNIFICANCE OF PLACEMENT LEARNING

Encountering Risk

Programmes of occupational therapy education require students to undertake a minimum of 1000 hours of assessed fieldwork placement experience, as identified earlier. Often, such experience takes place in established medical or rehabilitation centres for people with physical illness and disability and mental health issues. Many student placements rightly still take place in these settings, as individuals with acute illness or impairment have difficulty fulfilling their chosen occupations and activities. There continues to be, therefore, a well-founded and legitimate role for occupational therapists in health and social care.

However, in the context of changing health and social care policy worldwide, there is increasing emphasis on the prevention of ill-health and the promotion of health-improving behaviours (WHO 2008), to make better use of scarce financial and professional resources. One of the consequences has been a greater emphasis on community-based interventions with increased social relevance. In response to this trend, many occupational therapy programmes have been including role-emerging and non-traditional placements in their curricula for a number of years. Role-emerging placements usually take place in settings where there has been no previous occupational therapy service (Totten and Pratt 2001) or where there is no established occupational therapy role (COT 2006). 'Non-traditional' refers to the fact

that many of these placements are outside the statutory medical or social setting of current practice and are found within private, voluntary or charitable organizations.

Initially these placements were used in the UK to address a foreseen shortfall in placement opportunities for students. More recently, role-emerging placements have been seen as a means of exploring new opportunities for employment and to enhance learning opportunities. These placements have grown in number and frequency and have taken on a new meaning through the language of occupational science (see Ch. 3). Such placements occur where there is evidence that individuals and communities have unmet occupational needs, often due to societal or policy consequences, such as homelessness and unemployment, and which may or may not relate specifically to illness or impairment (see Ch. 29). These types of placements often provide an opportunity for students to design what they think occupational therapy can offer in the given context. However, this means that students have to learn to use their knowledge base confidently, investigate the context and the needs of the people within it, and are appropriately supported in their learning and developing practice.

Exposing Students to Risk; from the Known to the Unknown, the Predictable to the Unpredictable

Role-emerging placements could be seen to expose some students to greater risks, as not all students have the life experience or confidence to accept their insecurities about a situation and learn their way through it. Cooper and Raine (2009) raise the issue of whether students who are thought likely to struggle should be exposed to the additional pressure of a role-emerging placement. This is an issue that is debated often and while one would not wish to see students fail placements unnecessarily, the debate needs also to encompass the evolving nature of occupational therapy practice and be clear about how competence is interpreted. The issue could be about why students *should not* be exposed to role-emerging placements if the aim is for them to achieve competence for current real-world practice and future practice in evolving contexts. When students work in the real world of practice, there are some core expectations of what practice learning will help them to develop. Barker et al. (2010) identified core learning attributes achieved on international placements, which are often role-emerging:

- Thinking outside the box
- Adaptability/flexibility
- Cultural sensitivity
- Recognizing the value of interpersonal relationships
- Gaining confidence by working outside one's comfort zone
- Increasing autonomy
- Critical reflection on the appropriateness of occupational therapy practice.

These attributes indicate what students can achieve through core learning. Similarly, Tanner (2011) identified three threshold concepts to indicate student learning about the realities of practice:

1. *Person-centred practice and use of self:* including overcoming a fear of the setting, which was often based on a lack of understanding of people with a disability rather than seeing the person as a real person in a real world. Students often expected that they would tell patients what to do rather than engage them in making choices
2. *Developing a professional identity:* including thinking and acting like a professional and being able to explain their role to others
3. *Practising in the real world:* including the need to understand the reality of practicing in a world with all its policies and systems that impact on service delivery and, inevitably, on patient choices. This threshold also identified the importance of a student's ability to apply learned theory.

These core learning attributes and threshold concepts are echoed in a small, qualitative study by Fieldhouse and Fedden (2009), where person-centred practice, therapeutic use of self, linking theory with practice and developing a professional identity also featured strongly. Taken together, the core learning attributes and threshold concepts support situated learning – that is, learning in the real world of practice, familiar and unfamiliar, where the integration of professional knowledge and skill are facilitated and mastered to a level of proficiency. While these findings are drawn from international, health and role-emerging

settings, it is clear that this core learning would be a desirable outcome from any placement – national or international, role-emerging or traditional.

Different placement contexts are likely to expose different expectations and different levels of familiarity with the situation. For example, most students may have some generalized expectations of what is expected of them in a hospital setting. Students are likely to have previously visited a hospital to see a relative or for personal treatment. However, being a student practitioner is less familiar, because of the expectation to demonstrate competence to practice in very specific and measurable ways. Unfamiliar situations, such as working with a prison population, being attached to an employment centre or undertaking an international placement, potentially create more challenges. This might expose students to an increased risk of failing. Conversely, an unfamiliar placement setting may also heighten the students' awareness of their learning needs, creating an enhanced opportunity for learning.

It is possible that the enhanced opportunities of a role-emerging or unfamiliar placement setting enable student learning and professional development to a higher level, justifying the possibly increased risk. Anecdotal evidence from students suggests that role-emerging placements are where many, although not all, identify their most significant learning; where their professional identity becomes more secure; where they feel most autonomous and where they are able to use a greater range of their professional skills. Somehow, intentionally placing students in these settings sharpens their perspective on what occupational therapy is and what occupational therapists can do. Role-emerging placements seem to create a greater sense of 'work excitement' where the learning environment fosters individual growth and development (Lickman and Simms 1993). They define work excitement as 'personal enthusiasm and commitment for work evidenced by creativity, receptivity to learning, and ability to see opportunity in everyday situations' (p. 211).

Vickers (2007) identifies the transformative nature of learning when students are exposed to 'dynamic and fundamental learning experiences as opposed to a simple enlargement of knowledge (and skills)' (p. 38). She defines 'transform' as a 'significant change from the learner's established way of thinking and acting, and towards a new way of understanding their world and their place within it' (p. 38.). Role-emerging placements may help students to consolidate what they know and understand but also change the way they think and act in less familiar situations where the learning environment enables work excitement to emerge. Achieving new understandings requires strategies for managing risk and facilitating transformation, which will be discussed next.

Managing the Risk and Facilitating Professional Development

Strategies for managing role-emerging placements have been identified (COT 2006; Fieldhouse and Fedden 2009; Lorenzo et al. 2006). To prepare, a robust infrastructure needs to be established: for example, how to identify appropriate placements; identifying learning opportunities in the placement; establishing day-to-day supervision roles; ensuring that professional supervision is available; creating links between the university, professional supervisor and day-to-day supervisor; establishing robust communication channels; frequency of supervision and so on. Much of this is well-documented with guidance, for example, from the College of Occupational Therapists in the UK (2006). While the preparation and infrastructure to support role-emerging placements is vitally important and should not be underestimated in managing risk, it is the *process* of supported learning through the placement that will further mitigate risk for the student and for service users.

Lorenzo and Buchanan (2006) have adopted an action learning approach to support students working with disadvantaged communities in South Africa. This approach facilitates reflection in and on practice, enhancing the relevance of practice learning by encouraging sitting, listening, observing, questioning and reflecting on everyday practice and experiences, with the potential to bring about real change and real learning. The approach is an educational process, not a therapeutic process, and is concerned with creating a learning environment in which all participants benefit. Lorenzo and Buchanan (2006) argue that it is an inclusive way of learning for students, service users, placement educators and supervisors and university teachers. Our focus here though is on the students, their learning and developing competence and their particular relationship with their supervisor(s) and service users.

Galvaan (2006) comments on how students manage being in an unfamiliar and unknown situation. She identifies that students are aware that they are working outside their comfort zone, where their attitudes, values and assumptions are challenged, often where their knowledge and skills do not seem to fit. Using the work of Savin-Baden, she acknowledges that this results in a sense of disjunction where the student's sense of self becomes fragmented as they venture on a journey of self-discovery. The students use their previous knowledge to build on their emerging experiences within the role-emerging context. Equally, they use their lack of knowledge and skill in that context to discover what they need to know, at a point when that knowledge is needed, so it can be applied. This is an inductive way of working, enabling the student to come to an understanding of what occupational therapy can offer, rather than jumping to a conclusion that there is a problem to be fixed.

So that competence can be achieved and demonstrated, the student's process of self-discovery should be supported by the placement educator. Through supervision, students should be encouraged to admit their fears and feelings of powerlessness in the placement situation, as it is this honest exposure that creates the right environment for growth (Galvaan 2006; Lorenzo et al. 2006). They propose a number of specific strategies for supervision, which placement educators could use with the student:

- Allow opportunity to deconstruct occupational theory and literature so that it can be reconstructed to provide appropriate meanings in the placement context
- Investigate the literature and identify the evidence base that informs why the role-emerging placement works as it does, so that the student can value the work done by the placement
- Help the student to recognize the application of their knowledge and skills in this context
- Facilitate student understanding that the issues presented by the placement are serious enough and legitimate for intervention with an occupational focus
- Help the student to create a structure in the placement to control any feelings of being overwhelmed
- Facilitate the students' organizational and management skills
- Identify personal coping strategies
- Develop the students' sense of, and confidence in, being able to take informed risks and to act on identified needs
- Create and harness a sense of work excitement and agency.

In adopting the strategies above, placement educators need to be secure in their own role as an educator in the workplace. This is quite a different approach to the more traditional apprenticeship model, where students learn by modelling the core professional skills of their supervisor in a particular practice environment. The latter is about skill development and 'cloning' for a given situation; the former is concerned with enabling students to learn and develop the new knowledge, skills and thinking required to re-position or re-define occupational therapy in unfamiliar situations and in which cloning, based on accepted practices, may have limited application.

In creating role-emerging opportunities for students, we are in fact also creating role-emerging opportunities for placement educators and academic staff. All the actors in this scenario will be working outside their comfort zone to a greater or lesser degree but the strategies identified above place responsibility on academic staff and institutions, placement educators and students, to ensure optimal success through risk management, rather than risk avoidance.

SUMMARY

This chapter has identified and discussed the political, professional and educational contexts that impact on the practice and education of occupational therapists. It has described the current process of occupational therapy education and the factors that influence the process from professional and regulatory perspectives and the subsequent effects on professional development. The different aspects of competence and their contribution in creating a competent practitioner were explored, before considering how role-emerging placements can be used to further enhance competence in the changing context of health and social care. The chapter concluded with a discussion of why exposing students to risk may be desirable with strategies for how academics, placement educators and students can mitigate against failure while working for success.

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SERVICE USER COMMENTARY

This commentary is based upon my reflections on occupational therapy following a serious postnatal illness, and my subsequent role as an educator.

Suffering from a mental illness is an incredibly bewildering experience. Your belief systems change and you can lack insight. Important personal relationships are put under strain. Mania gives you the energy to realize that there is nothing you can't achieve; depression makes you feel worthless.

Two weeks after having a baby, I was approached by occupational therapists asking if I wanted to play badminton. Along with another patient, I was taken to a sports centre. It was empowering to be away from the ward setting. Even more so, to know that the sports centre staff thought I was the carer rather than the patient. This demonstrated all three occupational therapy threshold concepts:

1. Person-centred practice: I was asked if this was something that might interest me and was taken in a very small group
2. Professional identity: the occupational therapists explained that their role is to help us develop confidence
3. Practice in the real world.

While in the grips of mania, my mind was constantly overflowing with ideas. These were coming so thick and fast that I struggled to remember them. Relationships with my family were tense; we didn't seem to be able to communicate in the normal way. The hospital was my sanctuary. My relationship with the other patients was good and with the occupational therapists, even better. Under mania you will try anything; I was surprised that I enjoyed art classes and was able to express myself in ways I did not expect. It became therapeutic.

Like virtually all inpatients, I was quickly medicated. Within a fortnight, I went from mania to 'zombiefication': I was unable to function or stay awake. I had every side-effect of medication: severe sunburn, aching joints, lack of facial movement, swollen tongue and 'jet-lag'. Again, occupational therapy helped. I was unable to move my arms and hold a paint brush. I lacked the concentration to make quills to stick onto cards. Simple alternatives were always suggested to me. I was allowed to do whatever I was able. If I wanted to rest, this was my choice. As a patient, little is of your own choice. Occupational therapy gave me a sense of control.

Several years later, I was invited to speak to students about my experiences. Gaining insight into what it feels like to be a service user is an important part of student learning. I hope that students can ask me questions that may not be appropriate in a clinical setting.

I observed that students from other health and social care disciplines do not understand what occupational therapy is, having a vague idea that it might be something to do with rehabilitation. In my workshops, I have made time for occupational therapists to discuss their roles with other health professionals. There is a gap in the education of the other health professionals relating to occupational therapy, which needs to be embedded in their core curricula. Without this knowledge, strong working relationships cannot be developed.

I developed my own teaching practice to 'service user facilitated inter-disciplinary learning' (Ward and Padgett 2012). I don't think healthcare fits into neat little boxes and specialisms. Professionals need 'to think critically to prepare them for tomorrow's challenges', as suggested in this chapter.

Now, I recount a portion of my story, pause to ask the class what they would do, from the point of view of the health professional. This is normally greeted by stunned silence. Students tell me they haven't been asked to think from the perspective of other health professionals and find this an alien concept. I ask them to start a conversation about what they might do. Normally, conversations start off quietly, building to full discussions. Then I ask the students to pause, and tell me their ideas. I make comments from my perspective. This can often raise challenging issues; occasionally my perspective is the opposite of the established 'best practice'. For example, I was not directly told about arrangements for my hospital admission. This was exactly the right approach; I trusted my husband and family GP who arranged the admission. To understand why I was going to hospital would have meant that I would have to have accepted that I was ill. This was something that I did not do for several weeks or even months. This led to challenging discussions. What do students do if the legislation and procedures tell you one thing and the patient perspective is another? When I co-facilitate with an academic, we can also discuss this, and it is something which can be followed-up in subsequent lectures.

As discussed in this chapter, the author wants institutions to be 'at the forefront of the action, wake up their students and communications, and plan strategies to bring about rapid change' (Thibeault 2006). This is what I hope to do with my teaching practice.

As I left hospital, my named nurse said to me, 'we can only guess at what's it's like for you. You know, you have precious knowledge'.

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13 AN INTERSECTIONAL APPROACH TO INEQUITY

MARINA MORROW ■ SUSAN LYNN HARDIE

CHAPTER CONTENTS

INTRODUCTION

This chapter begins with a review of the evidence for the social and structural determinants of mental health, with particular attention to the ways in which mental illness diagnoses have resulted in discriminatory practices and beliefs about people experiencing mental distress. The concept of intersectionality is then introduced as a way of understanding the complex interconnections between different forms of power and social positioning. Although the development of intersectional policy and practice is in its early stages, it is a promising paradigm for occupational therapy practice and in line with the aims and goals of occupational justice. Next, there is a review of recent mental health reforms, which indicates the complex environment in which occupational therapists practice. We concentrate on the historical move away from institutional care to community care and the adoption of recovery and wellbeing models. Neoliberal government agendas are analysed for how they reinforce individual models of wellness and self-sufficiency, which more easily play into the predominant biomedical paradigm in mental health.

We suggest that the adoption of an intersectional framework in occupational therapy can assist practitioners in better understanding and responding to the

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lives of the people with whom they work. The next section explores activism and how people with lived experience/service users critique psychiatry, through their involvement in the development of mental healthcare policy and in directing care towards their own needs and concerns. We show how intersectional frameworks can be used in the practice of reflexivity, to foster the awareness of occupational therapists working with a diverse clientele and to better respond to the power relations inherent in their work. Finally, an example is given, of a structural-level intervention that is being developed in Canada to address some of the larger issues faced by people with mental health issues with respect to employment – the social enterprise model. In this chapter, we use the term *inequity* to refer to 'differences that are unfair or unjust as a result of structural arrangements that are potentially remedial' (Pauly 2008, p. 5).

Occupational Therapy and Mental Health Practice

> *Questions about power and justice are often viewed skeptically as being too political. Yet not addressing power and justice is also political; [occupational therapy] can either remain silently compliant with client/consumer injustices and our professional lack of empowerment, or we can take a visible, active stance to advocate for change.*
>
> ***(Townsend 2003, p. 85)***

Occupational therapists face constantly shifting social and economic contexts and increasingly complex and diverse practice situations. Recognizing this, it is essential that all practitioners realize the importance of, and work to acquire, the knowledge and competencies to engage with these practice realities, while upholding the profession's core values and principles inclusive of equity, social inclusion, cultural awareness and human rights. This requires, rather demands, that occupational therapists' competencies include engaging in, critically analysing, and contributing to the 'larger political debates' and dialogues (Richards 2008, p. 26) that shape the profession. Engaging with practice realities, while upholding values, can influence the resources and opportunities available to people striving to attain meaningful experiences in all life activities (Whalley Hammell 2009). The larger political and policy landscape is concerned with social inclusion, workforce modernization, extended roles and new ways of working, which require a greater breadth of knowledge beyond traditional psychiatry.

Political Contexts

Occupational therapy can be understood as a profession embedded in larger political, social and cultural contexts. These contexts include complex and often contradictory political environments. For example, there is increased reliance and focus on recovery and on community mental healthcare. Yet, there is limited commitment of governments to provide the resources necessary to maintain these supports. There is a legal environment internationally that upholds the rights of people with disabilities, whereas at the national level, mental health legislation often undermines these rights. Paradoxically, while research and practical experience show that the social environment is critical to mental wellbeing, responses continue to be biomedically focused. Indeed, the continued historical reliance on the biomedical model of psychiatry has restricted development of a mental health system that responds adequately to the stresses caused by the social determinants of mental health (McGibbon 2012). Occupational therapy itself is embedded in a set of complex relationships to a range of professions dominated by a biomedical paradigm, which influences the frameworks occupational therapists use in their practice. This paradigm also marginalizes occupational therapy as a profession, because of the increasing professional focus on social justice and the social causes of mental distress (Townsend 2003).

These contexts raise important and compelling questions for occupational therapists who are working towards addressing 'unjust inequities that limit opportunities for participation in society' (Braveman and Suarez-Balcazar 2009, p. 7):

- How do the frameworks used by occupational therapists impact on existing social and structural inequities associated with mental health and the attainment of meaningful occupation?
- What is the role of occupational therapists with respect to larger political debates about reforms in mental health?
- What does it mean to be a reflexive practitioner and advocate for occupational justice?

While there is a long and rich tradition of occupational justice in occupational therapy, which has oriented practitioners towards a social justice framework and has meant that professional organizations have engaged in larger political debates (Townsend and Wilcock 2004; Kronenberg et al. 2005; Bass-Haugen 2009; Braveman and Suarez-Balcazar 2009; Wilcock and Townsend 2009), less attention has been paid to the day-to-day reality of occupational therapy, to ensure that practitioners are skilled and knowledgeable and supported in responding to the complexities of practice. For example, many people present with multiple health problems within their families, which can be complicated by who they are, where they live and who they live with. These complexities can be understood by considering the social and structural determinants of mental health.

THE SOCIAL AND STRUCTURAL DETERMINANTS OF MENTAL HEALTH

The evidence concerning the interconnections between social and structural inequities and mental health and mental illness is clear. Occupational therapy as a profession has been on the forefront internationally in recognizing inequities in the context of mental health and work (e.g. Townsend 2003; Townsend and Wilcock 2004; Kronenberg et al. 2005; Bass-Haugen 2009; Braveman and Suarez-Balcazar 2009). Regardless of their origins, experiences of mental illness and distress take place in social, cultural and historical contexts (Hacking 2002; Shorter 2008). These contexts include practices and policies, which ameliorate, reinforce or worsen existing forms of discrimination based on psychiatric diagnoses and social positioning, such as gender, race, ethnicity, class, religion, ability and sexuality (Ussher 1991, 2011; Caplan and Cosgrove 2004; Chan et al. 2005; U'Ren 2011).

Discrimination is structured through legal, medical and psychological practices and policies. These practices and policies play out in distinct ways for different groups within society. Before proceeding with the research evidence, it is necessary to clarify the use of the terms 'social and structural inequities'. Within the health literature, social inequities are defined by Whitehead and Dahlgren (2006, p. 2) and by Pauly (2008, p. 5) as the result of structural arrangements, which are *systematic, socially produced* and *unfair*. Pauly (2008) understands inequities as leading to differences in health status among and between different social groups and recognizes that these inequities are the result of social processes, which can be acted on to produce equity.

In the mental health field, there are similar definitions (Aneshensel 2009; Benbow 2009; Depauw and Glass 2009). Graham (2004, p. 101) argues that:

> *the social factors promoting and undermining the health of individuals and populations should not be confused with the social processes underlying their unequal distribution. This distinction is important because, despite better health and improvement in health determinants, social disparities persist.*

It has been noted that, although these definitions emphasize unfair systemic social processes, they are lacking in their ability to describe overlapping and intersecting forms of inequity (Ingram et al. 2013). For example, there is an absence of analysis of the many complex ways in which power operates within the mental healthcare system itself, and the ways in which psychiatric diagnoses can become a form of oppression.

In this chapter, the term *social inequities* is used to put the emphasis on the 'social' first, rather than on 'health'. Social inequities and mental health are defined by Ingram et al. (2013) as being caused by structural social arrangements, which result in inequitable distribution of resources and active discrimination against individuals because of their membership in one or more disenfranchised group.

Relevant Literature

The literature on social inequities and mental health comes from diverse paradigms and perspectives. The literature can be classified in the following (albeit overlapping) categories:

- Literature that utilizes *a social determinants framework* (e.g. Alegría et al. 2003; Candy et al. 2007; Li et al. 2009)
- Literature that addresses equity in the context of *access to services* (e.g. Marmot et al. 2008)

- Literature that focuses on examining several *specific social locations/processes* (e.g. gender and ethnicity) to establish relationships between mental health and social context (e.g. Harris 1997; U'Ren 2011)
- *Critical and feminist literature* that challenges psychiatry and the concept of mental illness (e.g. Caplan 1995; Caplan and Cosgrove 2004; Metzl 2009).

Further literature, from the work and scholarship of occupational therapy, uses a social model of disability and a social justice lens (Townsend 2003; Townsend and Wilcock 2004). Collectively, this body of literature constitutes rich evidence that documents the ways in which social inequities intersect with mental health, both in terms of exacerbating existing mental health problems and contributing to poor mental health. These frameworks for understanding inequities highlight different things, as the following examples illustrate.

A Social Determinants Paradigm

Literature that uses a social determinants paradigm for understanding social inequities has been at the forefront of documenting that social supports, housing, meaningful activity and adequate income are key factors in mental wellbeing and in recovery from mental distress (Mental Health Commission of Canada 2012). Where one is positioned in society also impacts mental health, that is, the social gradient of health extends to mental health (Marmot et al. 2008; U'Ren 2011). In this example, poverty can both lead to mental health problems and exacerbate them (e.g. Harris 1997) and how a person perceives their social status compared to others is also a mental health stressor. Many scholars have also investigated the links between racial discrimination, experiences of migration and mental health (e.g. Morrow et al. 2008). Researchers have documented the effects of social inequities such as homelessness, racism, colonialism and poverty on mental health, both with respect to exacerbating existing distress and/or creating distress (Boyer et al. 1997; Kirmayer et al. 2001; Mental Health Commission of Canada 2009). The links between trauma, experiences of violence, substance use and mental health are well documented and practitioners have begun to establish programmes to support people (Harris 1997; Poole and Greaves 2012). What these types of scholarship share in common is an interest in understanding the relationship between socially unequal contexts and treatment and mental health.

Stigma and Access to Services

Practitioners and scholars have also widely noted that many populations are under-served within the mental healthcare system (Marmot et al. 2008). The intense stigma experienced by many individuals in their communities is one reason why services are not accessed. Other reasons include the lack of culturally appropriate services and supports. For example, despite the variety of mental health services and supports available, many women, particularly those who are economically disadvantaged, are unable to access appropriate treatment, to meet their complex and diverse needs (O'Mahoney and Donnelly 2007). In addition, there are barriers to mental health treatment for immigrant women due to limited financial resources, language skills, education and mobility (Chui et al. 2005). Self- and social stigma have also been found to play an important role in women's access to social support and their decisions to seek mental health treatment (Chui et al. 2005). This problem extends especially to communities that have been further marginalized or historically pathologized by psychiatry, for example gays, lesbians, bisexuals and transgendered people. More medically oriented literature has made the argument that certain groups in society are more vulnerable to mental health problems and are thus at risk of not receiving services and supports (Patterson et al. 2008; Standing Senate Committee on Social Affairs, Science and Technology 2009).

Critical and Feminist Analyses

Critical and feminist analyses challenge psychiatry and the concept of mental illness. Typically using social constructionist paradigms, these scholars investigate the ways in which social and structural inequities are built directly into psychiatric diagnostic practices, resulting in discriminatory labels being applied to disenfranchised groups. So, for example, there are now substantive bodies of literature which illustrate the ways in which the practices of psychiatry have served historically to pathologize some groups of people (e.g. women, racialized peoples, people living in poverty) over others (Caplan 1995; Baker and Bell 1999; Caplan and Cosgrove 2004; Appignanesi 2008; Metzl 2009).

This has resulted in psychiatric diagnoses being disproportionately applied to certain groups (e.g. schizophrenia to black men) and the 'psychiatrization' of women's normal life experiences such as the post partum period and menopause (Ussher 1991, 2011; Metzl 2009). Furthering this critique, is the argument that diagnoses and labels of mental illness in and of themselves constitute a form of inequity (Morrow and Weisser 2012). This is referred to as 'sanism' (Perlin 2000, 2003; Birnbaum 2010; Fabris 2011; Ingram 2011) or in LeFrancois's (2013) terms, 'psychiatrization', which she sees as the practice, or result, of sanism. Sanism and psychiatrization are thus used to understand the discrimination against people diagnosed with mental illness, but also go further in their aim to unsettle assumptions about rationality, normality and madness.

Other scholars have investigated the ways in which the understanding of what constitutes mental health problems differs dramatically across cultures (e.g. Summerfield 2001; Watters 2010). Some seek to reinforce the dominance of Western psychiatry as a framework for understanding distress, while others point to the ways in which the categorization of experience is beyond psychiatry and deeply culturally and historically rooted. Still others posit alternative world views based on long-standing indigenous traditions that point to very different modalities of support and care for people (Kirmayer and Valaskakis 2009). Occupational therapists have adopted and utilized a variety of these frameworks in their work.

Power and Explanatory Paradigms

The varied literature on the connection between social inequities and mental health indicates tensions around which explanatory paradigms are used to understand those connections. Some scholars working in this area adhere to a biomedical understanding of mental health and understand the social environment as relevant only in the context of treatment and recovery, while others suggest that it is the social environment itself that can make people ill and finally, some question the whole validity of the 'psy' sciences (psychiatry, psychology and criminology) (Chan et al. 2005) and are pushing the boundaries of how we conceptualize differing states of mind/consciousness. Taken together, however, these varied ways in which scholars and activists have understood social inequities in mental health tell us something about the ways in which power is distributed in society and how this extends to the mental healthcare system itself. Chief among these forms of power is biomedicalism, which, when coupled with neoliberalism and the erosion of the welfare state, has led to a system that rations resources based on diagnosis and severity of symptoms, and responds primarily through medication and medication management over and above social supports and responses. In order to build on the existing literature and expand our understanding of the ways in which social and structural inequities operate in mental health, we propose the use of an intersectional lens for the practice of occupational therapy.

INTERSECTIONALITY AND MENTAL HEALTH

Intersectionality is a paradigm, which seeks to reveal the complex interactions among multiple social categories, such as gender, race, class, culture, age, ability and sexuality, and systems and processes of domination and oppression, such as sexism, racism, classism, colonialism, ageism, ableism and homophobia, which simultaneously produce experiences of discrimination and privilege (Morris and Bunjun 2007; Hankivsky and Cormier 2009; Hankivsky 2012). Thus, intersectionality involves a relational analysis that seeks to disrupt homogeneous health analyses (e.g. those based on only one or two factors, e.g. gender or race) in favour of understanding the relationships between and among social categories and experiences, to enhance population health and wellness in the pursuit of social justice through the amelioration of health inequities.

These experiences of discrimination and privilege are also the concern of occupational justice (see Chs 3, 29). Understanding of the social and structural barriers which interact to maintain inequity and injustice can be enhanced and clarified by using an intersectional framework. The framework has the potential to reveal the ways in which power works within occupational therapy and mental health, by showing how processes and systems of power operate to either reinforce or ameliorate discrimination. The promise of intersectionality comes in its ability to work both as an analytic lens through which to understand inequities but also as a powerful policy and practice tool for working with individuals

and influencing social policy. There is growing attention being paid to the value of intersectional frameworks for practitioners, policy actors and researchers to examine increasingly complex practice realities (see Burman and Chantler 2003; Burman 2004; Morris and Bunjun 2007; Hankivsky 2011, 2012; Rossiter and Morrow 2011). Responses to inequities at an individual and collective level in mental health can be informed and shaped by understanding the social and structural determinants and how they intersect or connect.

Origins of Intersectionality

Intersectionality has its roots in Black American feminist writing and thinking, emerging primarily during the second wave (i.e. 1970s and 1980s) of the feminist movement in North America (e.g. Combahee River Collective 1977; Cherríe and Anzaldúa 1981; Hill Collins 1990; Crenshaw 1991) and the critique of forms of feminism that focused on gender as the sole or most important form of oppression. Indigenous, Black, Latina and South-Asian feminists argued that gender and race could not be understood separately and that indeed, all forms of oppression/privilege are interconnected and inseparable. More specifically, they pointed to the ways in which forms of oppression/privilege like patriarchy, white supremacy, class domination, etc., are interconnected, and prop each other up through professional practice and the use of legislation, policy and ideology. Essentially, they called into question that women could find solidarity in their shared oppression as women and thus began intense debates about diversity and difference and the multiple ways in which oppression affects women. Although the term intersectionality was not coined until the 1990s (Crenshaw 1991), its historic elements are visible throughout these early works.

Traditionally, the knowledge of professionals (i.e. expert knowledge) has been seen as superior to knowledge that comes from personal experience. In intersectional frameworks, personal experience is understood as epistemologically significant, that is, it is recognized that personal experience is deeply shaped by oppression and privilege and thus, a significant form of knowledge and evidence (e.g. Combahee River Collective 1977; Hooks 1984; Hill Collins 1986, 2000). Knowledge that arises from the margins of society can deeply inform our understanding of the social world and the practices we engage in as professionals (see also Ch. 29). Intersectionality must always be coupled with a social justice framework, which understands social and health inequities to be about differential access to power and resources (e.g. Hill Collins 1990; Burgess-Proctor 2006; Hankivsky and Cormier 2009).

It is implicit in intersectional frameworks that resources and power are distributed in inequitable ways in society and that these inequities should be challenged and addressed. As Lynn Friedli (2009, p. 111) indicates,

> *'Levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice, which erode the emotional, spiritual and intellectual resources essential to psychological wellbeing'.*

Although intersectionality has a long history, especially as an activist paradigm and a body of theory, it has only more recently been used in the field of health and mental health as a methodology, research, policy and practice paradigm.

A Critical Tool for Theory and Practice

Thus, in the context of mental health, intersectionality can be seen as a critical tool for both theory and practice (Rossiter and Morrow 2011). It can help us understand how macro-structures of power such as mental health services operate and enable us to appreciate the impact on the lives of individuals. Intersectionality as a framework in mental health has an emerging focus on gender, race, ethnicity and class, to the exclusion of other social categories and processes (e.g. homophobia, transphobia, ableism and ageism). The framework has been applied primarily to certain populations (African Americans, South-Asians) and mental health problems (depression) (Rossiter and Morrow 2011). This focus on certain social categories and processes and on certain ethno-cultural groups and mental health problems has resulted in a dearth of knowledge about a broad range of social categories and mental health issues (Rossiter and Morrow 2011). Some, for example, argue that one of the key forms of oppression that must be attended to in mental health is sanism (Fabris 2011; Ingram 2011). In the use of the term 'sanism', there is an attempt to understand how

the diagnoses and labels of mental illness can result in active forms of discrimination against people, for example barring them from making their own medical decisions or from participating in civil society (Perlin 2000; Birnbaum 2010). Naming sanism is also meant to challenge our assumptions about what constitutes normal behaviour (Fabris 2011; Ingram 2011).

Challenging Simple Categories

Thus, despite a growing interest in intersectional approaches in mental health (e.g. Mental Health Commission of Canada 2012), there is still a lot of work to be done to move beyond analyses of social categories to analyses of social processes of discrimination and oppression – that is, systems of power and how they operate in mental health. Attention to structural processes is critical for overcoming the limitations inherent in the treatment of social categories as static and unchanging variables, an approach that artificially simplifies complex phenomena by categorizing individuals according to broad group membership (Warner 2008). Intersectional scholarship, exploring multiple interlocking forms of oppression, challenges the assumptions that result from simplistic categorization of individuals, thereby helping researchers, policy-makers and practitioners to better understand the complexity of lived experiences, and determine the implications of these intersections for service delivery (Burman 2004). This is especially challenging in environments where rapid psychological assessments are encouraged and where community-based mental health organizations, which arguably can come to know their clientele well, are under-resourced and over-stretched.

Although intersectional scholarship and practice is complex, it is well-suited to understanding the diverse experiences of people who come into contact with the mental healthcare systems and/or who experience mental distress. Intersectionality has the potential to reduce psychiatric stigma and discrimination, and increase opportunities for recovery, inclusion and citizenship (Rossiter and Morrow 2011). Thus, its utility in the field of occupational therapy is such that it is consistent with the goals of occupational justice – namely, to strive to create space in society for the integration of people with mental health problems to engage as full citizens and members of their communities.

MENTAL HEALTH REFORMS AND THE COMPLEX PRACTICE ENVIRONMENT

This section begins by laying out, in general terms, the broader context in which occupational therapists do their work. There is particular emphasis on the historical importance of mental health reforms, which have resulted in a shift from institutionalized to community care, a move towards recovery-oriented practice and promoting mental health and wellbeing, and an emphasis on the involvement of people with lived experience in policy and programme development (see also Ch. 2). The focus here is on an inclusive understanding of occupational therapy, as pertaining to a wide range of meaningful life activities, which may or may not include paid employment. In this context the changing nature of work is particularly relevant. Tensions have arisen from shifting government agendas and neoliberal reforms, which favour reduced social welfare benefits and put the emphasis on individual self-sufficiency (Oliver and Barnes 2012). Context is important because occupational therapists are required to adapt to a constantly changing work environment and the degree to which progressive shifts towards a social justice orientation are supported are, in part, contingent on this environment.

From the Institution to the Community and the Changing Nature of Occupation

Although deinstitutionalization has been unfolding for almost five decades in Europe and in North America, in some places the closure of large psychiatric hospitals is still ongoing or is relatively new (e.g. the Canadian provinces of British Columbia and Manitoba). With this, has come a shift to community-based care, which in practice, has meant that most places now maintain a wider range of care options from acute psychiatric inpatient care, to a range of outpatient programmes and housing options (Pilgrim 2005; Hill 2006). Although institutions, themselves, have not disappeared, what has changed is a commitment to ensuring that people, regardless of their level of disability, be supported to live as independently as possible. With this has come a changed and expanded role for occupational therapists. Specifically, occupational therapists have been challenged to work in a variety of institutional and

community settings and have themselves in many instances shifted from older rehabilitation models to approaches which foster recovery and wellbeing (see also Ch. 23). With this development, a space has opened up for increased attention to inequities that limit opportunities for participation in society and about the social causes of mental distress and thus, for a dialogue in occupational therapy about social justice and health inequities (e.g. Townsend and Wilcock 2004; Kronenberg et al. 2005; Braveman and Suarez-Balcazar 2009; Wilcock and Townsend 2009).

Occupational Apartheid

The concept of *occupational apartheid* has been used to describe the inequities that people with disabilities face in gaining access to paid employment (see Chs 2, 21). Nilsson and Townsend (2010) remind us that occupational apartheid is an outcome of forms of governance and social policies which structure access and participation in meaningful work and activities. They point to the division of labour and the classification of occupations as two key structural factors that contribute to occupational injustice (Nilsson and Townsend 2010). Put slightly differently, Stadnyk et al. (2010) talk about forms of exclusion from the workforce, which include, occupational alienation, occupational deprivation; occupational marginalization and occupational imbalance (see Chs 3, 29 for elaborations of these concepts). The contemporary political and economic context is important for understanding how social policies, in particular, influence these forms of injustice. The social model of disability is useful for understanding the current context and is discussed next, followed by neoliberalism, another perspective on this context.

Social Model of Disability

The social model of disability takes issue with biomedicalism, or medical ideas which view the body as objectively mechanistic and as something that medicine should strive to fix, to conform to ideals about what is normal. By contrast, the social model of disability points to the fact that disability is experienced within specific social contexts that often engender discrimination and exclusion from society. That is, while people have many physical variations, these in and of themselves do not lead to disability but rather it is society's response to these people that is disabling (Oliver 1990). Shakespeare (2004) reminds us that the concept of social disability arose in Britain in a political context influenced by Marxism and the labour movement and was tied closely to the disability rights movements of the 1980s and 1990s. What this suggests is that the understanding of disability shifts and changes in part due to theoretical developments in the field but also in response to the political context. Indeed, the social model of disability has often been used to explain why people with disabilities have been excluded from the labour market and/or used as under-employed forms of reserve labour (Grover and Piggott 2005) (see also Ch. 11). From a social model perspective, disability can be reduced or overcome by a social response rather than individual efforts to change. This directly challenges neoliberal emphasis on individual autonomy.

Neoliberalism

Neoliberal ideologies currently prevail and are having a substantive impact on how we understand the body, health and disability (Rose 1989; Grover and Piggott 2005). Neoliberalism is an unfailing belief in market forces, economic liberalization, privatization and free markets. In recent years, the term neoliberalism has come to be used to describe a whole system of governance that critics feel is severely eroding the social welfare state. When translated into policy, neoliberalism promotes individualistic understandings of complex social problems, the increased use of market mechanisms in health and mental healthcare delivery ('managerialism') and favours self-reliance and volunteerism. Consequently, neoliberalism has a way of propping up biomedicalism, since both are focused at the individual rather than social level. One of the cornerstones of neoliberalism is its promotion of autonomy of individuals from the state and therefore its adherence to individualistic understandings of complex social problems. Thus, in a neoliberal climate, individuals are increasingly asked to assume the roles and risks of the state, and governments can then avoid addressing systemic problems, resulting in, for example, unemployment and poverty.

Changes to Health and Welfare Programmes

Although the form that neoliberalism takes differs in different contexts, several recent examples in Canada and the UK help to illustrate our points. In the Canadian

context, the shift towards neoliberalism can be traced back to significant social policy changes in the mid-1990s, which were accompanied by massive cuts to health and social welfare programmes. Through the 1990s and into the present day, some provincial governments (notably British Columbia, Ontario and Alberta) have responded by either introducing work for welfare programmes; tightening access to disability and employment insurance programmes; failing to raise social assistance rates to meet rising costs of living and/or stressing self-reliance and volunteerism. These changes have had specific implications for people with mental health problems with respect to income security and employment opportunities (Morrow et al. 2009).

In the UK, the shift towards neoliberalism is usually credited to the policies of Margaret Thatcher, supported by her famous statement, 'there is no such thing as society'. This shift has been supported by successive governments, and, as in the Canadian example, resulted in new forms of governance and, in particular, in more regulation and scrutiny being placed on people with disabilities and those living in poverty. For example, in the UK, the introduction in 2011 of the work capability assessment, which was applied to people receiving incapacity benefits, resulted in the re-assessment of people receiving benefits to get them back to work. Leading up to this policy shift people speculated on the devastating implications:

> *We've found that the prospect of IB reassessment is causing huge amounts of distress, and tragically there have already been cases where people have taken their own life following problems with changes to their benefits. We are hugely worried that the benefits system is heading in a direction which will put people with mental health problems under even more pressure and scrutiny, at a time when they are already being hit in other areas such as cuts to services'.*
>
> ***(Farmer et al. 2011)***

In the UK, the re-assessment process has been intensified and has now been outsourced to private companies, who are paid for their successes in getting people off of benefits (Jolly 2011).

A similar kind of disability benefits re-assessment was initiated in British Columbia Canada in 2002, where 19,000 people were contacted for reassessment of their eligibility for disability benefits, resulting in reports of extreme stress and some suicides by people with mental health problems. Advocates pressured the government to reconsider and as a result, people with mental health problems (5,000 individuals) were exempted from the re-assessment. A subsequent review concluded that the government had moved too hastily, not properly assessing whether the risk of paying benefits to ineligible recipients was high and not adequately exploring other options for confirming eligibility. The process cost the government over $5 million to find that just 40 of the ministry's 62,000 disabled clients were ineligible for continued assistance (Auditor General of British Columbia 2004).

In the UK, the 2012 Health and Social Care Bill requires that all health services are commissioned by boards who can award contracts to any qualified provider, with a lack of clarity about how the quality and efficacy of the kind of care they propose will be guaranteed to meet required standards and needs. It appears that rules about competitive tendering may favour private providers (Reynolds and McKee 2012). In this environment, brief interventions are often favoured, such as IAPTS (Improving Access to Psychological Therapy Services), which are services which deliver brief cognitive behavioural interventions, often over the telephone, to people with mental health problems.

These changes have occurred alongside welfare state retrenchment and an increasingly intensified governmental discourse that promotes individualism and independence. These developments undermine the possibility of understanding people's needs as inter-related and the possibility of seeing interdependence as a possible ideal in the context of occupational therapy. The complex lives and experiences of people with mental health problems could be overlooked in a system that adheres rigidly to individualism, and ignores the diverse needs of differently situated populations. Neoliberal ideology has influenced economic and social policy in ways that significantly shape how services and supports for people with mental health issues are designed. These practices can hinder people's ability to participate as full and active citizens in occupational and community life and arguably increase occupational marginalization, alienation, deprivation and imbalance.

Occupational Justice as a Critical Response

Although not a direct reaction to neoliberalism, occupational justice can be seen as a critical response (Townsend and Wilcock 2004), which combines the vision of an 'occupationally-just world supported by public health and societal initiatives' (Nilsson and Townsend 2010, p. 57) with an ethical vision of the commitment of occupational therapy to empowerment and social inclusion. Nilsson and Townsend (2010) contend that building a theoretical bridge to practice is essential to 'inspire and empower' professionals to advance the social inclusion of populations who routinely experience discrimination. They describe occupational justice as a 'justice of difference' that is, 'a justice to recognize occupational rights regardless of age, ability, gender, social class, or other differences' (p. 58). Their work dovetails with the goals and aims of intersectional frameworks, concerned with the root causes of inequities and the structures of power which support them.

Intersectional frameworks are built on the belief that lived experience is an important source of knowledge about the understanding of oppression. Thus, the contributions and activism of people with lived experience of mental health problems are central to intersectional frameworks.

ACTIVISM

Nothing about us without us

(D'Aubin 2003).

One way to use an intersectional framework is to recognize the power in collective action. Thus, it is important to recognize the contributions of people with lived experience with respect to documenting and speaking out about the abuses of psychiatry and of institutional living (e.g. Burstow and Weitz 1988; Chamberlin 1988; Barnes 1991; Capponi 1992, 2003; Blackbridge 1997; Shimrat 2000; Beresford 2003, 2005). Historically, these anti-psychiatry activists have joined with academic and professional allies (e.g. Szasz 1961; Breggin 2008; Metzl 2009) with the goal of making visible their lives and their experiences, and the political aim of changing responses to people experiencing mental distress. Mental health activists have made many of the same claims that disability activists have made, namely that experiences that do not conform to norms and standards should not always be seen as pathological.

These historic roots of the psychiatric survivor activism continue today, yet the breadth of users and survivors and the scope of activities engaged in have expanded. Today, people with lived experience are supported in making informed choices, which include the choice of disclosure, and how to self-identify. Intersectional frameworks point to the importance of locating oneself as a way of recognizing power but also as a means for reclaiming identities that have been marginalized and maligned. Today, people involved in activism may choose to use the historic psychiatric survivor label. They may also use other terms such as user, consumer, consumer/survivor, client or patient. To emphasize the point that people with lived experience of mental health issues are human beings with minds, bodies and spirits they may choose to identify as a person, a person with a mental health issue or a person with a diagnosis of a mental illness. The use of the term 'person' is used to raise societal consciousness that people are much more than a psychiatric label: they are people with hopes, dreams and rights, who deserve to be treated with dignity and respect equitable to all citizens.

Recurrent Themes from Lived Experience of Mental Health Service Use

Increasingly, people with lived experience have begun to tell their stories with the psychiatric and broader health and social services systems. Recurring themes have emerged, including poverty, lack of stable housing, lack or absence of employment, food insecurity, experiences of violence, discrimination, oppression and lack of access to services consistent with recovery, mental health and wellbeing. These contextual factors have been repeatedly identified, highlighting the powerlessness and oppression people with mental health problems can experience when the 'problem' is 'individualized' with limited attention paid to social and structural inequities. Although the DSM-IV-TR, the core tool used within psychiatry to assess and intervene, does acknowledge both psychosocial and social determinants of mental health, McGibbon (2012) argues that the brevity of attention in the manual ensures the predominance of the biomedical model of

psychiatry, which is limited in its ability to incorporate the economic and political origins of mental health struggles.

As psychiatric survivor activists have experienced increased opportunities to work with those active in the disability movement, there is a growing awareness of common themes across the collective lived experience as well as distinct differences. A common theme flowing from this collective work is the shared understanding of the importance of the active participation of people with lived experience of mental health problems and people with disabilities in all processes impacting their lives. This understanding is reflected in the phrase 'nothing about us without us' (D'Aubin 2003), which continues to guide grassroot activism in Canada and abroad.

User Involvement

Increasingly, mental health policy has highlighted the importance of including people with lived experience in all aspects of governance, planning, service delivery, evaluation, research and leadership. For example, in the first Mental Health Strategy for Canada (Mental Health Commission of Canada 2012, section numbers below from strategy document), peer involvement in all aspects of the health, social and other systems impacting their lives is seen as an essential component of a transformed mental health system grounded in the recovery, health and wellbeing of people (2.2). Also contained within this strategy are specific recommendations about instituting peer support throughout the mental healthcare system, a recognition that increased support should be given to peer-run organizations (3.4), peer research (6.2.3); and, the ongoing grassroot, capacity building of leaders within the activist community to bring forth the voices of those they represent (6.4). With support in principle for active participation of people with lived experience in national, provincial/territorial and regional mental health plans grounded in recovery, mental health and wellbeing, the next phase is implementation.

The process of involving people with lived experience, or service users, in working for service development and change is complex and can easily become tokenistic. For example, implementation of user involvement has often been facilitated by the people with both positional and fiscal power, while the activists with actual experience in the movement are excluded. This can result in an individual with lived experience being selected as a 'representative', yet with no connection to other diverse groups of people with lived experience within their locale, nor knowledge of others needs or historical knowledge of the activism of people with lived experience. This kind of token representation can stifle the transformative nature intended. There is a growing awareness that individuals representing other people with lived experience in any capacity must be connected to, and accountable to, a broader collective of individuals in specific locales, otherwise, the benefits of representation of the voices of people with lived experience grounded in the democratic process will be lost.

International Approaches

Partly in response to these concerns, some countries have supported policies regarding people with lived experience with substantive investments in developing peer innovation. Different countries have approached this in a different manner. In the late 1980s in the USA, there were two technical assistance centres funded to support the development of peer innovation across the country, which led to the emergence of peer-led and -run organizations (Budd et al., 1987; Chamberlin 1988; Zinman and Harp 1994). In England, there has been a significant investment in supporting the creation of peer support positions throughout the mental health system; whereas, in Australia the decision was made to create a national council of consumers, and subsequently state and regional bodies to foster peer leadership and involvement. In New Zealand, users took the lead in developing recovery standards that continue to guide system transformation internationally. In Canada, an initial investment was made in fostering grassroot leadership through the federal government's Secretary of State Department, specifically the Disabled Persons Participation Program. This department had regional, provincial/territorial and national offices that supported (through core funding in the mid-1980s) the development of peer innovations and networks across Canada. In the early 1990s, this funding shifted to project funding.

Individual activists, and collective movements of people with lived experience and service users around the world continue to work towards the co-creation of

a more just and inclusive society. There are many factors that play a role in the development of this collective movement including the leadership of people with lived experience, government and organizational policies, dedicated resources (e.g. financial, time, space, etc.) and opportunities to support grassroots peer-run organizations to fulfil local needs as these relate to meaningful occupation. As so many factors regarding the development of a coherent grassroots movement reside outside user and survivor organisations, the broader psychiatric user and survivor movement has variable development around the world, yet the collective vision is sustained.

Enabling Occupation

The link between the activism of people with lived experience and the work of occupational therapists can be found in the movement towards client-centred practice and the notion of 'enabling occupation' (Townsend 2003). Thus, there is a belief in empowerment through action which has been important to occupational therapy throughout the profession's existence. Historically, occupational therapy departments have provided resources for activists, from money for paid (sheltered) work to access to printing and places to meet. Community-based occupational therapy often involves bringing people together and empowering them to become self-supporting. The link between activism and occupational therapy can be further found in scholarship through the increased uptake of participatory action research paradigms (Cockburn and Trentham 2002). Occupational therapists are well positioned to work side by side with people with lived experience as allies in the struggle for occupational justice.

In order to do this work with integrity, reflexivity and reflexive practice is necessary. Reflexivity is a 'process of seeing and a process of being. To be reflexive means that we are fully conscious of the lenses through which we view the world. We understand both our situationality and our positionality, our circumstances and our locations' (Kaufman 2013, p. 2). As Kippax and Kinder (2002, p. 2) indicate, reflexivity

> *involves more than an analysis of prior learning of attention to the grounds or justification of one's beliefs and generalisations (content) … what is essential is the taking up an epistemological stance that recognizes multiple positionings and situated knowledge.*

For reflexivity to be useful, it must move beyond acknowledgement of social location to the recognition of how those locations intersect with wider social, economic, cultural, political, historical and structural factors.

Social Enterprises

In line with the activism and leadership of people with lived experience are emergent user-run social enterprises. Designed to address high unemployment rates and stigma and discrimination experienced by people with lived experience in the workforce, social enterprise models typically combine employment with social supports and other workplace accommodations. International evidence suggests that these models can assist people with mental health problems to find employment (Savio and Righetti 1993; Neufeldt et al. 2000; Bond et al. 2001; Crowther et al. 2001; Boardman 2003; Kober and Eggleton 2005; Cohen et al. 2008; Kin Wong et al. 2008; Morrow et al. 2009). Although not all social enterprise models are user-led and run, those that are appear to have the most potential for supporting the economic security of people and adhering to the recovery oriented values of fostering autonomy, independent decision-making and leadership.

In a review of some of the social enterprise programmes in one Canadian province (British Columbia) it was found that they demonstrated considerable flexibility, openness and creativity in adjusting to the needs of their workers. Workplace accommodations (e.g. facilitating return to work after illness, part-time hours in recognition of earnings exemption thresholds) involved tailoring both the organization and the type of work to the capacity, comfort level and interest of employees (Cohen et al. 2008). In particular, it was found that the provision of social supports, such as on-site job coaching, personal and life skills counselling and referrals to other services, reflected a conscious remodelling of the employer–employee relationship on the part of the social enterprises. Employees benefit from these supports which provide opportunities for the enhancement of personal and economic resources,

normalization of mental illness, and continuity of socially supportive networks to assist in mental health recovery (Morrow et al. 2009). Importantly, income supports that are available on an ongoing, as-needed basis after workers were successfully employed have also been shown to be a factor in success. For example, one study showed that employment rates increased from 50% to 80% when income supports were not immediately cut off (Razzano and Cook 2005). Social enterprise models thus show promise as one possible response to the systemic inequities faced by people with lived experience of mental health problems. However, even more cogently, the above suggests that further social welfare reforms such as income supports are necessary to truly address and the systemic exclusion from paid work.

IMPLICATIONS AND SUMMARY

Historically, occupational therapy practice was structured solely around the needs of the psychiatric hospital system (see Ch. 1). Today, occupational therapists work in both psychiatric hospital and community settings and the focus of their work has shifted. Recognizing the increased growth of practice inclusive of and beyond psychiatric care, professional associations dedicate both time and resources to re-examine current roles, responsibilities and practices in relation to their essential vision of meaningful occupation. At the same time, the profession is engaged in exercises to develop a vision for the future of occupational health and mental health. Occupational therapists work in increasingly complex environments, which include those related directly to reforms in mental health but also larger political and economic trends such as neoliberalism, the latter of which threatens to undermine understandings of mental health that are grounded in people's lived experience and an analysis of social and health inequities. In this context, occupational therapists are called on to uphold the values of their profession (equity, human rights, social inclusion and cultural awareness), while working to expand their scope of practice and push their thinking with respect to how they understand mental health.

Intersectional frameworks which foster understanding of the interlocking nature of oppressions based on race, class, gender, ability, etc. and the underlying systems and processes of power (which keep these inequities in place) are an important tool for occupational therapists. Intersectional frameworks help to counter the prevailing ideology of neoliberalism, which reinforces individualised frameworks for understanding mental distress. Mental health professions should think about how their work is embedded in larger social contexts that are imbued with relations of power. Given that most occupational therapists are working at a local level with specific individuals and communities, it can be challenging to find opportunities to be reflexive about their own practice and context. One collective mechanism is through the International Advisory Group on Human Rights of the World Federation of Occupational Therapists, who have been encouraging occupational therapists to share their stories of practice (Bryant 2010) (see also Chs 11, 29). Reflexive practice will assist occupational therapists in responding to the changing nature of their work and in maintaining their goals of addressing inequities that limit the participation of people with lived experience in society. This will enable engagement with the larger debates that frame the discipline and practice of occupational therapy and the mental healthcare system more generally. These debates can be accessed by practitioners in forums and continuing education events that are shaped around the broader political needs of people with lived experience and the changing mental health and social policy environment. Occupational therapy is well-positioned to further the discussion about mental health and social inequities and to integrate into their work an intersectional occupational justice framework.

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Section 5 OCCUPATIONS

14 PHYSICAL ACTIVITY FOR MENTAL HEALTH AND WELLBEING

FIONA COLE

CHAPTER CONTENTS

INTRODUCTION

This chapter presents students and practitioners with a rationale for incorporating physical activities within mental health practice. It will clarify terminology, summarize current evidence, and explain the mechanisms underpinning the proven benefits of physical activity. Acknowledging that this is a contested arena of inter-professional practice, the chapter will also critically analyse a distinctly *occupational* perspective of physical activity and engagement. To this end, it will consider the motivations for, and personal meanings of, being physically active within the context of individuals' environments, and will reflect on how this informs person-centred goal-setting and intervention planning. Factors to consider when planning individual and group programmes utilizing physical activity and the evidence-base that underpins such interventions will also be discussed.

Physical Health and Mental Health Promotion

The value of physical activity in promoting health and wellbeing has received significant attention within the last decade, placing it firmly on national agendas. The Chief Medical Officer in the UK (DH 2004) summarized evidence of the substantial, negative impact on both individual and public health of an inactive lifestyle. The report specifically identified the preventative and therapeutic potential of physical activity in relation to six chronic conditions: cardiovascular disease, obesity, diabetes, musculoskeletal problems, cancer and mental health problems. Since this influential document, the inclusion of physical activity within health-related policy and guidance has become widespread. There is an emerging consensus – based on research from disciplines such as medicine, exercise sciences, sports, psychology and public health – that exercise and physical activity can be important aspects of mental health promotion (Grant 2000; Hendrickx and van der Ouderaa 2008; Dugdill et al. 2009).

Occupational therapy has a longstanding tradition of using physical activity for its therapeutic benefits, particularly within psychiatric institutions (Wilcock 2001). This was based initially on intuitive, practice-based reasoning that activities such as sports, dancing and horticulture improved mental wellbeing. Occupational therapists and occupational scientists are now developing an evidence base for a specifically *occupational* perspective of physical activity (Alexandratos et al. 2012; York and Wiseman 2012).

Occupational therapists aim to facilitate individuals' performance across a balance of occupations to support recovery, health, wellbeing and social participation (Creek 2003). This broad therapeutic purpose can be further magnified if physically active occupations are utilized. As the Chief Medical Officer for England (DH 2010) noted:

> *the potential health benefits of physical activity are huge. If a medication existed which had a similar effect, it would be regarded as a 'wonder drug' or 'miracle cure' (p. 21).*

PHYSICAL ACTIVITY AND MENTAL HEALTH

The Nature of Physical Activity

Caspersen et al.'s (1985) definition of physical activity as 'any bodily movement produced by skeletal muscles that results in energy expenditure' (p. 126) is still in use worldwide, including the UK Department of Health and the World Health Organization. The emphasis on *physical activity* (as distinct from *exercise*) in health policy and guidance is significant because it is broader and more inclusive; encompassing sports and leisure activities, but also including everyday activities arising during employment, housework, DIY, gardening or walking to school or work for example (see Table 14-1). This means individuals who would not normally choose strenuous exercise can still derive benefits from physical activity, which were previously only associated with vigorous activity (see Table 14-2).

Significantly, there may be additional advantages from moderate-intensity activity because it is less likely to incur health risks for individuals who are not acquainted with vigorous exercise (Dugdill et al. 2009). Research has indicated that health benefits appear to be proportional to the overall amount of physical activity (US Department of Health and Human Services 1996) because every increase in activity added some benefit. Therefore, the revised recommendation of the UK's Chief Medical Officers (DH 2011a) for health promotion in adults is to aim for *daily* activity and to accumulate 150 minutes of moderate-intensity physical activity over a week, which can be accumulated in periods of 10 minutes or more (see Table 14-3).

Emphasizing the total *amount* rather than the *intensity* of physical activity gives people more options for incorporating physical activity into their daily lives. This flexibility is important because Handcock and Tattersall (2012) caution occupational therapists that physical activity recommendations could become prescriptive and the targets could be overwhelming for service users. The promotion of moderate-intensity physical activity was found to offer considerable health gains; particularly to the least fit. However, despite these amendments, and the potential multiple health gains, it is still a major public health concern that participation rates are so low. According to the UK's Chief Medical Officers (DH 2011a), only 40% of adult men and 28% of adult women met the previous recommendations for health. This meant 27 million adults in England alone were not active enough to benefit their health. Furthermore, there are distinct health inequalities in relation to physical inactivity according to income, age, gender, ethnicity and disability.

TABLE 14-1

A Summary of Activity Terminology

	Definition	*Intensities and Examples of Activities*
Physical activity	'Any bodily movement produced by skeletal muscles that results in energy expenditure' Caspersen et al. (1985) This includes all activities from everyday lifestyle through to competitive sports	**Light:** e.g. ironing, cleaning/dusting walking/strolling at 2 mph **Moderate:** e.g. painting and decorating, vacuuming, walking at 3 mph, golf (self-caddying), 'social badminton', doubles tennis, walking briskly at 4 mph; mowing the lawn (walking with a powered mower), cycling at 10–12 mph **Vigorous:** e.g. aerobics, cycling at 12–14 mph, swimming (a slow crawl), singles tennis, running at 6 mph
Lifestyle physical activity	Activities incorporated into everyday life, e.g. walking or cycling to school or work; heavy housework or DIY, gardening, physically demanding jobs (DH 2011a)	
Exercise	Activity which is volitional, planned, structured, repetitive and aimed at improvement or maintenance of any aspect of fitness or health (Caspersen et al. 1985), e.g. swimming, jogging, 'keep fit' activities. This is a subdivision of physical activity	
Sport	Activity which is rule-governed, structured, competitive, and requires physical prowess, e.g. athletics, football, hockey Not all sport is health-enhancing, e.g. darts (Biddle and Mutrie 2008)	

There may be overlap between these categories that depend on individual interpretations and contexts

Increasing intensity of Activity

TABLE 14-2

Types of Physical Activities Related to Physiological Indicators

Physical Activity Recommendations (DH 2011a)	*Physiological Indicators*
Light-intensity physical activity	Breathing rate is comfortable and conversation is easy
Moderate-intensity physical activity	Heart rate is raised and the pulse can be felt and the person feels slightly out of breath but still able to talk There is a feeling of increased warmth, possibly accompanied by sweating on hot or humid days The amount of activity needed to reach this varies from person to person depending on fitness and factors such as being overweight
Vigorous-intensity physical activity	Heart rate feels rapid, breathing is hard and the person cannot comfortably hold a conversation
Muscle strengthening (weight training, working with resistance bands, carrying heavy loads, heavy gardening, push-ups, sit-ups)	The large muscle groups of the body – legs, hips, chest, abdomen, shoulders and arms – work or hold against a force or weight. Muscles will feel fatigued, and if using structured weight training, then exercised to the point where it is a struggle to complete another repetition

Though participation rates for people with mental health problems are not specifically recorded, it could be postulated that some of the consequences of living with mental health problems – such as lethargy, lack of motivation, and anxiety arising from social and/or economic inequality and from stigma – could exacerbate the challenges that people may generally face in becoming more physically active. An important role for occupational therapists, therefore, is collaboration with individuals to analyse the complex factors

TABLE 14-3

A Summary of Physical Activity Recommendations According to Age

Age Group	*Recommended Level of Activity*
Children and young people (5–18 years)	Individuals should engage in moderate to vigorous activity for at least 60 minutes and up to several hours each day Vigorous-intensity activities, including those that strengthen muscle and bone, should be incorporated at least 3 days per week
Adults (19–64 years)	Individuals should aim to be active daily, e.g. at least 150 minutes of moderate-intensity activity (in bouts of 10 minutes or more) per week, or 75 minutes of vigorous-intensity activity spread across the week, or a combination of moderate and vigorous. Individuals should also undertake activities to improve muscle strength on at least 2 days per week, and minimize extended periods of being sedentary (sitting)
Adults with disabilities (physical or mental health)	The same guidelines as above (for adults) apply. This may need to be adjusted for each individual depending on exercise capacity and any health or risk issues
Older adults (65+ years)	The same guidelines as above (for adults) apply

Note: Within this document there are also physical activity recommendations for early years (under 5s) depending on whether or not they are walking.
Source: Department of Health (DH 2011a).

influencing engagement, in order to incorporate physical activities within their daily occupational lives. The next section supports this kind of intervention by summarizing the evidence-base for the positive impact of physical activity on mental health and wellbeing.

The Health Benefits of Physical Activity

For the past decade, there has been a consensus regarding the benefits of physical activity on depression, mood, anxiety, stress reactivity and cognitive functioning, and on self-esteem and subjective quality of life (Grant 2000). More recently, empirical evidence for the positive impact of physical activity for people living with schizophrenia (Gorczynski and Faulkner 2010), dementia (DH 2011a) and substance misuse (Biddle and Mutrie 2008) has emerged. Indeed, the National Institute for Health and Clinical Excellence (NICE) recommends physical activity to varying degrees within its guidelines for dementia (NICE 2011a); depression (NICE 2009a); depression with chronic physical health problems (NICE 2009b) and schizophrenia (NICE 2009c). Additionally, improving the physical health of people with mental health problems is among the government's top six mental health policy objectives (DH 2011b). Links between these objectives and the evidence-base for the role of physical activity in contributing to them are highlighted in Table 14-4.

A substantial evidence-base now exists detailing the positive relationship between physical activity and improved mental health and a strong mental health promotion perspective is developing concurrently with this (Dugdill et al. 2009). This mirrors the growth of health promotion within occupational therapy (COT 2008). It is a timely justification for developing roles incorporating physical activities such as health-promoting partnerships between occupational therapists and community/third-sector organizations.

A more detailed consideration of the evidence for the use of physical activities with various service user groups will now be offered. This evidence has emerged within a diagnosis-based framework, though it is acknowledged that occupational therapy does not operate according to such delineations. However, accepting that this framework exists, this overview provides a resource for occupational therapists to draw on in their more person-centred work with individuals.

Depression

The strongest evidence supports the benefits of physical activity for people living with depression. Seminal systematic reviews of research, such as Lawler and Hopker (2001), have concluded that there is an inverse relationship between physical activity participation and the occurrence of depressive symptoms. The UK

TABLE 14-4

Mental Health Policy Related to Physical Activity

Mental Health Policy Objectives (DH 2011b)	*Related Evidence for the Impact of Physical Activity*
More people will have better wellbeing and good mental health Fewer people will develop mental health problems	Physical activity can improve mental wellbeing and also prevent the onset of mental health problems
More people with mental health problems will recover and experience a good quality of life	Physical activity can be an intervention to address mental health problems and can contribute to improved quality of life. It can be a means of coping with and managing mental health problems
More people with mental health problems will have good physical health	There is extensive evidence for a clear inverse relationship between physical activity and ill health. The strength of evidence and degree of efficacy varies for specific health outcomes
Fewer people will experience stigma and discrimination	Physical activity is normalizing and inclusive, as it can be done by all people regardless of diagnosis

Sources: Fox et al. (2000); Department of Health (2004); Faulkner and Taylor (2005); Department of Health (2011a).

Chief Medical Officers (DH 2011a) reported an approximately 20–30% lower risk for depression (and dementia) for adults participating in daily physical activity. Thus, it has a protective effect; validating a health promotion perspective.

For those with clinical depression 'the weight of evidence suggests that there is a causal connection between physical activity/exercise and depression reduction' (Biddle and Mutrie 2008, p. 242). The NICE Guidelines for Depression specifically recommend physical activity as a psychosocial intervention for people with 'sub-threshold depressive symptoms and mild to moderate depression' and that physical activity programmes are delivered in groups by a 'competent practitioner' (NICE 2009a, p. 21). The term 'competent practitioner' is not defined, but occupational therapists with their specialist skills in activity are likely to be able to facilitate such groups depending on the nature of the activity, and the degree of collaboration with other professionals or physical activity specialists.

Occupational therapists' understanding of concepts such as self-efficacy, for example within the volitional construct of the Model of Human Occupation (Kielhofner 2008), is important when exploring participation with people who have depression. In addition to low mood, and associated anxiety, the person may also have thoughts and beliefs about their lack of competence that may further exacerbate difficulties. When setting goals, it is important to take account of a person's self-perceived ability as well as their actual abilities, and grade interventions in order to achieve success. Although identifying individuals' interests and values is essential, it should also be acknowledged that depression may limit satisfaction from activities previously enjoyed, or that people may report few current interests, even when their past ones were considerable. Therefore, physical activity may need to be integrated with approaches that also address psychological difficulties, such as cognitive-behavioural approaches, either in conjunction with, or in advance of, physical activities (Cole 2010).

Anxiety

According to NICE (2011b) the evidence supporting physical activity as an intervention for people living with anxiety-related problems is considerably smaller than that related to depression. It is therefore an area that merits further research. However, there is support for a short-term role in symptom management through reducing the physiological reactivity to, and enhancing recovery from, psychosocial stressors. Evidence also suggests that physical activity may contribute to the reduction of non-clinical anxiety (Biddle and Mutrie 2008); that is, individuals outside mental health services whose wellbeing may be improved with physical activity. For some individuals, it may also reduce long-term vulnerability to anxiety but explanatory mechanisms for this are not definitively evidenced. An occupational therapist, however, may interpret these positive influences on long-term

anxiety as being due to improved occupational performance and engagement in activities that have meaning, value and promote a sense of achievement.

The educational aspect of the occupational therapist's role may be important in countering any potentially negative consequences of physical activity – such as breathlessness, perspiration, and increased heart rate. While there is no evidence that exercise might induce panic or anxiety for people with anxiety disorders (Biddle and Mutrie 2008), these physiological responses to exercise may be distressing. Without education, reassurance and/or grading of the activity, these responses could lead to avoidant behaviours.

Low Self-Esteem

Exercise can be used to promote physical self-worth and other positive physical self-perceptions such as those related to body image, which may be beneficial for people with low self-esteem (Grant 2000). These self-perceptions have been strongly correlated with individuals' subjective sense of mental wellbeing and quality of life. Fox (2000) concluded that self-esteem is a significant factor influencing people's choice of, and participation in, healthy behaviours. He analysed concepts of the physical self and associated perceptions of self-worth and saw that improvements, through exercise, in physical skills, competence, fitness, and body image could enhance self-esteem. Crucially, he also noted that perceptions of inadequacy in performing physical activities can lower self-esteem.

Fox's (2000) suggestion that self-esteem develops through an improved sense of competence, autonomy, and control over the body highlights the importance of grading and/or pacing to establish the 'just right challenge' (Yerxa 1998) that is integral to occupational therapy.

Cognitive Problems and Dementia

The research consensus is that older adults who are fit display better cognitive performance than less fit older adults (Boutcher 2000) and there are indications that there is a reduced risk of dementia (DH 2011a).

The influence of physical activity on quality of life may be more readily explained than improvements in cognitive functioning for people with dementia. For example, it may help with sleep, and improve mood since depression and anxiety are commonly experienced with dementia (NICE 2011a). Maintaining physical mobility and muscle strength also promotes independence in activities of daily living, thus avoiding frustrations associated with prolonged sitting and inactivity that may lead to agitation. This is supported by Laurin et al.'s (2005) review of various studies, which concludes that 'physical activity can improve the functional status in frail nursing home residents with dementia, including Alzheimer's disease' and, importantly, that 'there is no evidence that physical activity or exercise (including vigorous) is harmful' (2005, p. 22).

Occupational therapists will understand the importance of active ageing through the work of Clark et al. in the USA (2004) and subsequently the Lifestyle Matters programme in the UK (Craig and Mountain 2007) and as promoted in the NICE Guidelines for occupational therapy and physical activity interventions to promote the wellbeing of older people (NICE 2008). The fact that physical activity may help to mediate cognitive decline is further support for occupational therapists' adoption of a health promotion role.

Schizophrenia

Schizophrenia can have a major impact on individuals' occupational functioning and quality of life. Neuroleptic medication is commonly prescribed to address positive symptoms such as delusions, hallucinations and thought disorders. Medication however, has little influence on negative symptoms such as lethargy, flattening of affect, social withdrawal and general lack of interest in activities. Indeed, the side-effects of medication such as drowsiness, weight gain, fatigue and dry mouth may contribute to this lack of interest (Mutrie and Faulkner 2003).

A Cochrane review concluded that exercise significantly improved negative symptoms and that 'given the physical, mental, and social benefits of regular exercise, clinicians should ensure their clients are becoming and staying active' (Gorczynski and Faulkner 2010, p. 13). A wider systematic review by Holley et al. (2011) that also included qualitative studies focused on the role of physical activity on psychological wellbeing and found improvements in perceptions of autonomy, competence, social interest, psychological and physical health, and overall self-concept.

People living with schizophrenia may also experience depression and anxiety and the beneficial effects

described previously in relation to these disorders may equally apply to people living with schizophrenia.

Occupational therapy's focus on the contexts within which occupations occur is particularly pertinent to people living with major mental health problems since there are so many compounding influences on a person's ability to participate in occupations in general, including physical activities. Such people may experience barriers related to stigma and social and/or economic deprivation that precludes access to community resources. Smyth et al. (2011) discuss this in the context of social exclusion and additionally report that the weight gain associated with neuroleptic medication may cause individuals to feel more self-conscious and uncomfortable when out in public. These factors serve to compound the difficulties of managing health-related lifestyle issues such as diet, physical inactivity and smoking.

Substance Misuse

There is more evidence for the physical health benefits of exercise for people with alcohol dependence than for its influence on mental health problems. People who abuse alcohol often have poor physical health, such as decreased cardiovascular fitness (NICE 2011c), which can be developed through exercise and may contribute to improved physical self-worth.

There is also some suggestion that exercise programmes promoting lifestyle behaviour change may contribute to developing self-control and coping strategies and alternatives to drinking (Biddle and Mutrie 2008). Donaghy and Ussher (2005) recognized the importance of interventions to enable participation in a range of new or previously enjoyed activities in order to contribute to the rehabilitation goal of maintaining abstinence or controlled drinking. However, they noted the particular challenges of working in this context, such as low starting levels of physical fitness, social isolation, lack of support and relapses into drinking. (This is considered in more detail in Ch. 28 regarding substance misuse.) The small-scale research of Ussher et al. (2000) reported that a programme incorporating exercise had a positive impact on the lives of the participants and that 'the occupational therapist was shown to play a pivotal role in promoting fitness-oriented physical activity for those with substance misuse problems' (p. 603). Consequently, it should be recognized that physical activity interventions can usefully be integrated with other therapeutic approaches such as cognitive behavioural therapy, self-help or support groups and practical lifestyle interventions.

There is a dearth of published research concerning the benefits of physical activity amongst illicit drug users, although there is some suggestion that the improved sleep patterns associated with exercise are of benefit in the withdrawal stage from drugs, and anecdotal evidence of the popularity of physical activity as a therapeutic intervention (Pope 2003). Biddle and Mutrie (2008) suggest that improvements in physical health, diversion from drugs, and engagement with alternative social networks may help prevent relapse. This reinforces the efficacy of engagement in meaningful and valued activities within enabling environments. Additionally, people with alcohol and drug dependencies may also be susceptible to other mental health issues, particularly depression (Boden and Fergusson 2010), further reinforcing the potential for physical activity interventions.

Physical Health Problems

The UK government's mental health outcomes strategy (DH 2011b) emphasized the connections between mental and physical health (see Table 14-4) and the Operating Framework for the NHS in England 2012/13 indicated that the physical healthcare of those with mental health problems required particular attention in order to reduce excessive mortality (DH/NHS Finance, Performance and Operations 2011). Specifically, people with schizophrenia and bipolar disorder (Buhagiar et al. 2011) and depression (NICE 2009b) have higher morbidity and mortality rates resulting from coronary heart disease and stroke. Similarly, Naylor et al. (2012) note that 'research evidence consistently demonstrates that people with long-term [physical] conditions are two to three times more likely to experience mental health problems than the general population' (p. 3). NICE guidelines report that if a person has both depression and a physical health problem, then the functional impairments are likely to be much greater than either condition alone.

Integrated treatment approaches to addressing physical and mental health needs are becoming prominent on health agendas (Naylor et al. 2012). Physical activity and the holistic practice of occupational therapy and are both uniquely placed in collaborating with other health professionals in responding to these needs.

Using and Generating Research-Based Evidence

Despite the number of rigorous research studies, many researchers still urge caution when considering the methodological issues of measuring participation in physical activities (mainly via self-recording) and its impact on mental wellbeing (Daley 2008; Hendrickx and van der Ouderaa 2008). Furthermore, while meta-analytical Cochrane Reviews evaluating the impact of physical activity on schizophrenia (Gorczynski and Faulkner 2010) and depression (Mead et al. 2009) focus on randomized controlled trials and systematic reviews that meet 'gold standards' for research rigour, it should be noted that such research tends to analyse relationships between physical activity and alleviating symptoms, rather than on its contribution to engagement in satisfying and fulfilling life roles. This has presented occupational therapists with a challenge in providing an evidence-based justification for their interventions and demonstrates the need for further occupation-focused research to inform service development and commissioning.

The benefits of physical activity are clearly wide-ranging and Biddle (2005), one of the key researchers in this field, has suggested that:

> *physical activity may not be the 'magic bullet' we are looking for, but it comes a lot closer than most things!* ***(p. xvii)***

Fortunately, more qualitative research is now emerging in recognition of the complexity of individuals' subjective experiences related to mental health and physical activity. For example, Carless and Douglas (2010) utilize the narrative accounts of people with enduring mental health problems to explore how physical activity and sport can contribute to their recovery. Such reports offer valuable insights to support therapists in effective, client-centred programme development.

PHYSICAL ACTIVITY AND MENTAL WELLBEING

Explanations for the positive effects of physical activity on mental health and wellbeing are still much debated as the evidence for various biochemical and physiological mechanisms is inconclusive. An example of a biochemical mechanism frequently postulated as positively influencing mood relates to the increased production of opioids such as endorphins. In fact, this has limited supporting evidence and appears to require a high-intensity exercise which the general population, regardless of any mental health problem, will be challenged to achieve. It may, however, be relevant for those people who already engage in physically intensive occupations such as running, hence the 'runner's high'. For further discussion of the mechanisms of this, see Bouchard et al. (2007) and Biddle and Mutrie (2008).

This inconclusive evidence is challenging for positivists, such as exercise scientists, who generally take a reductionist approach and need to know the 'why' and 'how' of the relationship between physical activity and mental wellbeing and advocate that research should refine this understanding (Biddle and Mutrie 2008). This may have some relevance when an educational approach is required within occupational therapy interventions but overall, a holistic person-centred approach will not usually have the exploration of explanatory mechanisms for symptom reduction as a priority. Rather, in order to enable occupational engagement, it may be more relevant to understand the relationships between psychosocial factors and wellbeing, and the influence of the individual's environment.

Psychosocial Influences

Evidence indicates that being physically active, rather than fitness itself, is responsible for the benefits in short- and long-term mental wellbeing (Morgan 1997; Biddle 2000). Significantly, increases in aerobic fitness are not necessary as people without such physiological gains can experience positive psychological effects similar to those experienced by people who have improved their fitness. Widespread evidence (Crone 2007; Carless and Douglas 2010; DH 2011a) now supports psychosocial determinants of wellbeing through physical activity. Thus, individuals may choose activities that suit them, and need not focus on the aerobic effect of training. Occupational therapists interpret this as selecting 'activities for their potential to engage client interest, participation and enjoyment' (Creek 2003, p. 23). The psychosocial mechanisms postulated include experiencing a sense of achievement, mastery, self-determination and self-confidence in physical abilities (Biddle and Mutrie 2008). Again, this reflects an occupational therapy perspective in that engagement

in meaningful activities involves choice or control, a sense of challenge, and a sense of mastery (Law 2002; Creek 2010). This concept of engagement is important to understand when collaborating with people to establish physical activity goals. Townsend et al. (2007) recognized that focusing only on doing an activity – occupational performance – did not fully reflect the whole experience of the active, engaged individual and therefore they amended the Canadian Model of Occupational Performance to become CMOP-E (where 'E' stands for engagement). Therefore, when setting physical activity goals, it is essential that all features of engagement are considered, thereby activating the psychosocial mechanisms which influence wellbeing. Another explanatory mechanism for the relationship between physical activity and mental wellbeing is the influence of the environment.

Environmental Influences

The term 'environment' encompasses the social and physical contexts that people live within. Occupational therapists are assured in their understanding of the role of environment in people's occupational lives. In practice, person–occupation–environment models are common (Turpin and Iwama 2011), therefore exploring these interactions is important in conceptualizing people's physical activity aspirations.

The benefits of physical activity may be significantly enhanced by social environmental influences. Carron et al. (2001) identified that exercising in groups or with a supportive family member or friend enhanced positive attitudes and mood, reflecting a fundamental need for interpersonal attachment. Indeed, social influences on wellbeing have been the focus of much investigation over the past decade. Carless and Douglas (2008, p. 1179) used interpretive enquiry with men with 'serious mental illness' to explore how social support was important when initiating and maintaining exercise participation. Research led by an exercise scientist into people's experiences of exercise referral schemes (Crone et al. 2005) and walking programmes (Crone 2007) uncovered psychosocial explanations for the mental health outcomes of physical activity. Interestingly, this work identified themes familiar to those recognized by occupational therapists, such as a sense of belonging and a sense of purpose, in addition to sensations of enjoyment and physical health improvement.

Occupational therapy research specifically acknowledges social environmental influences (Alexandratos et al. 2012; Wensley and Slade 2012). Birch (2005) researched how conservation work at a Green Gym could meet occupational needs, and observed how the participants particularly valued the social and teamwork aspects of the activity. He also noted the value of working in the natural environment for its impact on wellbeing.

There is a growing body of evidence for the positive impact that natural green environments can have on psychological wellbeing (MIND 2007). The synergistic benefits of physical activity and exposure to nature – be it in natural wilderness, or everyday parks, gardens and open spaces within urban areas – are increasingly well evidenced (Pretty et al. 2005; Hynds 2010). (These phenomena, and the interventions associated with them, are explored more fully in Ch. 20 in relation to green care.)

The Chief Medical Officer for England (DH 2010, p. 21) referred to physical activity as 'nature's cure' and said the challenge is to build these benefits into daily lives. Exercise and physical activity programmes are now commonplace, especially through public health initiatives and through third-sector organizations (British Heart Foundation National Centre for Physical Activity and Health 2010). Occupational therapists are also developing and researching physical activity interventions that aim to meet this challenge from England's Chief Medical Officer, for example, utilizing horticulture (Fieldhouse 2003; Birch 2005; York and Wiseman 2012). It could be hypothesized, however, that we have yet to fully market our unique skills in facilitating occupational engagement in physical activities.

ADOPTING AND MAINTAINING PHYSICALLY ACTIVE BEHAVIOURS

The initiation, maintenance and resumption of many health behaviours, including being physically active, is rarely easy, especially when compounded by the effects of mental health problems. Complex psychological, social, environmental and biological factors influence participation (Biddle and Mutrie 2008), which highlights the difficulty in understanding each individual's support needs, in order to enable engagement. Occupational therapy assessment of individual needs within the context of the person's

overall care programme aims to identify these factors. Additionally, motivational influences are also relevant in goal-setting.

Motivating Factors

Biddle and Mutrie (2008) concluded that *intrinsic* motivation is key to sustaining involvement in exercise behaviours; that is, doing something for its own sake in the absence of external (extrinsic) rewards or pressures. Enjoyment, social contact, satisfaction and sense of achievement are positive outcomes and engagement is often linked to feelings of self-control or self-determination. In contrast, *extrinsic* motivation is usually through pressures outside of the person's control such as being told to exercise because of being overweight or due to other health concerns, or because 'it's good for you'. From a psychologist's viewpoint, Biddle and Mutrie (2008) suggested that if these external pressures were removed, motivation would decline in the absence of any intrinsic interest. This is analogous to the occupational therapy perspective summarized by Creek (2003, p. 33) that 'the value that an individual ascribes to an activity influences her/his commitment to spend time on it'. The challenge for the occupational therapist is then to identify as far as possible intrinsically motivating factors which enable engagement. This could involve considerable ingenuity, because, for example, people with depression may have difficulty recalling the intrinsic motivator of enjoyment, due to a loss of pleasure in life (Stewart 2010).

Behaviour Change Perspectives

From psychological and occupational therapy perspectives, motivation alone may inadequately explain people's capacity to be physically active. An understanding of readiness to make behavioural changes allows the therapist to plan interventions which are most likely to promote successful engagement. Several models of behaviour change are well evidenced, most notably in Prochaska and Marcus' (1994) Stages of Change within the Transtheoretical Model applied to exercise. They recognized that different approaches to facilitating exercise behaviours were required, according to whether an individual was unaware of the need to change, thinking about change, or actively making changes. (More detail about these stages of change in relation to behaviour change and addiction is provided in Ch. 28.) An awareness of the degree of readiness then influences the selection of appropriate cognitive and behavioural strategies to support the adoption and maintenance of physical activity. Biddle and Mutrie (2008) provide a comprehensive analysis of the application of health behaviour models to physical activity that may also inform occupational therapy practice. An occupational perspective of change, with some commonality with the Transtheoretical Model, is used within the Model of Human Occupation (MOHO) (Kielhofner 2008) to present a continuum from exploration, to competence, to achievement.

Within MOHO, *exploration* is the first stage whereby people try out new things and learn about their own capacities, preferences and values. This requires a relatively safe and undemanding environment that provides opportunities for discovering ways of being active, such as an informal badminton session with other mental health service users. In the *competency* stage, people begin to consolidate new ways of 'doing' that they discovered through exploration. This may involve the development of new skills and habits in order to support occupational performance. For example, the group may book a regular time at a local community centre for playing badminton, learn the rules of the game, and associated social activities such as organizing refreshments. Ideally, people will reach *achievement*, whereby the new occupation becomes integrated into their lives. Occupational identity can be reshaped when the person has sufficient skills and routines to allow engagement. For example, 'I'm a badminton player, I play every week'. This process from exploration to achievement is illustrated in the vignette involving Lisa, which follows later in this chapter.

Change processes do not always follow a smooth, linear pathway and both Prochaska and Marcus (1994) and Kielhofner (2008) acknowledged that individuals may move back and forth between stages due to the complexity of factors influencing personal change, and also due to environmental influences, such as having people to play with or access to facilities.

ENABLING PHYSICAL ACTIVITY: DIFFERENTIATING BETWEEN *PARTICIPATION* AND *ENGAGEMENT*

Occupational therapy service users may wish to increase their participation in physical activity because a particular form of exercise meets their occupational

needs and has value and meaning. As with any occupation, physical activity may fall into one or more of the three broad areas of self-care, productivity and leisure (Townsend et al. 2007). For example, a dancer may engage in Pilates exercises as a self-care activity to improve her flexibility and control, a postal delivery worker may build-up his walking tolerance to return to work, or a group of friends may go cycling for leisure and enjoyment at the weekend. These occupations, therefore, have intrinsic value, and also social, cultural, symbolic and spiritual significance for the individuals concerned (Creek 2003). Goals for occupational therapy intervention will therefore have direct relevance to overcoming the occupational performance difficulties that limit engagement. Physical activity per se may not have value or meaning for some individuals who may yet wish to participate because they are aware of the mental and physical health benefits of doing so, or because it enables them to achieve other occupational goals.

Interpreting meaning and values is especially pertinent in that they can be viewed from different perspectives. This influences the approach taken within occupational therapy. This involves distinguishing between *participation* in an activity and *engagement* in an occupation. There are many public health campaigns that encourage and 'nudge' people (Marteau et al. 2011) into activity as an obligation. Thus, the sense of personal *choice* to become more physically active – a dimension of occupation that is so fundamental – may be absent. Becoming more active may feel like a duty, in other words. Alternatively, many people make occupational choices to cycle, dance, swim or garden, for example because of the value, meaning and purpose they ascribe to it; that is, due to the *nature* of the occupation itself (Molineux 2010).

These two types of 'doing' could be viewed as points on a continuum from 'activity' to 'occupation'. What the individual actually does could then be seen as ranging from 'participation' (in an activity) to 'engagement' (in an occupation) on that same continuum. For occupational therapists, the term 'physical activity' is ambiguous. It may refer to the act of walking to university, for example, to engage in the occupation of studying; or it may refer to something more akin to a physical *occupation*, such as playing netball as a member of the university team. Differentiating between these two perspectives is warranted because it will help occupational therapists to collaborate with their service users in setting activity goals. Understanding the meanings that individuals ascribe to, and derive from, their involvement in physical activities is essential to person-centred occupational therapy. The next section presents two approaches to occupational therapy that take account of the individuals' values and motivators for being physically active, and illustrate the distinction between 'participation' and 'engagement'.

A Lifestyle Approach to *Participation* in Physical Activity

For people whose occupational identity does not include being physically active, but who nevertheless want to improve their mental and physical wellbeing, a lifestyle approach to participation is recommended. Incorporating activity within everyday routines avoids the necessity of having to overcome motivational and practical barriers of finding time and resources to do additional exercise-related activities. Examples of potential lifestyle activities are indicated in Table 14-1. A key aim is for such activities to become habituated, so participation becomes a routine part of daily life (Kielhofner 2008). Occupational analysis can ensure that lifestyle physical activities are incorporated within more meaningful occupational goals. Case Study 14-1, describing Michael's walking, illustrates this point.

These perspectives on walking reflect the European framework definitions of *occupation* and *activity* (Creek 2010), which see an *activity* (such as walking) as a structured series of actions or tasks that contribute to *occupations* (such as shopping or attending college).

The UK Chief Medical Officers (DH 2011a, p. 17) recommend a lifestyle approach such as this because 'for most people, the easiest and most acceptable forms of physical activity are those that can be incorporated into everyday life. Examples include walking or cycling instead of travelling by car, bus or train'. Additionally, a holistic approach to improving wellbeing through other lifestyle behaviours such as diet, sleep and social interactions, will likely have a greater effect than focusing on physical activity alone (Hendrickx and van der Ouderaa 2008). In this way the practical approach of an occupational therapist synthesizes with interprofessional perspectives as discussed by Holley et al. (2011). For example, promoting physical activity for

CASE STUDY 14-1

Michael

Michael has been recovering from schizophrenia since his late teens and is now 35 years old, living independently with mental health team support. His occupational goals are to return to college and resume his interests in computer science, which were interrupted when he became unwell. He also wants to improve his overall health and wellbeing, and acknowledges the need for more physical activity. However, Michael is not interested in exercise and his attempts at participating in an exercise referral scheme (DH 2001) were unsuccessful. The occupational therapist, in collaboration with Michael, recognized that a lifestyle approach to incorporating walking within his activities to achieve wider occupational goals might be more realistic. Professional reasoning suggested that, while walking had only minimal intrinsic value for Michael, it still enabled him to improve his health and wellbeing and contribute to achieving wider occupational goals. By incorporating walking into Michael's occupational *engagement* in shopping and going to college, for example it promoted his overall recovery.

people with schizophrenia needs to be realistic in terms of understanding what they want to achieve by it, and may be used in an instrumental fashion to help them pursue other meaningful areas of their lives. Ultimately, individuals such as Michael may come to enjoy walking for its intrinsic value, as an added benefit, but that need not be the initial goal of the intervention.

An Occupational Approach to *Engagement* in Physical Activity

The following vignette describes a contrasting approach to physical activity by Lisa, who is intrinsically motivated through her enjoyment of physical activity.

Although recommended for treating depression, physical activity may be insufficient on its own, or other interventions may be required to lift mood sufficiently prior to engaging in it (Cole 2010). The therapist reasoned that, because Lisa perceived herself as being unable to overcome her volitional challenges in order to participate, a physical activity could be used as an adjunct treatment and be introduced using a cognitive

CASE STUDY 14-2

Lisa

Lisa has intermittently experienced depression throughout her adult life. It has been exacerbated by a 6-month absence from work due to chronic back pain, initially triggered by an incident in her job as a home care support worker. In addition to her low mood, she is becoming increasingly anxious about meeting people and is becoming socially isolated at home. She is 35 years old, married with two children aged eight and ten. The occupational therapist utilized MOHO and the Occupational Self Assessment (OSA) because it is 'designed to give voice to the client's perspective and to give the client a role in determining the goals and strategies of therapy' (Kielhofner 2008, p. 246). This empowered Lisa who, when depressed, experienced a sense of powerlessness and inability to change. Lisa wanted to reintroduce physical activity into her lifestyle to enjoy it for its own sake, and also to help with managing her back pain.

behavioural approach. This enabled Lisa to challenge negative thoughts about herself and her abilities. This frame of reference can effectively be integrated within a MOHO conceptualization in order to comprehensively meet service users' needs (Nicol 2008).

Lisa needed to experience success to develop her sense of capacity and self-efficacy but recognized that her goal of resuming swimming was initially too challenging. Poor physical self-perceptions and body image are acknowledged barriers to participation in activities such as swimming where one's body is publicly visible (Carless and Douglas 2010). Therefore, the therapist worked with Lisa to identify intermediate physical activity goals. Table 14-5 presents Lisa's goals and occupational interventions.

The adoption and sustained engagement in physical activities can be challenging for anybody, regardless of health concerns (Biddle and Mutrie 2008). Therefore, the occupational therapy process – which comprises ongoing assessment and modifications, outcome measurement and review (Creek 2010) – is particularly pertinent. Lisa's progress in achieving her goals, her own perceptions and feedback to the therapist, and a repeat of the OSA all contributed to evaluation. Goal

TABLE 14-5

Lisa's Occupational Goals

	Goals for Physical Activities: Enabling Occupation	***Professional Reasoning – Using MOHO Concepts (Kielhofner 2008)***	
Increasing degree of challenge over time ↓	Gardening *Within 1 month, I will be able to perform light gardening at home, with the support of the occupational therapist*	Reducing support from the occupational therapist as Lisa's confidence in her own abilities develops (personal causation) Interest growing in gardening, and being outdoors (physical environment) Valuing a cared-for garden, maintained through her own efforts Increasing duration of activity, and physical challenge, e.g. tidying containers, light weeding, digging (performance capacity) Resumption of previous role of responsibility for the garden	Exploration – trying out activities and learning about one's own capacities, preferences, values. This requires a relatively safe and undemanding environment
	Dog walking with friend/ neighbour *Within 2 weeks, I will have spoken with Jo (neighbour) and have a regular commitment to walk our dogs together*	Re-engagement in an habituated routine Support and social contact (social environment)	Competence – beginning to solidify new ways of doing that were discovered through exploration
	Walking children to school *Within 2 months, I will be walking my children to school at least 3 times a week, and remain in control of my anxious thoughts*	Parenting role and habituated routine Confidence in socializing with other parents (personal causation, social environment)	
	Swimming *Within 6 months, I will be able to sustain my involvement in the weekly women's swimming sessions, by attending at least 3 times per month*	Longer-term goal attainment through occupational changes Sense of achievement (personal causation) and acknowledgement of swimming skills Regular engagement in planned sessions (habituation) Physical fitness, mastery, achievement of physical activity for health recommendations (performance capacity)	Achievement – integration of this new occupational engagement into Lisa's life. Her occupational identity as a swimmer is reshaped
	Additionally, these goals will be supported by cognitive behavioural activities such as thought records and diaries. As Lisa's mood and physical health improve, the occupational therapist will also be collaborating with her on achieving return to work goals		

attainment, enhanced feelings of self-worth and confidence motivated her to engage in other occupations that were meaningful through feelings of satisfaction and pleasure (Mee and Sumsion 2001). Over time, as her mood and physical functioning improved, Lisa commenced a graded return to work programme with support from her employer and the occupational therapist. Feedback from Lisa on her experiences of participating in this programme were also useful in enabling other people to become more active.

Considerations for Using Physical Activity in Group-Based Programmes

As discussed further in Ch. 16, there are many advantages to working towards occupational goals through group activities, and this can be particularly relevant to enabling engagement in physical activity. As noted above, social influences are significant to the sense of wellbeing derived from physical activity. Additionally, the support of others and a commitment to regularly planned group sessions can be important to overcome motivational barriers to engagement (Cole 2010).

Core principles illustrated in relation to Michael and Lisa will need to be applied when planning physical activity groups. Aims could vary from exploring options for physical activities through taster sessions, incorporating physical activities into habituated lifestyles, enabling other occupational goals such as developing opportunities and confidence for social interactions, transferable and vocational skill development such as organizational skills and leadership, and engaging in physically active occupations for their intrinsic value.

Essential occupational therapy values of enablement and empowerment should be incorporated wherever possible. Tremendous opportunities exist to utilize service users' skills, for example, in horticultural knowledge for a gardening/allotment group, familiarity with local geography for planning walks or safe cycling routes or coaching skills and previous experiences for sports sessions. People who have experienced the challenges of overcoming barriers to maintaining an active lifestyle such as motivational problems, or broader societal issues such as stigma and social exclusion are well placed to offer practical and emotional support to others.

Sustaining Engagement

Integration with community resources should be an aim of interventions in order to facilitate social inclusion (Smyth et al. 2011) and also the long-term sustainability of engagement beyond the occupational therapy intervention. Fortunately, in addition to a multitude of local sports and leisure centre-based activities, many health-promoting programmes exist, such as Green Gyms (Birch 2005) and Walking for Health (Hynds and Allibone 2009). Many also offer volunteering opportunities that may fulfil people's long-term occupational goals. For example, individuals may train as voluntary walk leaders or undertake vocational qualifications through horticultural organizations or through voluntary groups, such as the British Trust for Conservation Volunteers. Volunteering is congruent with occupational therapy and occupational science philosophies, which value its role in promoting health (Wilcock 2006) and in supporting recovery and social inclusion (Farrell and Bryant 2009).

TYPES OF PHYSICAL ACTIVITIES

A wide range of options exist for improving health through physical activity, greatly increasing the scope for choice and control. Earlier sections of this chapter discussed the positive influences of physical activity, highlighting that the activity need not be particularly vigorous. However, evidence is still inconclusive about what type, frequency, intensity or duration is required in order to improve wellbeing (Kirkwood et al. 2008). What follows is an overview of the limited evidence of benefits from certain types of activity which may assist occupational therapists' work with service users.

Repetitive and Rhythmic Activities

Wright et al. (2012) researched the experiences of people with bipolar disorder and described participants' favourable reports of a calming effect from rhythmic, repetitive activities such as running, walking, cycling and swimming, compared with more erratically paced racket and team sports. Lisa (see Case Study 14-2) reported comparable mentally calming experiences from the physically demanding activity of repetitive digging in her garden. Similarly, anecdotal evidence from service users with psychoses indicated benefits of rhythmic activities, such as rowing or swimming, in symptom management to distract from hearing voices (Mental Health Foundation 2000).

Weight Training

There is increasing attention paid to studies investigating the potential of weight training and other muscle-strengthening types of exercise such as intensive swimming or rock climbing, to improve self-esteem. It seems that the increased muscle tone and body definition may lead to improved physical self-perceptions

and body image, which are strongly associated with self-esteem across the lifespan (Carless and Fox 2003). The feeling that one's body is improving through exercise may be sufficient to generate increased perceptions of health, physical competence, fitness and body image (Fox 2000).

Walking

Walking is a universal physical activity that requires minimal organization and no specialist equipment or economic cost. It can effectively be habituated within a person's lifestyle as noted with Michael (Case Study 14-1) and, as Johnsgard (2004) observed, 'nothing can compare to what walking has to offer those of us who are struggling to leave a sedentary life behind' (p. 257).

Walking is accessible, convenient, economical, easily graded and paced to accommodate people's level of fitness and abilities. Walking has been shown to promote wellbeing through a sense of achievement, purpose and enjoyment (Crone 2007). Research into group walking programmes consistently identifies the social element as being a strong motivator and influence on positive emotional experiences (Hynds and Allibone 2009; Wensley and Slade 2012). It is therefore an activity that occupational therapists can incorporate within programmes at low financial cost for potentially significant gains.

RISK ASSESSMENT

The UK Chief Medical Officers' report (2011a) states that the risks of participating in physical activities are low, and that 'continuing with an inactive or sedentary lifestyle presents greater health risks than gradually increasing physical activity levels' (p. 17). Whilst there are some considerations specific to physical activity, the assessment and management risk need not be significantly different from any other therapeutic intervention.

Fitness Levels

Initial fitness levels need to be considered when choosing activities because of the association between mental health problems and physical illnesses, particularly cardiovascular disorders (Naylor et al. 2012). Therefore, it is imperative that occupational therapists utilize activity analysis, grading and adaptation, particularly when initiating engagement. The side-effects of medication (described earlier in relation to neuroleptic medication) are further justifications for a gradual approach (Mutrie and Faulkner 2003).

Mental Health Considerations

The particular features of each person's mental health difficulties may also need consideration. For example, Wright et al. (2012) concluded that there is some risk of physical activity exacerbating symptoms for people with bipolar disorder. This could develop into an upward spiral of mania, as the quantity and intensity of exercise increase. Furthermore, research outcomes are inconclusive about potentially unhealthy exercise dependence that could become a compulsive behaviour, particularly for people with other dependencies, such as alcohol or drug use (Biddle and Mutrie 2008). Its prevalence is unknown but may create problems such as excessive fatigue, chronic injury, relationship problems and unwanted weight loss. Biddle and Mutrie (2008) also discuss exercise dependence secondary to eating disorders and the controversy about whether it triggers an eating disorder and/or is a consequence of conditions such as anorexia nervosa. They assert that exercise may be used within eating disorder programmes through modifying the activities and associated calorific expenditure while positively influencing psychological wellbeing. Thus, lower-intensity activities, such as walking rather than running, or flexibility and weight training sessions instead of aerobic exercise, can be incorporated within programmes. The time spent on activity may be similar but fewer calories will be expended.

Occupational therapists are well placed to be mindful of physical and psychological risks, due to their holistic practice within physical and mental health contexts, and their knowledge and understanding of facilitating physically active behaviours.

SUMMARY

This chapter has explored extensive evidence for the benefits of physical activity to health, specifically focusing on its relationships to mental health and wellbeing. It is prominent on the health agenda from both treatment and prevention perspectives, yet it is evident that participation and engagement are complex phenomena involving a multitude of

physical, psychosocial and environmental considerations. Occupational therapy, with its holistic activity-focused practice and professional reasoning capable of engaging with complexity, is uniquely placed to meet these challenges within contemporary health and social care environments.

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SERVICE USER COMMENTARY

I am a service user diagnosed with bipolar for over 25 years now. During these years, I have had to manage, cope with, and understand my illness in order to move forward with my life. Doing physical activities has played a very important role in my recovery. Many years ago, I started playing cricket and badminton. This enabled me to meet other people, thus improving my fitness generally; body and mind. These activities improved my mental health and wellbeing and my general health. Because I am on certain medication long term, I have to drink a lot of water when playing, or risk problems later. I now also play for an outdoor bowling team and meeting great people has had another positive effect on my health. When I was a teenager, I was very much into PE. Back then, we started the first Indian hockey team at our school and I was also captain of my school football team. But then my depression hit me hard, changing everything. Since moving home 17 years ago, I rediscovered my sense of direction again in my life and physical activities once again played a very important part in my life. We also set-up a target sports club many years ago which proved to be effective too and the feedback from other service users was positive. I hadn't made my mind up to do it. It just happened when the opportunity presented itself and then it just got better and better.

Looking at this chapter overall, everything that I have read indicates that activity is good for everybody. My personal experience confirms this. However, the illness has to be understood too in order for it all to work together positively.

The London Olympics in 2012 raised a lot of awareness about disability and activity but we also have to remember that there is no 'cure' for certain illnesses like bipolar, but certain things we do can help. Training for staff and students by experienced service user trainers working from their own perspective is the key to addressing this need further in order to improve mental health and wellbeing. Family members and the public can be educated too, to get involved and encourage others. The nation's health can be improved by activity and wellbeing in so many ways, such as providing information and guidance about activities, holding conferences and seminars, and providing more opportunities to get involved.

My conclusion is that it does take money, commitment and dedication to achieve all of this. However, what I have achieved in 17 years – with very little money, but a passion to succeed for others and to make a real difference, when millions are failing this world right now – shows what is possible. My commitment to mental health work and activities has helped me and others to try and lead a normal life again.

Daljit Saini

15 COGNITIVE APPROACHES TO INTERVENTION

SARAH LEE ■ RACHEL WEST

CHAPTER CONTENTS

INTRODUCTION

The *Oxford English Dictionary* (2004) defines cognition as 'the mental action or process of acquiring knowledge through thought, experience, and the senses'. Cognitive learning theories, therefore, describe ways in which the brain learns to interpret, store and recall information. Accordingly, it has been noted that cycles of both adaptive and maladaptive behaviours are developed on the basis of how an individual thinks and feels about their actions and their consequences (Hagedorn 2000; Segal et al. 2002) (see Fig. 15-1).

In the field of psychology, there has long been an understanding of the significant role of cognitions and the ways in which they influence human performance. Therefore, it is essential for occupational therapists to understand not only what is meant by cognition and cognitive impairment but also how cognitive deficits will directly affect occupational performance.

This chapter describes how cognitive impairment can present in mental health practice, considers the effect of the impairment on occupational performance and participation, and explores cognitive interventions. An overview of psychological approaches, assessments

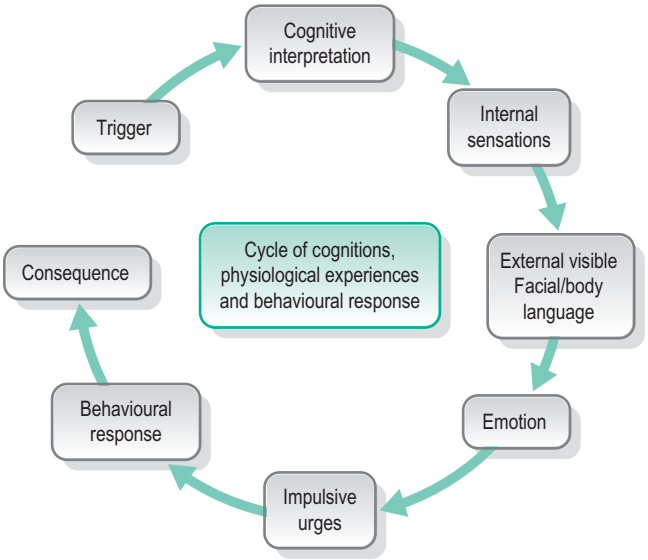

FIGURE 15-1 ■ The cycle of cognition.

and case presentations of interventions will assist readers in integrating theory into practice.

COGNITIVE IMPAIRMENT

There are two primary areas in which cognitive impairment can have a significant effect on occupational performance: organic brain syndrome and mental health problems.

Organic Brain Syndrome

Organic brain syndrome is the term used to describe a range of disorders in which an underlying neurological dysfunction causes problems with attention, concentration and memory. The individual may also appear confused, anxious and/or depressed, as a result of damage to, or disease in, the brain. These disorders include, acquired brain injury (traumatic), cardiovascular disease (strokes, vascular dementia) and degenerative disease (Creutzfeldt–Jacob disease and Huntington's disease). Since these disorders are of a more physical nature, this chapter will not expand further but will focus on problems commonly encountered in mental health practice.

Mental Health Problems

This section introduces a range of mental health problems that are likely to present with elements of cognitive impairment, and begins to describe the impact of this on functioning.

Affective Spectrum Disorder

Affective spectrum disorder is the overarching term to describe a wide range of mental health problems which include those typically associated with intense changes in mood or extremes of mood-affecting thoughts and behaviours, such as depression, bipolar disorder and general anxiety disorders. Some individuals with affective disorder may also experience psychotic episodes, including delusions, hallucinations or other losses of contact with reality, although this is not necessarily so in all cases (Forty et al. 2009; Mazzarini et al. 2010).

Individuals who experience anxiety disorders may experience problems in their functional performance, as a result of cognitive impairment due to attention deficits and memory difficulties (Ferreri et al. 2011). Routine and roles may be lost during significant mood changes and due to the self-critical judgements often prominent in depression. With anxiety disorder, worrying has a tendency to be overwhelming and affects daily life, interfering with routine activities, including job roles and social life.

Autistic Spectrum Disorder

There has been a significant increase in both the understanding of autism and Asperger syndrome and in the number of individuals diagnosed with Autistic Spectrum Disorder (ASD). Limited space within this chapter allows only the elements of cognition and cognitive impairment to be discussed and readers are

encouraged to explore ASD further elsewhere (see Frith 1991, 2003; Frith and Hill 2004).

The term *spectrum disorder* implies a vast range of symptoms that may be present and the difficulties an individual may experience, which can vary from mild to very severe. There may also be a co-existing learning disability and the need for long-term support with specialist intervention. Autism and Asperger syndrome both develop in early life and persist throughout adulthood, affecting three areas of neurological development: communication, social interaction and creativity (Frith and Hill 2004). The cognitive impairment can be wide ranging from severe learning disabilities to high cognitive functioning. Consequently, individuals with ASD will require comprehensive assessment and the amount of support will depend on the level of functioning.

Dementia

Dementia is a disorder in which there is a progressive decline in the cognitive functioning of an individual outside of the normal ageing process – such as in Alzheimer's disease (APA 2000). Dementia is characterized by multiple cognitive deficits including memory loss, attention deficit and disorientation of people, place and time. Individuals with dementia also experience difficulties with problem solving, a decline in their ability to learn new things and often their speech and language ability are impaired.

Psychosis

Psychosis has become the overarching term for a number of mental health problems, including schizophrenia, bipolar disorder and schizoaffective disorder. The term 'psychosis' describes a set of symptoms that include delusions, hallucinations (usually auditory or visual but may be other sensory modalities also), disorganized speech and confused or disturbed thoughts with a loss of contact with reality (APA 2000). These symptoms may also be apparent in some forms of dementia, epilepsy, Parkinson's disease and as a result of occasional or continual alcohol or substance misuse. People living with psychosis frequently experience a range of cognitive deficits, which impact on their functional ability, including attention deficits, memory problems and problem-solving skills. There may also be the additional cognitive impairment where alcohol or substance misuse problems co-exist (see Ch. 28).

Personality-disordered individuals may experience transient psychotic episodes, including 'transient, stress-related paranoid ideation or severe dissociative symptoms' (APA 2000). These individuals may also experience periods of intense flashbacks and heightened emotional dysregulation that may have a similar presentation to psychotic episodes. Emotion dysregulation is an inability to regulate emotions, particularly negative emotions, and a high sensitivity to emotional stimuli with a slow return to an emotional base line (Linehan 1993a). Consequently, there may be cognitive deficits which will impact on individuals' functional capacity in similar ways to those described previously, although these may be of a shorter duration:

> *Emotions, in turn usually have important consequences for subsequent cognitive, physiological and motor behaviour.*
>
> ***(Linehan 1993a, p. 38)***

Much of the work in developing cognitive behaviour therapy stemmed from the theory that a person's clinical depression or anxiety problems were closely linked to their cognitions, thinking patterns and beliefs. Cognitive behaviour therapy has been further developed to include dialectical behaviour therapy and mindfulness-based cognitive therapy, both of which will be of interest and relevance to occupational therapists and will be discussed in more detail later.

COGNITIVE APPROACHES

Cognitive Behavioural Therapy

Cognitive behavioural therapy (CBT) was developed by Aaron Beck in the 1960s, as short-term psychotherapy for depression (Beck 1964, 1991). Further work by Beck, in the 1970s and 1980s highlighted that the way we think about 'self', the world and others, has a major impact on both our emotions and behaviour (Beck 1976).

CBT is now widely used as an evidence-based psychotherapeutic approach, based on the theoretical framework of behaviour therapy and cognitive therapy and is now the preferred approach for addressing many other mental health problems (DH 2012), including obsessive compulsive disorder, general anxiety

disorder, substance misuse, eating disorders and post-traumatic stress disorder (PTSD) (Beck 1995). A detailed examination of the theory and practice of CBT follows later in this chapter.

Contemporary CBT has developed significantly over the last few decades and now encompasses additional theoretical frameworks, referred to as the *third wave* of behaviour therapy (Hayes 2005). The more recent additions to CBT include dialectical behaviour therapy (DBT) (Linehan 1993a); acceptance and commitment therapy (ACT) (Hayes et al. 1999); mindfulness-based cognitive therapy (MBCT) (Segal et al. 2002); and mindfulness-based stress reduction (MBSR) (Kabat-Zinn 1991); all of which provide further evidence-based therapies. This new generation of therapies is no longer necessarily the domain of psychology, which was the profession originally providing CBT. There are now many other clinical professions utilizing CBT approaches in their therapy, including occupational therapists (Duncan 2003).

Another cognitive approach developed by Jeffrey Young in the mid-1980s is schema therapy, which focuses more specifically on the individual's schema and changing behavioural responses (Young and Klosko 1993; Young et al. 2003). Schema are described as the emotional and cognitive patterns that developed early in life and which then repeat throughout life; they include memories, emotions, cognitions and internal body sensations. The goal of this therapy is to assist individuals to stop using maladaptive coping strategies, to get in touch with their core feelings and to detach from their self-defeating schema. What follows is an overview of the new generation of cognition-based therapies.

Dialectical Behaviour Therapy

Dialectical behaviour therapy (DBT) was originally developed by Marsha Linehan (1993a), as a comprehensive cognitive behavioural approach 'for the treatment of chronically suicidal individuals' (Dimeff and Linehan 2001, p. 10) who also met the criteria for borderline personality disorder (BPD). It has also now been extended to other mental health problems, including substance misuse, eating disorders and suicidal/depressed adolescents. DBT is used in community settings, in hospital settings and prisons. It differs from CBT, in that it combines the basic behavioural techniques with Eastern mindfulness practices.

> *Mindfulness is the awareness that emerges through paying attention on purpose, in the present moment, and non-judgementally to things as they are.*
> ***(Williams et al. 2007, p. 47)***

Linehan (1993a) recognized that severe emotion regulation problems led to cognitive distortions, automatic assumptions, rigid beliefs and dichotomous thinking. It also became apparent that there were many dilemmas facing both individuals with BPD and their therapists, including a lack of understanding of the nature of BPD, poor therapeutic relationships, frequent therapist burnout and limited change in inappropriate behaviours. Consequently, Linehan (1993a) ensured that the treatment package included individual therapy, group skills training and a weekly consultation for the therapists. Thus ensuring there was an educative element, consistency, therapist support and adherence to DBT principles.

Occupational therapists will recognize the strengths of DBT and particularly identify with the skills training modules which are, in essence, skills for life, and will see this format as comparable with skills training in occupational therapy.

Acceptance and Commitment Therapy

Acceptance and commitment therapy (ACT) is a mindfulness-based behavioural therapy, which differs from traditional CBT in that, rather than trying to teach people to have greater control of their thoughts, feelings, sensations and memories, it teaches them to notice thoughts and judgements and to accept situations as they are, in the moment. Similar to CBT, it involves experiential exercises and values guided behavioural interventions (Harris 2008).

Mindfulness-Based Approaches

Mindfulness-based cognitive therapy was developed as a therapeutic approach by Segal et al. (2002), in response to the need for an effective, evidence-based treatment and relapse prevention method for depression. Similar to CBT, it is time-limited, collaborative, requires active participation of the service user, explores new ways of thinking and experiencing and the acceptance of things as they are, in the moment. It consists of an

8-week programme based on the stress reduction programme for the management of pain using mindfulness meditation (Kabat-Zinn 1994).

Kabat-Zinn (2004) initially developed the mindfulness-based stress reduction (MBSR) programme for individuals with chronic pain in the USA and, following the success of the 8-week programme, extended it to other chronic physical or life-limiting illnesses where stress and pain were intrinsically linked together. As above, this approach consists of experiential mindfulness exercises, active collaboration and commitment from participants. The mindfulness-based approaches have been welcomed by many professions, not only as a treatment approach for service users but also as a stress-reduction programme for staff. Such is the wide recognition of the MBSR programme that it is also used in the corporate world for stress reduction of staff (Fries 2007).

Schema Therapy

Schema therapy involves two phases of treatment. The first phase focuses on helping the individual identify schemas, to understand their origin in both childhood and adolescence and then to relate them to the current problem. The second phase uses cognitive, experiential/behavioural and interpersonal strategies to 'heal' schemas and to replace maladaptive coping strategies with more adaptive/appropriate behavioural responses (Young et al. 2003).

Other cognitive approaches with people with a primary diagnosis of schizophrenia are beginning to gather momentum. McGurk et al. (2007) and Roberts and Penn (2008) have explored the relationship between the introduction of a cognitive intervention and changes in cognitive functioning in individuals with schizophrenia. Cognitive remediation therapy (CRT) (McGurk et al. 2007) and social cognition and interaction training (SCIT) (Roberts and Penn 2008) show evidence of improvement in cognitive functioning, notably memory – which has an impact on occupational participation and performance. This kind of research is still in its infancy but if the evidence demonstrates that the use of cognitive approaches is able to effect change and improve quality of life for individuals then occupational therapists are well placed to contribute to this research agenda. Occupational therapists may also benefit from exploring the effect of combining cognitive work with psychosocial education and regular occupational therapy interventions focusing on structure and meaningful occupation and life roles (Creek and Lougher 2008).

While accepting the extensive influence of CBT, DBT, ACT, MBSR and increasingly MBCT, it is fundamental to the professional identity of occupational therapists that they maintain their core occupational focus. Duncan (2006) challenged the use of CBT by occupational therapists but also recommended the use of cognitive behavioural principles within an occupational therapy context (Duncan 2003). To this end, the following section will discuss the theoretical framework of CBT.

AN OVERVIEW OF THE THEORETICAL FRAMEWORK OF COGNITIVE BEHAVIOURAL THERAPY

CBT combines both cognitive and behavioural techniques. Behaviour therapy was developed from work by the Russian physiologist, Ivan Pavlov, in the 1920s, based on animal behaviour in which he identified, through experimentation, how behaviours could be influenced by the environment; this became known as classical conditioning (Hawton et al. 1998).

Building on this early work, American psychologist BF Skinner recognized that it was possible to increase or decrease the frequency of the behaviour occurring, depending on the specific event immediately following the behaviour. Skinner realized that both positive and negative consequences could reinforce the behaviour. He referred to this as operant conditioning (Hawton et al. 1998). This traditional behavioural approach was widely acknowledged in mental healthcare over the 1970s and 1980s. In recognition of the importance of increasing the appropriate behaviours and decreasing inappropriate behaviours, the 'RAID' (reinforce appropriate, implode disruptive) approach to the management of extreme behaviour (Davies 2001) was developed using contingency management as the key component. The term 'implode', here, literally means to cause to collapse inwards, because the intent is to discourage disruptive behaviour by ignoring or giving minimal response to it. Contingency management is based on the fact 'that the consequences of our behaviour influence what we learn' (Koerner 2012, p. 104),

thus how one responds to either appropriate or inappropriate behaviour will influence the likelihood of the behaviour recurring. As a result, many therapeutic programmes may now include it as a behavioural treatment approach, not only to enhance the effectiveness of CBT but also to assist the staff working in a more positive and constructive therapeutic manner with a complex and challenging patient group (Long et al. 2008).

CBT involves behavioural experimentation. This requires the individual to practice new behaviour changes learnt within therapy or through using a CBT workbook. It is collaborative, involving full and active participation of the client and therapist. Indeed, there is great emphasis placed on this therapeutic relationship, which is perceived to be integral to the outcome of therapy.

CBT focuses on five key areas: thoughts, behaviours, emotion/mood, physiological responses and the environment. Each of the five areas impacts on the other areas. CBT focuses on the fact that by changing one's thinking, one can change one's emotions and the responses one makes (Greenberger and Padesky 1995).

Beck et al. (1979) identified three levels of cognition: *full consciousness*, *automatic thoughts*, and *core schema*. *Full consciousness* is defined as a state in which rational decisions are made with full awareness. *Automatic thoughts* are those that 'pop into one's head'. In healthy individuals, they can be either positive and constructive or negative and judgemental. In depression, these thoughts are more frequently negative, critical and often illogical and are known as 'negative automatic thoughts' (NATs). Conversely, in anxiety disorders, automatic thoughts often involve overestimation of risk in situations and underestimation of ability to cope (Wright et al. 2003). It is important to recognize these automatic thoughts when assessing the individual, since they will frequently have a direct effect on how they manage their daily routines.

When automatic thoughts inappropriately impact an individual's behaviour, the therapist can begin to challenge the thoughts with the individual and encourage new alternative ways of thinking. This involves trying new approaches to different situations and environments. Linehan (1993b) describes 'acting opposite to the current emotion', which involves observing one's thoughts, judgements and acting opposite to the emotion. For example, when feeling frightened – unless there is a real threat to one's life – this would mean noticing the thoughts and judgements arising in the situation, but then approaching, rather than avoiding the fear-inducing situation. This process is not the same as simply turning negative thoughts into positive thoughts. Challenging automatic thoughts is about gaining a wider perspective of situations, looking at new alternative views and identifying solutions to overcome problems.

Schemas are at the deepest level of one's thinking, as described earlier. They are absolute core beliefs which are shaped in early life and which continue to affect the way we see the world and see ourselves. Schemas are usually more difficult to challenge, given the length of time they have been held as fact. They may indeed be so entrenched that we are unaware of them. Consequently, they will affect our self-esteem and coping strategies. Such beliefs may include 'I am bad', or 'I am good', or 'I am a horrible person'. Since schemas play such a major role in regulating an individual's self-worth and subsequent behavioural coping strategies, they become a necessary focus for CBT interventions (Young and Klosko 1993).

Current attention within CBT now focuses attention less on the levels of cognitions and more on the following phenomena – as depicted in Figure 15-1.

- Trigger: the event prompting the cognitive response
- Thoughts: the interpretations, assumptions and judgements that follow
- Emotions
- Behaviour.

GENERAL CHARACTERISTICS OF COGNITIVE BEHAVIOURAL THERAPY

CBT has four characteristics that set it apart from other psychotherapeutic approaches, as follows:

1. It is focused on the present. CBT includes a historical assessment of the individual to provide the context to current difficulties but the therapist using CBT is more interested in exploring the presenting problem and identifying ways in which it can be addressed

2. It is time limited. There is an agreement between the individual and the therapist regarding the duration of treatment and the times for evaluating/reviewing therapy
3. It is collaborative intervention. Both the therapist and the individual work together to develop a shared understanding of the presenting problems and actively seek more effective ways of coping
4. It is problem-focused. The therapist identifies the individual's problems and then arranges them (through negotiation with the service user) in hierarchical importance, in order to define a list of priorities and establish the focus of interventions.

There is an on-going assessment process following the initial assessment, which includes gathering historical information, as well as current information regarding the presenting problem. A case formulation is generated collaboratively with the service user and their interpretations of their presenting problems, as well as using research and theory. In order to ensure therapeutic openness and clarity, psycho-education regarding CBT is provided for the service user. Following this, the interventions are agreed. These may involve individual work and activity-based work, such as exposure therapy, whereby an individual with agoraphobia, for example, may start with the small step of simply going out of the door but progress later to taking a bus into town. This engagement with specific activities underlines the close association that CBT has with occupational therapy. At the conclusion of the intervention, the therapist aims to empower the individual to become their own therapist, recognizing their triggers and developing their own coping mechanisms in order to establish relapse prevention strategies.

In highlighting the general characteristics of CBT and in recognition of the third wave of behaviour therapies, it is unsurprising that many occupational therapists are attracted to the cognitive behavioural approach. It is therefore helpful to consider how CBT and occupational therapy can be integrated effectively.

The term 'cognitive behavioural therapy' (CBT) is often loosely used in occupational therapy, which then leads to confusion and frustration for both occupational therapists and cognitive behavioural therapists. Duncan (2006) recognized this dilemma and suggested that 'all forms of primarily didactic psychotherapy that use a CBT approach are referred to as CBT (or cognitive behavioural therapy), while the use of cognitive behavioural theory or practice within occupational therapy is referred to as employing a cognitive behavioural frame of reference' (p. 225).

The Cognitive Behavioural Frame of Reference in Occupational Therapy

Frames of reference, or approaches, provide a theoretical knowledge base that underpins therapeutic interventions, enabling the therapist to structure and evidence their intervention. The cognitive behavioural frame of reference provides a psychological structure but requires an additional specifically *occupational* perspective to assess or identify an individual's occupational performance or functional ability.

Certain occupational therapy models of practice recognize the value of combining frames of reference or approaches to gain greater insight into individuals' problems and deficits. Forsyth and Kielhofner (2006), for example, stated that 'occupational therapists using the Model of Human Occupation (MOHO) will also need to use other frameworks in order to understand and address performance capacity' (p. 85). A combination of frameworks can therefore be used to support a fuller understanding of an individual's occupational participation, and the cognitive behavioural theory is one such framework. However, it is imperative that occupational therapists use it with a clear appreciation of how they are integrating occupational and cognitive behavioural perspectives to understand an individual's needs.

Integrating assessment information and formulation will indicate areas for intervention. The occupational therapist and the individual must then work together to prioritize goals for therapy. Agreeing these can be a first step in the development of the therapeutic relationship, with the implicit aims being to understand each other's formulation of presenting difficulties and to agree a way forward.

Occupational Therapy and Cognitive Functioning

Identifying levels of cognitive functioning should be undertaken through careful assessment of the individual's presenting problems, developing an understanding of

past functioning, along with current challenges. Using the knowledge of the past level of functioning, current context and future aspirations, the occupational therapist can work with the individual to clarify the impact of the impairment on a person's occupational functioning.

In terms of cognitive functioning, various occupational therapy models of practice have attracted attention over time, as the evidence base has developed. While Claudia Allen's early Cognitive Disability Model and the later Functional Information Processing Model (Allen 1982; Allen et al. 2007) have been widely adopted in the USA, it has been suggested that limitations exist regarding their application in the UK, linked to the associated craft element and the fact that the terminology/instructions are American and differ from those generally used in the UK. Availability of the assessments has been problematic but they are now more readily available via websites (Pool 2006, p. 140). Similarly, the Model of Creative Ability (de Witt 2005), developed by Vona du Toit in the 1970s, has been widely used in South Africa but its use has only recently started to gain momentum in the UK (see Ch. 17 for a detailed look at this model).

The Model of Human Occupation (MOHO) (Kielhofner 2008), which supports a person-centred approach and has a wide range of assessment tools and measures that have been developed to enhance the models application, has been used effectively in cognition-orientated practice (Lee and Harris 2010; Lee et al. 2011).

Assessing Cognitive Functioning: The Role of the Occupational Therapist

The assessment of cognitive functioning is complex and a range of generic assessment tools exists to structure this process. The method of assessment is often through asking a range of questions for which the tools, such as The Occupational Circumstances Assessment Interview Rating Scale (Forsyth et al. 2005) and the Assessment of Motor and Process Skills (Fisher 2003, 2006), provide a range of standardized responses; or by carrying out specific tasks that have been standardized to provide a score system and a context to the scoring (Fisher 2003, 2006).

For occupational therapists, the focus is on performance during meaningful occupation. It is also important that the therapist maintains an awareness of performance adaptation and the potential for a service user to disguise the impact of cognitive impairment on occupational performance where, for example, they may have achieved the desired outcome but modified or missed tasks in the process. This type of observational information can help the occupational therapist formulate the strengths and needs when developing an intervention plan.

Assessment Tools

While unstructured observational assessments may be adequate and easy to carry out, there are several structured and standardized tools which can be used if more detailed information is required (see Table 15-1). Some use an observational or self-rating format, while

TABLE 15-1

Cognitive Assessment Tools Used by Occupational Therapists in Mental Health

Assessment	*Author*	*Use*
Allen Cognitive Level Screen (ACLS-5)	Allen et al. (2007)	Standardized task-based assessment of current cognitive functioning Six levels that indicate the impact of cognitive impairment across a range of functional activities Designed for an adult mental health population but expanded to include adolescents and people with neurological disabilities
Assessment of Motor and Process Skills (AMPS) (5th ed.)	Fisher (2003)	Observational assessment of motor and process skills in relation to daily activities Designed for age 2 years upwards and with more than 100 standardized tasks to select from Therapist must have undertaken specific training to administer this assessment

Continued on following page

TABLE 15-1

Cognitive Assessment Tools Used by Occupational Therapists in Mental Health (*Continued*)

Assessment	*Author*	*Use*
Canadian Occupational Performance Measure (COPM) (4th ed.)	Law et al. (2005)	Self- and therapist-rating using an individualized outcome measure Designed to detect change in an individual's self-perception of occupational performance over time Can be used with any individual with capacity to understand the scoring system
Canadian Model of Occupational Performance Measure and Engagement (CMOP-E)	Townsend et al. (2007)	As above, with the added perspective of occupational engagement
Model of Human Occupation Screening Tool (MOHOST) Version 2.0.	Parkinson et al. (2008)	Observational screening assessment that allows the therapist to gain an overview of the individual's occupational functioning No specific limitations related to diagnosis as it is a therapist observation assessment
Assessment of Communication and Interaction Skills (ACIS) Version 4.0.	Forsyth et al. (1998)	Formal observational assessment that provides a structured way to view communication and interaction to support the identification of strengths and habits that interfere with effective interaction No specific limitations related to diagnosis as it is a therapist observation assessment
Volitional Questionnaire (VQ) Version 4.1.	De las Heras et al. (2007)	Observational assessment of individual undertaking an occupational activity Indicating the impact of the individual's inner motives and the effect of the environment on performance and participation Designed for an adult population Paediatric version of the assessment is available
Occupational Performance History Interview (OPHI- II) Version 2.1.	Kielhofner et al. (2004)	Historical interview of life history, the impact of disability, and future direction Designed for an adult population
Occupational Self Assessment (OSA) Version 2.2.	Baron et al. (2006)	Self-assessment of performance and rating of the priorities of activities Designed for an adult population
Occupational Circumstances Assessment Interview and Rating Scale (OCAIRS) Version 4.0.	Forsyth et al. (2005)	A structured interview for gathering and reporting data on an individual's occupational participation Designed for adolescent and adult populations Specific interview formats available for both mental health and forensic mental health
Work Environment Impact Scale (WEIS) Version 2.0.	Moore-Corner et al. (1998)	A semi-structured interview and rating scale to gather data about the experience and perception of an individual in the work environment Designed for individuals in employment or who are reviewing employment opportunities

others include a standardized database to allow for results moderation. Occupational therapists also use explorative questioning to enhance the information available; often speaking (with consent) to family and carers, as well as the individual.

Application of the Occupational Therapy Process

Reasoning and Formulation

The occupational therapist first needs to establish the degree of an individual's cognitive impairment through an initial observation of their occupational performance. This may indicate the need for a more detailed standardized tool to be used in order to clarify which executive functions are affected and how this contributes to the performance deficit. The combination of initial observation and interview is likely to provide valuable information about an individual's deficits. The added dimension of self-assessment highlights personal priorities and previous/current meaningful occupations engaged in by the individual. This may lead to an assessment opportunity of an activity for gaining further performance feedback. A more detailed understanding of roles, relationships and interests further enhances the therapist's understanding of the life the individual has led prior to developing mental health problems, and which they may want to return to, assisting in the co-construction of goals and possible performance outcomes or measures also.

Making sense of the assessment data in order to formulate and set goals requires a clear understanding of the cognitive processes of a person without mental health difficulties, of a similar age, gender and culture. It requires an appreciation of the potential impact of the mental health problem and a sound understanding of the values of the individual and what constitutes meaningful occupation and core life roles for them.

Understanding the limitations of the tools being used is also essential, as this can present challenges to the therapist. For example, when using self-rating scales, the mood and mental state of the individual can contribute to inaccurate self-rating early on in the pathway. An individual experiencing low mood and a sense of worthlessness might self-rate harshly, whereas an individual who is elated may self-rate over-generously. Later in the intervention, when reassessed, the scoring may demonstrate inaccurate change due to the measures being incorrect at the start. For this reason, triangulation of self-assessment, observed performance and the gathering of historical information, should be used in formulation and review.

There is the option to introduce tools, including the Assessment of Motor and Process Skills (AMPS) (Fisher 2003). With its standardized database and assessor moderation, this tool can add value and assurance to the occupational therapy pathway. Becoming an AMPS assessor requires formal training to ensure assessor reliability and moderation. It therefore involves greater financial commitment than other tools. Furthermore, as the investment is tied to the individual rather than the service, this resource may be lost to a service if an AMPS-trained therapist moves on.

Using any manual-based tool requires the therapist to have a sound knowledge of the tool itself and of the evidence for its utility. The strengths and limitations of the more widely known tools can be appraised from the literature, and web-based technology provides the opportunity for therapists to interact with each other through forums and networks, making it possible to share insights and link in with research as it is being undertaken.

The occupational therapy process structures the phases of intervention. This includes the use of occupational therapy assessments, integration of assessment data with theoretical knowledge and other information to formulate the presenting problem, the establishment of the individual's priorities, goal-setting and intervention planning with the individual.

CASE STUDIES

The following three case studies illustrate the occupational therapy process and highlight the occupational therapy contribution to an overall care plan.

These cases demonstrate the application of the occupational therapy process in traditional healthcare settings, using the multidisciplinary Care Programme Approach (CPA) (DH 2008) as the care planning framework, thus enabling the cognitive approaches to dovetail with core occupational therapy principles, approaches and models.

CASE STUDY 15-1

Louise

Louise presented a few weeks after the birth of her first child with a diagnosis of postnatal depression. She was in her late 20s; a graduate with a successful career, sharing a home with her partner, the baby's father. The community mental health team were concerned about her rejection of the baby and withdrawal since the birth. The occupational therapist focused on getting to know Louise and carried out an initial assessment based on a Strengths Model (Rapp and Goscha 2006) followed by the Canadian Occupational Performance Measure (COPM-E) (Townsend et al. 2007), to identify performance problems and challenges within the domains of self-care, productivity and leisure. Louise rated the importance of each of these activities. The data showed that Louise was struggling to prioritize required activities, felt overwhelmed by the activities she felt required to undertake, and judged herself as a complete failure if she did not complete the tasks. Duties specifically relating to the baby were particularly problematic, indicating problems with the change of routine and lifestyle. Louise repeatedly stated that things were okay until the baby had arrived.

Following admission to hospital, observational assessment highlighted Louise's reluctance to play with the baby and her annoyance at the baby's demands. The team working with mother and baby were concerned that if her mood continued to decline and her bond with her baby was not established, there was a risk of her harming the baby – something she had previously voiced herself, though she did not think she would act on these urges.

The occupational therapist liaised with the cognitive behaviour therapist and psychiatrist to develop the case formulation. As a previously successful and independent woman, Louise had problems integrating her old roles with the new roles required to meet the needs of her baby. She had pre-conceived ideas of motherhood and childcare and her disappointment in not meeting these expectations reinforced her sense of failure. Occupational difficulties were related to a loss of work role and non-acceptance of her new maternal role, which meant little positive feedback for this role was forthcoming.

Louise's priority was to return home as soon as possible, as she worried about trying to explain a prolonged period of absence to her family and friends. The team's priority was to maintain the safety of Louise and the baby, to help stabilize Louise's mental state, and work on the relationships, while addressing her impaired cognitions around her judgements and feelings of failure. Developing positive experiences in order to support her adjustment to her new role of mother was imperative. Interventions from the team included antidepressants to stabilize her mood. Unfortunately, this meant Louise was not able to breast-feed, further challenging bonding and contributing to her feeling of failure. Individual sessions were commenced with the cognitive behaviour therapist, to explore judgements from childhood about being a success, such as those relating to her own expectations and measurement of success for a new task, her adjustment to new role requirements and changes in relationships and routine. Individual occupational therapy sessions had an occupational focus but also began to explore Louise's thinking patterns. AMPS assessments (Fisher 2003, 2006) were undertaken in three basic activities of daily living (ADL) tasks and identified no specific performance concerns. Through routine activity and the regular reviewing of her occupational performance, she began to see there was no evidence of her being a failure. The occupational therapist gradually introduced new activities starting with basic baby care and play sessions, balanced with activities directed at Louise's personal needs for her own time and relaxation. The sessions were short and task-focused, and over a period of weeks Louise slowly took over the care of the baby.

The skills being used in the hospital were transferred into the community through a graded community exposure programme, starting with a short walk in the garden, the wider grounds of the hospital, out into the local community and then to the local shops. A graded discharge home included short periods of time with staff support, then home with her partner and baby and eventually home just with the baby. Louise made a successful transition to home; weekly sessions with the cognitive behaviour

CASE STUDY 15-1 (*Continued*)

Louise

therapist continued for a further 4 months post-discharge to consolidate the generalization of skills into her day-to-day routine. The occupational therapist supported Louise in planning and structuring a meaningful day and to establishing links with her local community, including participating in a mothers and babies group. A repeat of the CMOP-E (Townsend et al. 2007) noted a significant improvement in the rating of competency in all areas of performance. Louise acknowledged that this was due largely to the associated judgements she held previously and the impact this had on her ability to perform essential activities. Pre- and postnatal sleep deprivation and hormonal changes had also impacted on her mood.

CASE STUDY 15-2

Josie

Josie was a 26-year-old woman with a diagnosis of borderline personality disorder (BPD). She had a long history of suicidal and self-harming behaviours and spent her early years in the state care system. Her behaviours impacted greatly on her schooling, which had been severely interrupted and she had never engaged in paid work. Josie had minimal contact with her brother and mother and no contact with her father or her step-father. Josie had been under the care of Child and Adolescent Mental Health Services since she was 14 years of age. She had many admissions to psychiatric intensive care units and prolonged inpatient stays. Following comprehensive diagnostic assessments and suitability for the treatment programme, she was finally admitted to a specialist inpatient unit offering DBT as the core psychological treatment.

Josie was assessed by the occupational therapist using both the occupational self-assessment (OSA) (Baron et al. 2006) and an Interest Checklist (Kielhofner 2008). She was allocated to the core occupational therapy sessions in the areas of activities of daily living, culinary skills, creativity and horticulture. The OSA allowed the occupational therapist to assess Josie's self-perception of strengths and needs. Understandably at this stage, there was recognition that her high emotional arousal could potentially distort her appraisal and it was immediately apparent that she had problems with overestimating her capabilities, while also having low expectations of herself. This led the occupational therapist to completing the MOHOST data sheet (single observation) (Parkinson et al. 2008) to score Josie in a variety of settings such as self-care, leisure sessions (such as craft and baking groups), to enable a more accurate assessment of her occupational performance. The occupational therapist had devised graded pathways (Lee et al. 2011), which incorporated the basic elements required for occupational balance (Creek 2003), while fitting with Kielhofner's (2008) assertion that human occupation involves three main areas of doing: activities of daily living, play and productivity. The timetabled sessions therefore, included: activities of daily living, vocational, culinary and horticultural pathways.

Josie's participation was observed to be restricted or inhibited by diminished motivation, specifically in terms of her appraisal of her ability and expectation of success. Josie required much encouragement to engage in sessions, as her concentration was also poor. Therefore, frequent short 10-minute sessions were facilitated to enable engagement in the programme. The occupational therapy programme was reviewed every 12 weeks, at which stage a full MOHOST was completed and changes in occupational participation identified. At the first 12-week review, there was minimal change in participation and Josie continued to fluctuate in mood and commitment to change. The occupational therapist maintained a consistent approach, informed Josie of the role and expectations of the occupational therapy programme and

Continued on following page

CASE STUDY 15-2 (*Continued*)

Josie

highlighted the importance of a structured routine and how her emotional dysregulation impacted on her occupational roles.

Over a 2-year period, Josie fluctuated in her presentation and commitment to change but gradually grasped the skills taught in DBT and how to generalize these skills to everyday situations, including all areas of occupational performance. Josie gained a clearer understanding of the nature of her problem and the impact on her occupational balance when she was emotionally dysregulated. She recognized the importance of attaining and then maintaining her habitual routines and roles, in order to maintain a life that was meaningful to her. The occupational therapy programme provided opportunities for her to gain both confidence and competence in many different environments and enabled her to learn how to structure her day with a balance of activities. While it was a slow process, the regular setting of goals in the short term linked to longer-term goals enabled Josie to make the transition from a low secure environment to a community placement.

CASE STUDY 15-3

Ted

Ted, a man in his early 20s, was admitted to hospital distressed by psychotic symptoms. He had no previous history of using local services, lived alone in a bedsit, and had moved to the area for work, with no family and few friends nearby. The occupational therapist met Ted on the day after his admission. The admission unit operated a core programme of activities including self-care, productivity and leisure (Reed and Sanderson 1999) aimed at early engagement with the occupational therapy team. The timetable was explained to Ted and he was encouraged to participate in these sessions.

Throughout this initial discussion, Ted appeared very distracted and suspicious of the occupational therapist and he did not engage in the programme initially. Using the MOHOST data sheet (single observation) (Parkinson et al. 2008) to provide a snapshot of Ted's participation in daily occupations, the occupational therapist gained initial information to later inform the full MOHOST. His morning routine was noted to be apparently chaotic, with the observation that Ted would return to bed and sleep in his clothes if left to his own devices. His eating pattern was erratic and he would secrete food to take back to his room. He participated in few activities, spending much of his time listening to music on headphones or sleeping in his room.

Ted was encouraged to complete an Interest Checklist (Kielhofner 2008) but declined and threw the assessment away. The MOHOST scoring identified restricted performance across all assessed areas, although the occupational therapist acknowledged his minimal engagement provided limited opportunity for assessment. Noting the lack of positive impact the admission was having on Ted, the team decided that once stable on medication, they would transfer him back to his home and try to help him establish meaningful routines in his life. Ted was introduced to an occupational therapist from the community team who over the next 2 weeks visited Ted in the inpatient unit. Ted was again encouraged to complete the Interest Checklist (Kielhofner 2008) and the Occupational Self Assessment (OSA) (Baron et al. 2006) but again declined.

Ted began to have short periods of escorted leave to his bedsit, where small tasks were undertaken, such as tidying up and sorting out bills. The bedsit was disorganized and the occupational therapist used the opportunities as they arose to assess Ted's capabilities as he prioritized tasks to be undertaken at home. The MOHOST identified Ted's performance to still be restricting or inhibiting, particularly in terms of patterns of occupation (roles and routines) and processing skills – such as problem-solving and organization.

CASE STUDY 15-3 (*Continued*)

Ted

Ted was discharged to his home, with the support of the community team. Interests in football and music were identified but limitations in daily living skills continued. Ted had not yet returned to work and he found structuring his day difficult. He was invited to join a men's group that focused on education about psychosis, skills for life and building a social network. Ted went once only. He rejected his diagnosis of schizophrenia and felt the group was irrelevant. At a 6-month follow-up, repeat of the MOHOST showed little change in Ted's performance.

Ted continued to struggle with routines and often missed appointments. Following assessment by the team's psychologist, Ted commenced CBT and they worked together to understand Ted's auditory hallucinations and his belief system. Combined with greater compliance with medication and acceptance of his diagnosis, Ted worked with the occupational therapist to establish and maintain a routine of daily activities, including self-care and incorporating structure to the day, with a balance of leisure and productivity. He returned to the men's group and started to contribute more. After 3 months in the men's group, he joined the football team and helped set up a weekly music group for community-based service users.

When a repeat MOHOST was undertaken some 9 months post-discharge, Ted was demonstrating significant improvements, particularly in his process skills. Ted was discharged from individual therapy after 6 months but remained a regular attendee of the men's group, supporting a number of newly diagnosed men through the early stages of acceptance.

DISCUSSION

Cognition-orientated practice highlights the need for integrated and extended roles. This can present challenges for occupational therapists in negotiating the boundaries between specialist and generic working. A number of occupational therapists complete post-graduate training in CBT and/or DBT and subsequently take on roles as both individual therapists and skills trainers. Difficulties can arise for occupational therapists (and other professionals) who try to maintain dual roles without first ensuring there are clear boundaries between post-registration specialism in CBT/DBT and occupational therapy that has a cognitive–behavioural orientation (Lee and Harris 2010).

This challenge is further compounded by the growing number of generic healthcare roles appearing in mental health services. For example, the Improving Access to Psychological Therapies (IAPT) programme in the UK, which aims to improve access to evidence-based talking therapies across the National Health Service (DH 2012), is greatly expanding the psychological therapy workforce. Interventions are approved by the National Institute for Health and Clinical Excellence (NICE) and are being delivered systematically by IAPT teams comprising practitioners with generic job titles, such as wellbeing workers and low/high-intensity workers, who have a range of professional backgrounds including occupational therapy. The current IAPT programme offers interventions to people with anxiety and depression, but this is expanding to include interventions across a number of new areas, including children and young people, people with severe mental health problems, and people with long-term conditions and/or complex needs (DH 2011, 2012).

While occupational therapists can be part of this evolving service, it should be noted that IAPT is a move away from the traditional role of occupation-focused practice to a more prescriptive form of psychological therapy:

> *It was created to offer patients a realistic and routine first-line treatment, combined where appropriate, with medication which traditionally had been the only treatment available*
>
> ***(DH 2012).***

SUMMARY

This chapter has provided an overview of the theoretical framework of CBT and its historical background and evidence base. It has also described the third wave of behavioural therapies, while highlighting both the opportunities and possible dilemmas of using CBT within occupational therapy. Cognition-orientated practice is open to occupational therapists who have been encouraged to identify different theoretical frameworks (Forsyth and Kielhofner 2006) and to integrate these as part of their interventions, while ensuring that there is a core occupation-focused conceptual model of practice.

Career progression within the field of cognition-orientated practice may involve post-graduate training in specialist areas including CBT, DBT and MSBR (as described earlier). The reader is encouraged to explore this further through related articles (see References) and also through accessing web-based resources provided by the UK's Department of Health and professional bodies.

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SERVICE USER COMMENTARY

Anticipating the job of providing a commentary on cognitive approaches used in occupational therapy, I was prepared for a chapter that explored only the role of cognitive behavioural therapy (CBT). Consequently, I was pleasantly surprised to find the inclusion of a range of cognitive approaches. Perhaps unusually for an occupational therapy text, the chapter begins with consideration of the effects of specific diagnoses on cognition. While this doesn't necessarily reflect occupational therapy's focus on people as 'occupational beings' (College of Occupational Therapists 2009, p. 1), it does provide a useful context and helps understanding.

This chapter highlights the theory behind, and application of, several cognitive approaches. It implicitly suggests their compatibility with occupational therapy values, as well as the role of activity within therapies, such as Dialectical Behavioural Therapy (DBT). As a service user, I felt the cohesion of the two approaches – DBT and occupational therapy – increased the efficacy of the interventions I engaged in. I was fortunate to have an occupational therapist as my DBT therapist and was aware of the focus on engaging in skills training around occupations that were meaningful, rather than contrived activities. On reflection, I also appreciate that occupational therapy skills of grading and adapting activities (Creek 2003), allowed me to participate in more challenging mindfulness exercises over time.

The challenge of merging occupational therapy approaches and specific cognitive therapies, despite considerable compatibility, is emphasized in this text. As a service user who received both DBT and occupational therapy interventions from the same therapist, I recognize this challenge. For example, initially the DBT interventions were so successful in considering my occupational needs that I felt unsure of any need for a separate occupational therapy intervention. However, on subsequent experience of such intervention, I realized there were areas of occupational therapy, such as goal-setting (particularly long-term goals), that are not sufficiently addressed by cognitive approaches. There appears to be very limited evidence available on the extent to which combining DBT with occupational therapy can support or limit recovery and I feel quite passionately that this is an important area for study.

As mentioned above, the start of the chapter considered groups of diagnoses, rather than individuals' needs or challenges. It is imperative that a person-centred approach is maintained and emphasized, and use of language can be very important in enabling this. As a service user, I feel uncomfortable reading that a person 'suffers from anxiety' or is a 'personality-disordered individual'. The semantics are important. I have been a person with borderline personality disorder and I have experienced depression. I was not defined by these diagnoses, nor was I a victim to them. Similarly, in the Case study of Josie, the extent to which Josie collaborated and influenced her interventions is not clear, especially when it is mentioned that she was 'allocated' to specific groups.

This chapter has highlighted a range of cognitive approaches and explored their compatibility with occupational therapy. It acknowledges the challenges of combining approaches that, while compatible in some respects, are clearly distinct. I would urge practitioners to engage with this challenge, not least to generate evidence and understanding as to the potential for occupational therapy to support cognitive approaches, and vice versa.

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16 CLIENT-CENTRED GROUPS

MARILYN B. COLE

CHAPTER CONTENTS

INTRODUCTION

Occupational therapists have conducted groups since the profession began. In many mental health settings, groups may be the standard form of intervention, not only for practical reasons, but also to maximize the therapeutic power of member interactions for social learning and emotional support. This chapter provides an overview of group leadership, dynamics and the design of occupational therapy group interventions in mental health practice. Additionally, it reviews and gives examples of current evidence of group effectiveness.

THEORIES SUPPORTING OCCUPATIONAL THERAPY GROUPS

Several recent theoretical developments help to validate occupational therapy's use of group interventions. First, the emergence of social identity theory affirms the importance of social learning in groups. Haslam et al. (2009) found 'a wealth of evidence demonstrating the positive impact of social connectedness on health and wellbeing' (p. 4). Additionally, complexity theory helps to explain the simultaneous levels of thinking therapists must master in order to design and lead effective groups, while client-centred principles shape the overall leadership approach of Cole's Seven Step structure.

The 'Social Cure'

Research on the impact of social identity (Haslam et al. 2009; Jettan et al. 2012) indicates that well-designed group interventions can have a powerful therapeutic effect on the physical and mental health of participants. Social identity is that part of self-identity that comes from one's membership and roles in a variety of social groups (Sani 2012). For example, nurses, bankers and teachers are social identities associated with work groups, while mothers, sons, homemakers and breadwinners are social identities associated with family groups. These examples might also be considered 'occupational roles', because they imply specific sets of tasks. How well we perform these tasks in our own and others' judgement has a significant impact on our self-worth.

However, social identity is not limited to social roles. People may consider themselves members of a minority group (African American), a nationality (Mexican), a religious group (Jewish) or a stigmatized group (disabled). St Clair and Clucas (2012) found that self-categorization within marginalized groups still offers a buffer against environmental threats, giving individuals a sense of having the social support of their peers.

For mental health service users, occupational therapy group leaders can build and support positive social identities of group members by incorporating client-centred principles such as inclusiveness, non-judgemental acceptance, respect and genuineness. Following the Seven Steps outlined in this chapter, will maximize the group's potential for interaction, self-disclosure, mutual support and an appreciation of the therapeutic value of occupation, to enable continued participation in the social groups that make-up the lives of members.

The Complex Nature of Groups

Group dynamics and occupational performance are complex phenomena. Put both together within a therapeutic group, and the number of interacting variables can be mind-boggling. Complexity theory bridges the gap between order (the scientific method, objective reality) and disorder (chaos theory, subjective realities). As applied to group dynamics, it acknowledges the existence of multiple factors influencing group behaviours and outcomes, some of which are, by definition, unpredictable. Yet, there are some theoretical principles that can be harnessed to increase the probability of positive outcomes; for example, Yalom's therapeutic factors of universality, altruism and cohesiveness (Yalom and Leszcz 2005) or Bandura's concept of self-efficacy (2004), reviewed later in this chapter.

Florence Clark (2010), used the metaphor of 'high definition occupational therapy: HD OT' (p. 848), to illustrate the complexity of occupational therapy practice. In a high-definition picture, we can zoom in for a better look at the detail of a person's face, the position of a tennis ball with respect to the foul line, or the number on a car licence plate, but then broaden the scope in order to take in the bigger picture, the multiple contexts within which the action takes place. Likewise, in complexity theory, scientific reductionism and complex holistic views can co-exist. For example, in applying theory, occupational therapists do not have to choose between a frame of reference, such as biomechanics (notably reductionist) and an occupation-based model, such as the Model of Human Occupation (Kielhofner 2008). Both views of the person are helpful in different ways, and one does not exclude the other. This theory helps to explain how an occupational therapy group leader considers each member individually, while simultaneously attending to the needs of the group as a whole.

Professional Reasoning in Groups

Acknowledging complexity paves the way to understanding the multiple levels of thinking that occur, often simultaneously, when facilitating an occupational

therapy group. Schell and Schell (2008) describe the following types of reasoning that therapists employ: (1) scientific; (2) narrative; (3) pragmatic; (4) ethical; (5) interactive; (6) diagnostic; (7) procedural and (8) conditional. It may be thought of as the therapeutic equivalent of multi-tasking, shifting attention from one level to another as needed, to address the real-time situations of an interacting, ongoing group. While this may seem impossible, expert clinicians do this multi-level thinking automatically.

For novice group leaders, much of this reasoning can be done at the planning stage. Cole's Seven Steps (described later) remind group planners to incorporate multiple levels of generalization, beginning with a concrete shared experience, and moving through discussions of feelings, responses to one another, possible cognitive meanings of their actions and interactions and the potential applications of the lessons learned for each individual in his or her own life.

When planning groups, it is first necessary to consider the typical challenges of a service user population and the published evidence about the effectiveness of certain interventions. Then, in matching the activity to the group members, they will analyse and grade the activity demands, and select an environment with appropriate characteristics. A frame of reference and/or occupation-based model of practice may guide the selection and adaptation of the group activity and environmental characteristics. These levels of thinking might be labelled diagnostic, procedural or scientific.

However, when therapists begin to interact with members of the group, they may need to alter their original group design. Each member has their own history and life story (narrative reasoning) and set of life circumstances. The mission, values and practical limitations of the setting will also need to be taken into account (conditional). Service users are likely to express their issues and concerns from a particular point of view, and often they will wish for an immediate solution to particular problems. These immediate issues must be addressed in order to promote members' interest in the activity and their engagement in the group process (pragmatic reasoning). The first thing a leader must do, is to establish a therapeutic group culture that includes respect, genuineness, open self-disclosure and non-judgemental acceptance (group values and ethics). Group leaders then engage in interactive reasoning and the therapeutic use of self in order to communicate empathy, encourage participation, facilitate interaction and otherwise assist members in developing trust in one another, and to move the group toward a state of cohesiveness; the ideal condition of all working groups.

Most mental health occupational therapists understand the efficacy of well-facilitated groups. Students, however, need to first practice group leadership by facilitating groups of their peers, so that the steps become second nature and their own personal style can develop.

WHAT ARE CLIENT-CENTRED GROUPS?

Regardless of health challenges or disabilities, most people seek to recover lost roles or develop new or adapted roles in society. Facilitating engagement in occupations can support service users' participation in desired social roles. When people understand the connection between occupational therapy group interventions and their own goals relative to social participation, their motivation to engage in group activities will usually increase (Cole and Donohue 2011). This connection is central to the client-centred focus of groups in occupational therapy.

An Overview of Client-Centred Principles and Updates

Client-centred groups follow the principles of client-centred practice originally defined by Carl Rogers (1961), such as non-judgemental acceptance (empathy for people with diverse viewpoints), conveying genuineness and respect (recognizing individuals' inherent expertise and ability to problem-solve) and client directedness (enabling service users to choose the direction of therapy). Sumsion and Law (2006) updated the evidence for central concepts of client-centred practice, such as power sharing, communication, choice and hope, as evolving principles of client-centred practice.

Creek (2003, p. 50) defined client-centred practice as 'a partnership between therapist and client in which the client … actively participates in negotiating goals for intervention and making decisions [while] the therapist adapts the intervention to meet client needs'.

When group members collaborate with the occupational therapy leader in setting goals and priorities, the client-centred therapeutic partnership is extended to the group as a whole.

Based on occupational therapy's appreciation of the environment as a context for performance, therapeutic groups provide a supportive social and cultural context within which people can experiment with new behaviours and learn to interact more effectively with others.

COLE'S SEVEN STEPS

For the new practitioner, Cole's Seven Steps establish the basics of therapeutic group facilitation and this prototype can then be adapted as the therapist integrates further knowledge of various health problems, models of practice and frames of reference, levels of human development (age groups) and health or social care delivery settings. These seven steps address the full range of needs, including those of highly functional group members, and, as such, are appropriate for students to practice with their peers also.

Step 1: Introduction

The session begins with stating one's name, the name of the group and one's role as the group leader. To assist the group members in learning one another's names, in addition to *stating names* around the circle, members can tell the group something else about themselves that is unique, such as where they are from, what most concerns them about the group, even something as simple as their favourite colour. What is shared should match service user factors such as cognitive level, disability and age. Names should be repeated at the beginning of each session, not only as an introduction but as a way to acknowledge the importance of each member's presence, a gesture which builds self-identity and encourages participation.

For many groups, a *warm-up activity* – of 5 minutes or less – is highly recommended. It can capture group members' attention (diverting them from whatever they came to the group thinking about) and prepare them for the activity to come. For example, members may choose picture cards with different facial expressions to express their mood as a warm-up for a group role play to promote self-expression. A warm-up can energize or calm. For example, a series of stretches may wake up an early morning group, while a short relaxation exercise might counteract agitation. Warm-ups may be formal or informal. When members know each other well, an informal chat about 'how they are feeling today', may suffice.

Setting the mood is another function of the introduction. The group leader conveys this through facial expression, body language and tone of voice, as well as with words. The mood of the group should match the goals and content. If the activity of the day is lighthearted, the introduction can be upbeat (with humour, smiles and a playful exercise perhaps), while a more serious tone may be needed for topics, such as work readiness or coping with loss.

Explaining the purpose clearly is vital to any introduction. It should occur after the initial greetings and warm-up, when members are alert and ready to listen. The goals and methods, and how the selected activity addresses the goals of members, should be clarified using everyday language. When people understand why they are being asked to take part in a group activity, they will actively participate more readily.

In groups which focus on learning, sometimes *introductory educational concepts* are outlined. For example, a cultural awareness group may begin with a definition of culture and some exploration of group members' perceptions of different aspects of culture. When member discussion is included, this may replace the warm-up, since it serves a similar purpose.

The final component of the introduction is a *brief outline of the session*. For example, saying 'we will be drawing for 15 minutes, then for the next 30 minutes we will share our drawings and discuss their meaning with the group'. This serves several purposes. First, the time limit gives group members a guideline for how detailed and complex their drawings should be. Second, it tells them that what they draw will be discussed openly with the group so they can decide to limit the content of their drawings to things they are willing to share. Third, it highlights that the emphasis of the group will be on discussion, not drawing, so they need not worry about their artistic ability. The point of the drawing is to clarify some aspect of the self and to communicate its meaning through discussion.

Research has shown that the initial guidelines, including purpose and structure set forth in the first

meeting, have a lasting influence on subsequent sessions (Gersick 2003).

Step 2: Activity

The activity provides the means or method for accomplishing group goals. In our prototype, this portion of the group lasts from 10 to 20 minutes and must generate enough raw material to sustain a meaningful discussion for the next 30–40 minutes. Activity selection is a complex process, based on the therapist's knowledge of theory and research, activity demands, service user factors and health conditions. A simplified method of selection will be outlined here, with the expectation that the novice group leader will refine it, as knowledge and experience increase. This selection process includes activity analysis and synthesis, consideration of timing, goals, the physical and mental capacities of members and the skill of the leader.

Most activities will need to be adapted for use with groups. This is accomplished through activity analysis and synthesis. *Activity analysis* is 'a process of dissecting an activity into its component parts and task sequence in order to identify its inherent properties and the skills required for its performance, thus allowing the therapist to evaluate its therapeutic potential' (Creek 2003, p. 49). *Activity synthesis* is 'combining activity components and features of the environment to produce a new activity that will enable performance to be assessed or achieve a desired therapeutic outcome' (Creek 2003, p. 50). The outcome of this complex matching process between member abilities, skills and preferences and the components of an activity determines the group activity selection.

The *timing* of groups informs the choice of activity. Most group sessions last from 30–90 minutes, with an average of about an hour. If discussion is emphasized, the activity itself should take no more than one-third of the total session time. In addition, members of the group need to be able to work on the activity simultaneously within the same environment.

Therapeutic *goals* will guide the selection of activities. In client-centred practice, service users' goals are prioritized, and group leaders aim to form groups of people who have similar goals and priorities. Ideally, therapists should hold a group discussion of goals and priorities, as well as activity preferences before finalizing the group design. However, not all participants are capable of this level of collaboration. In such cases, the occupational therapy leader relies on pre-group interviews with individual members, carers and/or significant others, to identify potential group member goals and priorities.

The *physical and mental capacities of members* will be a primary consideration in selecting any activity and formal or informal assessment of service users' occupational performance should inform group member selection. Interventions work best with groups of people having similar functional abilities. For example, Claudia Allen (Allen 1999, Allen et al. 1992) defined six cognitive levels and 52 modes of performance, giving occupational therapy one of its most well-researched and detailed set of assessments of cognitive ability. Each level (especially 2–5) defines guidelines for task selection, analysis and adaptation, cueing (assisting) during task performance, and adapting the environment to enable people's best ability to function. Allen suggested grouping people of similar Allen Cognitive Level.

The group leader also considers their *own experience* and selects group activities based on familiarity, comfort level and past effectiveness.

Step 3: Sharing

The activity should have a definite end. At that point, materials used during the activity are removed from view and the product is shared. The group leader may model sharing with their own example (such as drawing or writing) or may ask for a volunteer to start. The best way to make sure everyone gets a turn is to proceed around the circle, a norm which becomes automatic after the first few sessions. For activities which include group discussion as a common component, the sharing step is unnecessary.

Step 4: Processing

This addresses the questions: 'How did you feel about the activity, the leader, and each other?' Feelings are discussed first in order to prevent them from interfering with subsequent discussion. The group leader generates the discussion by asking open-ended questions, which require some elaboration. For example, asking 'What was hard about communicating non-verbally?' enables member expression of feelings of frustration, inadequacy or objection to the activity requirements.

'Whose drawing most relates to you?' encourages group interaction and emotional feedback responses.

Step 5: Generalizing

This addresses the question: 'What did you learn?' Abstract reasoning is needed to derive a few general principles from the data of the group activity. Again, group leaders facilitate generalizing by asking open-ended questions, such as 'What were some common triggers of stress we shared?' or 'Which coping strategies are good or bad?' Ideally, the general principles discovered by the group will closely align with group goals.

Step 6: Application

For learning to be effective, service users need to understand how the principles learned apply to their own lives. The group leader asks questions that facilitate this connection such as, 'What part of today's activity will you take home with you?' or 'How can you use social skills in your life outside of the group?' Each group member interprets the group experience in their own way. The application step offers each person the opportunity to verbalize the meaning of the group experience with respect to individual goals. Therefore, group leaders must ensure every member contributes to the discussion about applications and, if possible, gives a specific example. Assigning homework or keeping journals can reinforce the application of learning outside the group.

Step 7: Summary

A summary of the session reviews the highlights from each of the seven steps and reinforces the main principles learned. Preferably members should help summarize. Group leaders end by thanking members for participating and by sharing their own positive feedback on the group experience. Plans for the next session and reminders for application can be added as a final note.

PRINCIPLES OF GROUP LEADERSHIP

Group leadership is generally regarded as a formal position that carries with it certain responsibilities – such as selecting members, setting goals, designing the group methods and structure, and providing guidance during the sessions. Leadership has been defined as 'the process of influencing group activities toward goal achievement' (Shaw 1981, p. 317). A half century of research has concluded that there is no single preferred style of small group leadership. The consensus is that optimal leadership changes to meet varying needs and circumstances (Hersey and Blanchard 1969; Mosey 1986; Barge and Keyton 1994; Gouran 2003).

Mosey (1986) suggested a multilevel approach to the leadership of occupational therapy groups. She defined five developmental levels for assisting people in learning group interaction skills (see Table 16-1). Mosey's groups recapitulate (repeat) the normal sequence in which children learn to interact in groups. More recently, Donohue (2007, 2011, 2013) has validated Mosey's developmental group theory using structured observation with children's groups and mental health groups.

Three Styles of Occupational Therapy Group Leadership

Occupational therapy group leadership may best be understood as existing on a continuum that encompasses directive, facilitative and advisory styles. One is not better than the others, but rather each is preferred in different situations. Choice of style is informed by factors such as participants' abilities and maturity, goals of the task and theoretical approach (see Table 16-2).

Directive leadership exerts the most influence over the group. It is the best choice for people functioning at a low cognitive level or lacking motivation, and for addressing goals that require education, learning and the practice of skills. Groups using a sensory integrative model require directive leadership in continually grading and adapting the activity according to member responses throughout the session. The term *directive* should not be confused with authoritative or autocratic. Directive leadership should be used when client groups require considerable direction in order to benefit from the group activity.

Facilitative leadership is sometimes compared with a democratic approach, and as such, may be the most familiar to occupational therapists. The term *facilitation* means 'to make easier'. Group leaders use a variety of techniques to enable group participation, encourage communication and self-disclosure and to reinforce problem-solving and social learning during

TABLE 16-1

Mosey's Developmental Group Leadership

Group Level	Occupational Therapy Leader Role	Activity Examples
Parallel (directive leadership)	Providing task, structure and emotional/social support for members	Imitative group exercises, painting or other creative tasks, simple crafts
Project/Associative (modified directive leadership)	Providing some choices of task, encouraging member interaction around task issues and awareness of others. The leader continues to provide support	Structured learning groups, Allen's Level 3–4 craft groups
Egocentric – Cooperative (facilitative leadership)	Members choose the task. The therapist facilitates interaction and assists members in meeting social and emotional needs	Task-oriented groups, insight-oriented verbal groups, self-exploration and communication-focused groups
Cooperative (advisory leadership)	Relationships and socialization take precedence over task accomplishment Members provide social/emotional support for each other The therapist acts as advisor, provides resources as needed and assists with problem-solving or conflict resolution	Playing beach volleyball, having a birthday party Group outings
Mature (participatory leadership)	Members lead. The therapist participates as an equal co-member, using modelling, therapeutic self-disclosure and social learning to influence outcomes	Fund-raising events Self-help groups

TABLE 16-2

Occupational Therapy Leadership Continuum

Factors Influencing Leadership Style	Directive Leadership	Facilitative Leadership	Advisory Leadership
Power factors (extent of control over the group and its members)	Greatest influence. Providing structure, task and support	Medium influence. Encouraging group participation in decisions and support for each other	Least influence. Intervening as needed only
Group maturity	Low. Little connection between members	Medium. Interrelationships are inconsistent	Highly cohesive
Service user factors (mental and physical abilities)	Low cognitive level. Psychological issues create barriers to group interaction	Medium cognitive level. Capable of some reasoning and insight	High cognitive level. Highly motivated
Task factors	Productivity-oriented, non-verbal interaction, psycho-educational goals	Learning-oriented, self-awareness- or insight-oriented	Socialization-oriented, problem-oriented
Theoretical factors	Sensory motor and cognitive disability approaches	Psychodynamic and cognitive behavioural approaches	Developmental and systems-oriented approaches
Group focus	Task achievement skill training	Interpersonal learning, communication or relationship goals	Problem-solving, wellness or prevention goals

group sessions. Facilitation is the preferred style when group members have the capacity for reasoning and when the goal is to develop self-awareness and insight. Sometimes facilitation involves shared leadership, allowing group members to take on leadership responsibilities. Shiminoff and Jenkins (2003) have called this a *group-centred approach* to leadership.

Advisory leadership exerts the least amount of authority over the group and is reserved for mature and highly motivated groups where participants can structure and organize the group for themselves. An advisor intervenes only when members run into difficulty in solving a problem, require additional resources or expertise, or need assistance with conflict resolution. Advisory leadership is appropriately used in a consulting role when working with community groups.

Group Leadership Skills

Group leaders use several techniques for *facilitating interaction* among members, as this is desirable in most groups. When the group begins, members tend to look to the leader for direction, and care must be taken not to set up a pattern of communicating only through the leader. When asked a direct question, the leader can defer to another member, asking 'What do you think?' or 'What would you do in Mary's situation?' Observing who responds most often, the group leader looks for ways to involve less verbal members and to make sure all have an equal opportunity to participate. Silence may raise anxiety levels in some members, but jumping into every silent moment should be discouraged. Sometimes, silence allows members to think about the topic being discussed and to formulate their own contribution. When asking a discussion question, be sure that several, if not all, members have an opportunity to answer before moving on. Never assume that one or two members speak for the group as a whole. Only when every member has contributed can a true consensus on any issue be reached.

When members deviate from the group task or goal, the group leader needs to redirect them. In therapy groups, various techniques are used for *setting limits* on inappropriate behaviours that interfere with successful group outcomes. This is best accomplished using the least possible amount of authority. For example, when one member monopolizes the group, the group leader can interrupt by asking the other members, 'How does it make you feel when John does all the talking?' This invites the group members to share the responsibility for setting limits. A good rule of thumb is to never do for the group what the members can do for themselves.

Communicating empathy is one of the best ways to build trust among members; a necessary step in developing group cohesiveness. Empathy is an understanding of each participant's emotions and unique point of view. The group leader needs a broad feeling vocabulary to convey an accurate understanding of how people might feel about themselves, the task, or each other during the session. For example, 'You must be terrified of crowds if you're going to so much trouble to avoid them' might be an empathic response to someone who has shared an episode of agoraphobia. Such statements serve a number of purposes. First, they acknowledge the service user's feeling with non-judgemental acceptance, encouraging them to further self-disclosure. Second, they give other members permission to freely verbalize their own emotions. Third, they model for the group an empathic way to respond to one another.

In summary, according to Barge (2003, p. 200), 'effective leaders are complex information processors who are sensitive to the subtle qualities of individuals and the group environment'. Group leaders should remain flexible and adjust their style according to the group's level of development, members' psychological or cognitive maturity, the theoretical approach being used and the goal of the group activity.

UNDERSTANDING GROUP DYNAMICS

Groups are a good example of complex systems. Whiteford et al. (2005) describe complexity as 'the richness and variety of structure and behavior that arises from interactions between components of a system' (p. 5). The complex interplay of group interactions with contextual factors can render group outcomes unpredictable. The application of occupational therapy models of practice can help define the transactions between service users and environmental factors, thereby increasing the odds of positive group outcomes (Cole and Tufano 2008). In current practice, it is not uncommon to combine such models with particular frames of reference, such as sensory integration (Ayres 1979) or cognitive disabilities (Allen 1999, Allen et al. 1992),

when designing group interventions for specific populations (Cole 2012). Experienced group leaders learn to combine theoretical evidence with the unfolding narratives of members and situations in order to provide relevant group experiences.

Group Dynamics Defined

Finlay (2002) defined group dynamics as the 'forces, social structures, behaviours, relationships and processes which occur in groups' (Finlay 2002, p. 256). Researchers in many disciplines have studied group dynamics for nearly a century. This section reviews some of the highlights.

Yalom's (Yalom and Leszcz 2005) therapeutic factors offer insight into the healing power of groups (see Table 16-3). They were derived from the summarizing of many research studies over several decades. Falk-Kessler et al. (1991) found that group cohesiveness, hope and interpersonal learning, were most highly valued within occupational therapy groups.

Group Process

Group process may be best understood by what it is not. It is not content. Content includes what is said and done by the group members. Process refers to social structures, symbolic meanings, transference and countertransference, communication patterns, nonverbal communication and emotional responses that often lie beneath one's conscious awareness. Yalom and Leszcz (2005) described group process as a focus on reflection about the interrelationships of members in the 'here and now,' that is, during the session itself. They described a *self-reflective loop* with both an *experiencing* and a *reflecting* component. In simple terms, the group participates in a shared experience, and then reflects upon its meaning through group discussion.

TABLE 16-3

Irvin Yalom's Therapeutic Factors of Groups

Therapeutic Factor	Brief Interpretation for Occupational Therapy Groups
Instillation of hope	Even in anticipation of group membership, clients are inclined to believe that change is possible through the group experience
Universality	Through group sharing and interaction, members learn, often with great relief, that they are not alone
Altruism	With coaching and modeling members become aware that they have much to offer each other, and that offering help to others can benefit themselves as well
Imparting information	Groups offer a practical means of educating those with similar issues, but often the most useful information comes from the group members sharing advice, ideas and solutions
Corrective recapitulation of the primary family group	Maladaptive learning from one's own imperfect family can be openly explored and modified within an emotionally safe group environment, and through altered perceptions of reality
Development of socializing techniques	According to Bandura's (1977) social learning theory, people learn appropriate social behaviours through observation of others. Groups offer multiple opportunities to do this
Imitative behaviour	When group members observe that certain behaviours have positive consequences for others, they tend to imitate those behaviours
Interpersonal learning	Groups offer multiple opportunities for giving and receiving feedback from others. Through feedback, members develop a more accurate self-perception and reality-orientation
Group cohesiveness	Cohesiveness is a preferred state in which the group members accept and support one another and freely self-disclose
Catharsis	Emotional expression of previously hidden emotionally charged issues or experiences can have a healing effect
Existential factors	Many spiritual concerns, such as the meaning of one's life, the acceptance of anxiety as a part of living and an awareness of one's own mortality can be clarified through group interaction

Yalom and Leszcz 2005.

Cole's Seven Steps incorporate this concept using short structured tasks upon which to reflect through analysis of processing (feelings), generalizing (thoughts/ideas) and application (behaviours). Through the analysing process, group members may develop an awareness of how their own behaviours affect others and what must be changed in order to engage in meaningful relationships with other people.

Because of the subtle, yet complex qualities of group process, group leaders become skilled at observing and facilitating process only through experience. Consequently, supervision is necessary for students to become fully aware of these very powerful but often invisible forces within their groups.

Group Culture (Norms)

Group norms are customary ways of doing things within the group sessions, currently known as group culture (Yalom and Leszcz 2005). Explicit norms (or rules) are verbalized by the group leader at the outset, such as the venue and timings, the expectation for participation, and the importance of confidentiality and mutual respect. Non-explicit norms are not verbalized, but assumed. For example, social conventions, such as 'If you don't have something good to say, don't say anything', may incline members to avoid conflict, resulting in the censorship of negative emotions or responses. Therapists should discourage social norms which inhibit the free expression of emotion, while preserving a culture of respect and genuineness. Group leaders sometimes need to model the constructive expression of negative emotions or feedback. For example, 'Sometimes you come across as rude' can be stated more positively as 'when you use sarcasm it makes me (or others) feel defensive and I'm not sure that's the response you were looking for'. It is suggested that students practise doing this with each other before attempting to model it for service users.

Norms can be therapeutic or non-therapeutic. Group members speaking only to the leader, and not to each other, is a non-therapeutic norm. Once set, group cultural norms can be very persistent. Therefore, group leaders should never hesitate to redirect the group at the first sign of trouble. Therapeutic norms lead the group toward a state of cohesiveness, while non-therapeutic norms create barriers to group development. See Table 16-4 for some examples of therapeutic norms.

TABLE 16-4

Therapeutic Norms of Occupational Therapy Groups

Group Norm	Occupational Therapy Example
Open self-disclosure	Sharing personal drawings with the group, including both positive and negative aspects of self-identity
Group interaction	Members ask each other questions about their drawings and offer empathy responses
Focus on process	Open discussion of feeling responses to the task after sharing, including what was hardest and easiest and why
Giving feedback to others	Members discuss what they like and do not like about each other's behaviour, stating dislikes constructively
Receiving feedback thoughtfully	Therapist uses empathy to help members explore both positive and negative responses to feedback
Verbalize concrete application of group learning for each member	Members use an 'ideal person' drawing to define qualities they admire in a friend. They agree that each will identify, and have a conversation with, one such friend during the coming week

Group Roles

Roles in groups may be assigned or voluntary. In health and/or social care teams, for example, managers supervise staff according to a predetermined organizational structure, with each role (or job description) specifically defined – such as doctors, nurses, social workers and occupational therapists. In the classic study by Benne and Sheats (1948), three types of non-explicit or voluntary roles were identified: task roles, group maintenance roles and individual roles. Task roles include initiator, information/opinion seeker and giver, elaborator, coordinator, orienter, evaluator critic, energizer, recorder and procedural technician. These roles help the group to accomplish the task. Group maintenance roles influence the relationships among members: encourager, harmonizer, compromiser, gate keeper/expediter, standard setter, group (process) observer and commentator and follower. Members of a mature group voluntarily take on a variety of roles; or put another way, a member's comfort with a variety of roles is regarded as a sign of maturity. Group roles may

be understood as a form of shared leadership. When members take on task and maintenance roles, they can accomplish the group's goal with minimal intervention from the leader (advisory leadership). When members are unable or unwilling to play these roles, the leader steps in (directive leadership). Facilitative leadership falls somewhere in between these two opposites, as the group leader enables members to take on some roles while retaining others, in the group's best interests.

Problem Behaviours of Members

The individual roles defined by Benne and Sheats (1948, 1978) tend to interfere with group functioning and integrity, and thus may be seen as *problem group behaviours*. Attention-seeking roles such as dominator, aggressor, recognition seeker, special interest pleader and self-confessor, will divert the group to irrelevant issues unless redirected by the leader.

Empathy and group member involvement are possible strategies for meeting the member's need for attention or recognition, while allowing member feedback to expose the effect of their individually centred behaviours. Likewise, the blocker, help-seeker and playboy use self-centred behaviours, which meet their own emotional needs at the expense of the group. Blockers are often silent or stubbornly resistant to open self-disclosure, eventually causing other members to feel judged or criticized. Help seekers actively seek help but reject it, angering advice-giving members. Playboys remain cynical and uninvolved, also provoking resentment among members. These difficult behaviours must be dealt with effectively by the occupational therapy leader in order to preserve the group's integrity. When one member's behaviour continues to block the group's development, that member should be removed from the group and treated individually. The group leader should never sacrifice the group's wellbeing because of one member.

Group Development

Theories of group development have changed dramatically over time. Until the mid-1980s, there was relative agreement that all groups evolved through predictable stages of development. Phase theorists, such as Tuckman (1965), Bion (1961), Schutz (1958) and Yalom (1985), all defined an initial phase marked by a dependence on the leader and a search for structure and purpose. Subsequently, the group encountered a conflict phase, during which the leader, the task and/or the group structure was challenged. All theorists concurred that conflict must be resolved in order for the group to reach cohesiveness. Yalom and Leszcz (2005), later redefined the final two stages, suggesting that groups tend to embrace a new-found harmony, following resolution of the conflict, during which members avoid the expression of negative affect. Continued growth involves the free expression of both positive and negative emotions, moving the group toward cohesive maturity, the final and ideal group stage. Yalom continues to defend this model, explaining deviations as the 'revisiting' of issues from earlier stages.

Tuckman's (1965) model has also undergone revision as currently applied with work teams in business, also known as *team development*. A new final stage, entitled 'reforming', includes a team self-assessment after each work task ends, so that group members can improve the process of working together in future tasks. Table 16-5 summarizes both traditional and current models of group development.

Poole's Multiple Sequence Model

Poole (2003) challenged the validity of previous group development phase theory, focusing on decision-making in work groups. Central to Poole's developmental theory is the concept of *breakpoints*; points of change or transition. Poole (2003) acknowledged three types: normal (changes in discussion topic, different parts of the task), delays (setbacks due to emerging problems, group problem-solving) and disruptions (major conflicts, major changes required for the group to proceed). Poole suggested that no distinct phases occur in all groups, but that different tasks, goals and group member characteristics produce unique patterns of content and process.

Gersick's Time and Transition Model

Gersick (2003) studied eight diverse work teams to discover how their function changed over time. She changed the focus of group development, from one of typical behaviours to one which attempts to explain the mechanisms of change, considering both internal and environmental contingencies. The first half of the group's calendar time is an inertial movement, the direction of which is set during the first meeting. This places great

TABLE 16-5

Summary of Traditional and Current Group Development Models

Theorist	Year	Beginning of the Group				End of the Group
Bion	1961	Flight		Fight		Unite
Schutz	1958	Inclusion		Control		Affection
Tuckman & Jensen	1977	Forming	Storming	Norming	Performing	Reforming
Yalom	1985	Orientation		Conflict	Cohesiveness	Maturity
Poole	1983	Multiple sequences, cycles, and breakpoints, multiple activity tracks				
Gersick	1984	First meeting	Phase 1	Midpoint transition	Phase 2	Conclusion

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importance on the initial meeting at a time when the group's culture may be easily shaped. Groups undergo a *midpoint transition,* during which the direction of the group is revised. The group acknowledges earlier problems and faces the reality of limited time left to complete its task. The ideal outcome gives way to a more realistic one, and both content and process adapt to accommodate this altered goal. Progress may spurt ahead in order to reach a markedly accelerated conclusion.

The *influence of context* on groups, not addressed by phase theorists, is significant in Gersick's model. Context impacts on the group's development at three critical periods: (1) design of the group; (2) the first meeting and (3) the midpoint transition. In client-centred occupational therapy groups, when members take on more leadership responsibility, we are more likely to see the kind of dynamics reported in Gersick's study. Group leaders should acknowledge the importance of initial planning and of establishing therapeutic norms assertively during the first meeting. With today's economic pressures in health care, more therapeutic groups will be time limited. Subsequently, occupational therapy group leaders should anticipate the midpoint transition and use it as an opportunity to redirect and refine goals, correct non-therapeutic norms and provide needed resources to increase the likelihood of a positive outcome.

Ending Groups Therapeutically

Separation issues affect groups which have met over a period of time, and need to be considered as the end approaches. Just as in life, when relationships end, some people are better at letting go and moving on, than others. Group leaders need to be aware of both positive and negative coping. In an ongoing group of six or more sessions, *preparation* should begin 2 weeks ahead, with comments or questions during the session summary. This gives group members time to think about what needs to be done prior to the group's ending. *Unfinished business* from prior groups, such as inter-member conflict, should be revisited and openly discussed. Sometimes members withdraw emotionally from the group causing a regression in development and a devaluation of the group's benefits. When the group leader encourages *open expression of feelings* the value of the group is preserved. Reviewing the group's activities from the beginning can help the group to *summarize* what was learned. Finally, the occupational therapy group leader shares his or her own perspective, *reinforcing positive outcomes*. For those members who typically cope negatively with loss (anger, depression, withdrawal, re-emergence of symptoms), a positive group termination provides a model for future endings in life.

DESIGNING GROUP INTERVENTIONS

The importance of careful planning cannot be overemphasized. The written group plan, or *group protocol*, serves as a guide for group sessions and may also be used as a marketing tool. This section reviews the steps in designing a group protocol: needs assessment, member selection, group goal-setting, choosing a frame of

reference, logistics (group size, time, setting), session outlines, supplies and cost and outcome criteria.

Needs Assessment, Focus Groups

An occupational therapy needs assessment can be made using clinical case notes and meetings, referral sources, significant others (such as carers) and the service users themselves (through surveys or interviews). Focus groups, comprising representatives of the target population or others knowledgeable about them, employ group process in assessing the needs and priorities of potential group members (Cole 2012). In client-centred practice, the participants' collective occupational priorities form the basis for defining group goals.

Member Selection

Therapists select group members with common abilities and/or challenges. The purpose of group membership should be discussed with each client prior to the initial session. Designing a written group protocol can guide member selection by outlining the inclusion and exclusion criteria for membership.

Group Goal-Setting

Goal-setting is ideally accomplished in an initial group meeting with potential members. Collective goals are summarized as the basis for group design and will guide the selection of appropriate activities. Themes are combined with occupational therapy modalities in creating titles for occupational therapy groups, for example, 'Art for Social Skills,' 'Mental Gymnastics for Work Readiness' or 'Movement for Health'. Each title includes both goals and methods in a different occupational therapy frame of reference. The group protocol should include a list of at least five therapeutic goals with a rationale for each.

Theory-Based Groups

Selecting the occupational therapy models of practice and frames of reference that best address the therapeutic goals and problem areas of group members is integral to therapists' professional reasoning. Within the group protocol, the model and/or frame of reference should be identified and briefly justified for use with the specific populations and goals already described. For example, the *psychodynamic* frame of reference offers guidelines for the application of creative media with goals involving self-awareness, insight or reality orientation, effective expression or control of emotion and developing the skills for maintaining satisfying relationships with others. A group entitled 'Art for Social Skills' suggests using painting, drawing or sculpture to raise member self-awareness as a basis for forming trusting relationships with others.

'Mental Gymnastics for Work Readiness,' suggests the use of *cognitive-behavioural* exercises to build work skills. The cognitive-behavioural frame of reference suits goals which involve learning or the practice of skills. In this group example, communication/memory games or problem-solving tasks might be used with individuals who wish to find, or return to, work. The psycho-educational group uses cognitive behavioural strategies when working with goals like stress management, assertiveness, time management and the modulation of maladaptive occupational patterns such as compulsions or addictions.

'Movement for Health' applies *sensory motor* principles such as biomechanics or sensory integration in designing movement activities for groups. Depending on the importance of repetition and skilled movement, the activity portion of the group may be extended to two-thirds, and discussion time diminished to one-third or less if participants have a limited capacity to verbalize.

Ross's Five Stage Groups (1997, 2004) use the principles of sensory integration with a structure similar to Cole's Seven Steps, emphasizing non-verbal communication. Ross's groups work on goals such as increasing attention and alertness for people with minimal cognitive functioning. Bracegirdle (2002) described the advantages of various modes of physical exercise for mental health service users, such as sports, yoga and relaxation, most of which lend themselves easily to mind–brain–body connection goals in groups. However, the creative use of movement, such as in dance therapy, might better be understood using a psychodynamic frame of reference.

Group Logistics: Size, Timing and Setting

While the group leader may create a smaller group when more therapist assistance is anticipated, most therapeutic groups should not exceed eight members (Yalom and Leszcz 2005). Research on teams in the business sector confirms a similar size, recommending that managers 'avoid double digits … build teams of

no more than nine people' (Coutu 2011). It is interesting to note the similarities between groups in therapy and teams in corporations. Both do their best work when they 'work through their individual, functional, and hierarchical differences toward a common plan' (Katzenbach and Smith 2011). The *Harvard Business Review* defines a team as: 'a small number of people with complementary skills who are committed to a common purpose, set of performance goals, and approach for which they hold themselves accountable' (Katzenbach and Smith 2011, p. 17).

Meeting times for most group sessions is about an hour, although this changes with the activity selected and the attention span of members. The time and place for a group to meet may depend on contextual factors, such as the availability of equipment, the need for privacy and freedom from distractions or community-embeddedness.

Session Outlines

Outlines for each session should follow the format in Table 16-6. Activity descriptions should be clear and detailed enough for another occupational therapist to follow and lead the group as you intended. At least three open-ended discussion questions should be included for Steps 4–6 (see Cole's Seven Steps). Points for summary should be anticipated, even though they will change as the actual session unfolds. Planning at least six sessions is suggested when writing a group protocol.

TABLE 16-6

Group Session Outline Using Cole's Seven Steps

Title of group (overall theme)
Title of session (today's activity)
Number in sequence (e.g. Session 3 of 8 total)
Goals addressed
Timeframe (e.g. warm up – 5 min, activity – 15 min, etc.)
Supplies (list and include number needed)
Description
Warm-up
Activity instructions
Processing questions (at least 3 open questions)
Generalizing questions (at least 3 open questions)
Application questions (at least 3 open questions)
Points for summary

Supplies and Cost

Supplies and costs can be estimated from the session outlines. This information will be needed for marketing the group to service managers and/or community partners. Cost will depend upon the number of members, the average cost of items needed, and what resources might be available free of charge.

Outcome Criteria

Occupational therapists use outcome criteria to validate the effectiveness of group interventions by measuring goal achievement. Pre- and post-group assessment may determine what has changed. To assess progress during each session, a check sheet or rating scale may be designed. Occasionally, published assessment tools may fit specific group goals, and these may be incorporated into the sessions. For example, Oakley's Role Checklist (1984) may be incorporated into a retirement planning group, as a basis for anticipating changes in role status.

GROUP EFFECTIVENESS: THE EVIDENCE

While reports of group interventions have appeared more frequently in the occupational therapy literature, most of the larger studies of group effectiveness come from the social sciences. Kottler and Englar-Carlson (2010) conclude that ample evidence exists for the overall effectiveness of group counselling. However, some features of therapeutic groups make them more or less effective. Burlingame et al. (2003) report that groups with a behavioural orientation, such as knowledge acquisition or skill practice, are more effective than those with an eclectic orientation. While inpatient and outpatient therapy groups have both been shown to be highly effective, outpatient groups are more so (Kosters et al. 2006). Therapy groups that continue long term report better outcomes than brief group interventions (Tschuschke et al. 2007).

In studying the nature of the change process of groups, Holmes and Kivlighan (2000) attributed

positive therapeutic change to the group interactions and relationships among group members – such as through universality, altruism and vicarious (interpersonal) learning. Joyce et al. (2007) found that the quality of the therapeutic alliances or relationships between group members and with the therapist, was most predictive of good outcomes. Similarly, Shechtman and Gluk (2005), in studying the dynamics of children's groups, identified the relationship aspects of the group experience as most useful in generating positive outcomes.

Self-Efficacy in Groups

Many individuals with mental health problems lack a belief in themselves. According to Bandura (2004), 'human health is a social matter, not just an individual one' (p. 143). Belief in oneself, otherwise known as self-efficacy, plays a central role in building good health habits and maintaining social relationships. Occupational therapy group leaders can strengthen self-efficacy by having members practice different group roles. Members of a group can focus on expressing emotions, and empathizing with one another while doing activities together. A group leader can model effective responses and problem-solving, correct misunderstandings and resolve conflicts.

Occupational Therapy Group Evidence

Probably the best known evidence of occupational therapy group effectiveness comes from the University of Southern California Well Elderly study (Clark et al. 1997, 2011), a nationwide randomized controlled trial using multiple pre- and post- measures of health and wellbeing. This 9-month occupational therapy programme for community-living older adults combined group and individual interventions. The researchers state, 'the decision to execute the Lifestyle Redesign program mainly in groups was made primarily because of the therapeutic benefit of group process and only secondarily because of potential cost benefits' (Mandel et al. 1999, p. 26) and cite an earlier edition of Cole's Seven Steps (1998) in outlining the structure and leadership for their group interventions. A report of this study in the *Journal of the American Medical Association* described the intervention as 'an OT group, a social activity group, and a non-treatment control group' resulting in 'significant benefits for the OT preventive treatment group … across various health, function, and quality of life domains' (Clark et al. 1997, p. 1321). In a replication of the American Well Elderly study, Craig and Mountain (2007) conducted similar groups in the UK, with equally positive results. Some of the benefits outlined in the UK study were:

- A sense of validation by the older person's peer group
- Isolation broken down
- New skills practiced in a supportive environment
- Social support and friendships
- Generation of ideas through listening to each other and group problem-solving
- Modelling, where other members acted as role models.

(Adapted from Craig and Mountain 2007).

A follow-up study by these authors attributed the benefits of the group programme to an increase in self-efficacy that resulted from members doing activities with others and 'translat(ing) skills developed within the safety of the group into real world experiences' (Mountain and Craig 2011, p. 57). In both studies, participants had maintained gains in occupational participation, health and wellbeing in a 6-month follow-up measure after the programme ended. In other published studies, occupational therapists have reported many group interventions with positive outcomes. In an experimental study comparing inpatient mental health occupational therapy task groups with traditional psychotherapy groups, Cole and Greene (1988) found that all mental health service users preferred the occupational therapy task groups, and that those with borderline personality disorders also had a stronger preference for them. Table 16-7 summarizes some recent group examples in the occupational therapy literature.

SUMMARY

This chapter has reviewed some ways in which occupational therapy groups may enhance client-centred mental health practice. Finlay (2002) reminds us that 'group experiences are very powerful and can be destructive as well as beneficial' (p. 263). A carefully designed group (using Cole's Seven Steps), the application of appropriate theory, prudent selection of members, and service

TABLE 16-7

Group Examples in the Occupational Therapy Literature

Group/Population	Brief Description	References
Lifestyle Redesign Groups with community-living older adults	Small groups of community-dwelling seniors met 2 hours/week for 9 months, following a series of pre-set modules such as using public transport. The OT groups were shown to improve health and wellbeing of members as well as reducing healthcare costs. The results of a second randomized controlled trial are still in press	Clark et al. (1997) Mandel et al. (1999) Mountain and Craig (2011) Clark et al. (2011)
The Bridge Program Young adults with serious mental health problems	OT students from Columbia Uni, New York, offered lectures and group laboratory experiences to assist clients in learning the basic academic and social skills needed to succeed in a college environment	Gutman et al. (2007)
Bucket Drumming groups for men with severe mental health problems, including schizophrenia, in a homeless shelter	OT students from Columbia Uni, New York, designed and led bucket drumming groups in five sessions, using Cole's Seven Step method for facilitation. The groups showed positive outcomes in elevating mood and increasing social interactions both in and outside the group	Raphael-Greenfield et al. (2011)
Community Integration groups for adults with autism, transitioning from school to work	OT students at Towson Uni, MD, used focus groups with combined clients, family members, and peers, to involve clients in the planning process for a programme to help clients make a successful transition. Programmes included fitness, outdoor adventures, lunchtime discussions, and campus/community orienting tours	Crabtree (2011)
Meeting mental health needs of adolescents ages 11–18 in a Los Angeles non-profit community mental health centre	Occupational therapists partnered with social workers and counsellors in offering groups to adolescents at risk of poor academic performance, school suspensions/expulsions, gang involvement, foster care, substance abuse, mental health problems or parenting in an after school programme. Groups included a mural project, food fitness, a music group, teen parent lifestyle redesign groups and a gardening group. The groups used occupations to build coping, social and communication skills	Bream (2010)

user participation in goal selection, all go a long way towards ensuring positive outcomes.

To handle the challenge presented by mental health service users, group leaders need an understanding of group dynamics, as well as good leadership skills. Therapists may wish to write out a group protocol with discussion questions for each step when starting a new group, and to practice facilitating member involvement by using some of the techniques described here. This preparation allows students and therapists to apply some aspects of professional reasoning in advance, so that their attention can focus on member interactions during the group itself. Experienced group therapists can then personalize the steps to meet the unique needs of their service users. Group work continues to be a dynamic and cost-effective tool for both evaluation and intervention in occupational therapy.

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SERVICE USER COMMENTARY

This chapter gives a detailed account and analysis of client-centred groups in occupational therapy. It gives clear guidance on how such groups should be conducted and what criteria need addressing when planning, running and finishing a group. The client-centred focus has a direct impact on how the groups are done. This client-centredness is evident and it feels like great progress is being made in the understanding of what can be therapeutic in a group.

As a service user, being able to cooperate, participate or even lead in a group may depend on how well or unwell I am. The directions given in the chapter do take into account these individual differences and allow for different abilities to be evaluated and considered when selecting the members and the activities.

In the context of all this, it is refreshing to read that a member of the group may even lead the group while the occupational therapist's main function is, at that point, more of an advisor. In my experience, being given the trust and opportunity that I could do things and decide for myself proved to be one of the most therapeutic experiences I have encountered in mental health settings. Perhaps more still could be worked at towards giving the client the power to decide and do what he/she wants or needs.

The relationship with the leader and with the other members is presented as crucially important for therapeutic change. I agree strongly with this. The attitude, understanding and skill of the occupational therapist leader can allow or even determine how successful the group will be.

I found the discussion on how to address problem behaviours of members very constructive. While respect and consideration for the personal reasons that may make a member disrupt the group are given, it is suggested that engaging and involving the caring cooperation of other members, as appropriate, will be helpful.

The evaluation of the group outcomes could, I feel, be given more importance. I feel that for me to talk over and reflect on what I found beneficial helps me to focus and consolidate what I have achieved. In my experience of occupational therapy groups, the assessment – when done – was done separately from the group members. This, again, feels like it could be more client-centred if shared among members of the group. It would feel very empowering to be able to share and comment on each other's progress under the guidance of the leader who could mediate any unhelpful intervention.

The chapter offers clear guidance to how a group should be conducted. I feel that the needs of the clients are taken holistically into consideration and nothing is left unchecked. Reading this, I feel as if I could have the basis for running a group myself almost, so clearly outlined is the whole process of running one.

Lucia Franco

17 CREATIVE ACTIVITIES

JULIE H. WALTERS ■ WENDY SHERWOOD ■ HELEN MASON

CHAPTER CONTENTS

INTRODUCTION

Everyone, irrespective of age, gender or culture, can be creative through their occupations and leisure time (Reynolds 2009). Occupational therapy's belief that something new can arise through 'doing', means that occupational therapists seek to nurture the creative potential assumed to be inherent in *every* individual. The performance of many activities is thus synonymous with being creative and, therefore, creativity is part of everyday life. Just as occupation is central to being human, so is creativity (Perrin 2001; Blanche 2007). To express oneself creatively can positively influence an individual's health and wellbeing (Perruzza and Kinsella 2010) and, like engagement in meaningful activity, it can also be seen as a human right (Hammell 2008; Warren 2008).

One way in which occupational therapists can facilitate and encourage creative expression is through the use of creative activities, which have been used by occupational therapists throughout the history of the profession (Griffiths and Corr 2007).

Defining Parameters

What is Creativity?

The term 'create' comes from the Latin word *creare* meaning to make and the Greek *krainein* meaning to fulfil. To be creative is to have the ability to create or 'to bring into existence' (Merriam-Webster's Dictionary 2011) and creativity is the process of creating something new or original that is of value to the creator or to others (Fasnacht 2003).

Activity, Occupation, Meaningfulness and Creative Media

In discussing creative activities, this chapter does not make a distinction between *activity* and *occupation*. Furthermore, it assumes that most activities which are *meaningful* for an individual can involve creativity. For example, the daily choice about what to wear involves both practical considerations (about appropriateness for the weather, for example) and creative considerations such as the expression of one's sense of style and cultural identity.

Occupational therapists may engage with individuals' creativity through the use of creative media such as creative writing, painting, drawing, desktop publishing, silk screen printing, scrapbooking, clay work, sculpture, web design, needlecraft, knitting, willow work, felting, marbling, tie dyeing, card-making, music, singing, dance, photography, cooking, woodwork, metalwork, video and film-making.

A HISTORICAL AND CULTURAL CONTEXT

Occupational therapists have used creative media or crafts since the profession began. Their use grew out of the moral treatment movement (McKay 2008) and was subsequently influenced by the arts and crafts movement in the late 19th century (Thompson and Blair 1998). Both these movements are explored more fully in Ch. 1. Since then, their use has been shaped by various paradigms of healthcare prevailing at different times. Between the 1950s and 1970s, the use of creative activity became understood in terms of psychodynamic and humanistic approaches to health and wellbeing (Thompson and Blair 1998). However, in the early 1980s, occupational therapy underwent a crisis of confidence (Perrin 2001). This was due to the dominance of a positivist bio-medical paradigm, which valued experimental and quantitative research evidence and the profession's wish to adopt these values to maintain its scientific credibility (Perrin 2001; Creek 2009; Turner 2011).

A further influence on the use of crafts is gender. Creative activities have historically been seen as feminine and domestic. It has, arguably, been a challenge for a largely female profession to transcend this stereotype and use creative activities with pride and confidence (Pollard and Walsh 2000). However, an increase in recent research activity shows that there is a resurgence of interest in the therapeutic potential of creative activities (see Maratos et al. 2008; Clift 2011; Clift and Morrison 2011; Caddy et al. 2012; Crawford et al. 2012). It is proposed that there are three reasons for this revival: a growing recognition of the importance of building social and cultural capital, the technological advances of the digital age, and a cultural rebooting of creative activities that relocates them more gender-neutrally within our culture. Each of these will now be discussed in turn.

Social and Cultural Capital

A health service orientated exclusively to a narrow bio-medical paradigm will not have the resources to address the needs of a population that is living longer and with long-term conditions, because many of the challenges faced by people are about adaptation. Society has to find ways to engage with the enduring nature of conditions such as depression and schizophrenia and reduce the functional limitations they impose (Denton and Spencer 2010). Consequently, there has been increasing interest in building social and cultural capital within communities (Abel 2008), along with health promotion, and behaviour change management initiatives (Lancet 2012). (See Ch. 2 for further description of social capital.) Creative activities have a part to play in these processes hence the growth of the Arts in Health movement, which is explored later in this chapter.

The Digital Age

The digital age has increased the number of creative activities that can be explored by the lay person and many of them may be perceived as being comparatively gender-neutral. Desktop computers, laptops and mobile devices are powerful enough to manipulate text, graphics, sound, high-resolution images and video. People commonly capture images and video on their phones. You Tube, blogging and online social networking offer a readily available way of publishing this work to a global audience. Thus, we have the concept of 'curating the self' (Potter 2009), whereby each of us becomes a curator of our own online presence through our uploading, social networking, gaming and blogging activities.

Digital creative media can be utilized to motivate positive health choices and aid rehabilitation. For example 'Tree Fu Tom', an animated series made for children's television (see Further reading/additional resources, below), was developed in consultation with occupational therapists and incorporates exercises designed to help children with obesity and dyspraxia/developmental coordination disorder (Payne 2012). Similarly, 'Zombies, Run!' (Moses 2012) is a mobile phone app which combines a running aid with a story and game. It encourages users to become part of the story, running missions fed via their earphones and collecting items within a zombie-related narrative. It is an entertaining way to incentivize physical activity, the benefits of which are explored more fully in Ch. 14.

The Cultural Re-Booting of Creative Activities

Creative activities are escaping the confines of the domestic domain and are being performed in new ways and for new purposes. Yarn bombing is a form of benign graffiti where street objects are covered in knitting (Wollan 2011). It has practitioners all over the world and is supported by a vibrant online community (see Yarn Corps 2011). Similarly, guerrilla gardening, the subversive act of planting on urban wasteland, neglected traffic islands and pavement verges, brings beauty to public spaces and, arguably, improves the quality of life for all (Reynolds 2011).

WHO ELSE USES CREATIVE ACTIVITIES AS THERAPY?

Occupational therapists are but one group who understand the potential of creative activity to influence health and wellbeing. It is important that occupational therapists are aware of the approaches of other professionals and organizations working with creative activities so partnerships can develop. A short description of three groups who work with creative activities is outlined below.

The Arts Therapies

Art Psychotherapist, Art Therapist, Drama Therapist and Music Therapist are all protected job titles in the UK and are professions regulated by the Health and Care Professions Council (HCPC 2012). In the USA, Goodill (2010) identified art therapy, music therapy, dance/movement therapy, poetry therapy, drama therapy and psychodrama as arts therapies, stating that their focus is to combine artistic expression with psychotherapy to promote healing, wellness and personal change. In addition to being experts in their chosen media, arts therapists will have undergone a graduate or masters programme of study involving psychology and psychotherapy, as well as practice placements and coursework.

Arts in Health and Arts on Prescription

There has been growing interest in the promotion of the arts within healthcare, with initiatives such as Arts in Health (Clift 2011) and Arts on Prescription (Bungay and Clift 2010), which act as adjuncts to conventional therapies. They involve activities facilitated by artists and musicians, for example, rather than occupational therapists or arts therapists and are frequently accessed by people living in the community with mild to moderate health problems (London Arts in Health Forum 2010).

This kind of social prescribing is seeking to build social capital and community engagement for the purpose of enhancing health and wellbeing. However, in their review of the field of arts and health, Brodzinski and Munt (2009) state that they became aware that there is 'a lack of theoretical underpinning within the field' (p. 280), indicating that this is a developing area.

The Medical Humanities Movement

Medical humanities is an academic discipline which initially arose out of medical student education. It explores a person's subjective experiences of medical care and draws on areas such as philosophy, the history of medicine, anthropology, social sciences, history, literature, the arts and theology (Smith et al. 2006). It focuses on achieving authentic interdisciplinary collaboration, including collaboration with service users. The movement encourages anyone who has an interest to become involved and examines how new ways of thinking about health, ethics and wellbeing impact on the culture of healthcare provision. Creative activity such as literature, poetry and film are used as well as other creative media to support this exploration (Macnaughton 2011).

THEORETICAL UNDERPINNING FOR CREATIVE ACTIVITIES AS THERAPY

Researching Creativity

Creativity has been researched by many disciplines with differing emphases influenced by differing perspectives. For example, the business sector focuses on identifying and developing the characteristics, skills and attitudes of creative people so greater creative problem-solving and commercially original products may result.

From this perspective, cognitive science research has sought to identify the key features of 'creative people'. Such individuals are commonly described as highly motivated and possessing skills of decision-making, problem-solving, convergent and divergent thinking, evaluation and complex learning (Wang 2009). Cognitive science associates creativity with higher cognitive processes that discover new, original and useful relations between concepts, phenomena and events (Wang 2009). Within the education sector, there is much interest in the influence of the environment on creativity and purposely designed 'creative spaces', for example. These are rooms with design features, such as whiteboard walls with in-built computer software that allows for the easy expression of ideas within groups, allowing students' ideas to be easily recorded and with only minimal interruption to the flow of the group work. The aim is to encourage exploration, experimentation and experiential learning, which are essential features of creativity (Jankowska and Atlay 2008).

Also within education, Kleiman (2008) has offered a broad, research-based conceptualization of creativity as something process-orientated (that is, it may not be geared towards a tangible product) and as something product-orientated (creating something new, original and of value), which aims to bring about change internally or externally and to generate feelings of satisfaction and fulfilment.

Across these different perspectives, there is interdisciplinary agreement that creativity is influenced by the environment and can therefore be developed.

Creativity and Occupational Therapy

The existential view of human beings as constantly defining and redefining themselves through dialogue with the world is fundamental to the work of Carl Rogers, Abraham Maslow and Erich Fromm, and has been a huge influence on the development of occupational therapy. More recently, occupational scientists and occupational therapists have explored the relationship between creativity, health and wellbeing. For example, Blanche (2007) has identified that the meaningfulness and value of creativity relates to the goal of creating a product and/or to the pleasure gained from the *process* of creating. Pleasure may be gained from solving problems, asserting personal preferences, self-expression, or 'losing oneself' in the creative act and discovering something new about oneself. In this sense, Maslow (1974) and Zinker (1977) have suggested that the therapeutic impact of creativity is related to its capacity to foster transformation and change. Occupational therapists have also recognized that creativity can be a feature of the therapeutic process itself when, for example, a service user has entrenched problems for which there are no set solutions, and new solutions need to be co-created (Perrin 2001).

Research Evidence for Creative Activities as Therapy

Of the UK occupational therapists surveyed by Griffiths and Corr (2007), 82% reported using creative activities within their mental health practice, although, until recently, there has been little research-based evidence to support this work. However, two overviews of research in this field are noteworthy. Reynolds (2005) produced a comprehensive critical review of literature regarding the impact of the creative arts on health from the end of the last century until 2003 and Perruzza and Kinsella (2010) published a literature review on the use of creative arts occupations in therapeutic practice between 2000 and 2008. Both these reviews include evidence from a range of creative arts professions, as well as creative activities used in occupational therapy. Perruzza and Kinsella (2010) included 23 studies and identified six benefits of creative activities: enhanced perceived control, building a sense of self, self-expression, transforming the illness experience, gaining a sense of purpose, and building social support.

Other notable research regarding creative arts therapies includes the following:

- A Cochrane systematic review (Maratos et al. 2008) which reviewed five randomized controlled trials of music therapy for people with

depression. Four trials reported greater reduction in depressive symptoms among participants randomized to music therapy compared with those allocated to standard care

- Clift and Morrison (2011) demonstrated that community group singing can have substantial benefits in aiding the recovery of people with a history of serious and enduring mental health problems
- Crawford et al.'s (2012) multi-site randomized controlled trial of group art therapy for people diagnosed with schizophrenia – known as the MATISSE study (Multicentre Study of Art Therapy In Schizophrenia: Systematic Evaluation) – is thought to be the largest piece of research on an arts therapy in mental health practice to date. Although the findings were inconclusive, this rigorous study stimulated a lively debate in the *British Medical Journal* where Kendall (2012) commented, 'arts therapies, because they rely on creative expression rather than verbal communication, … still have the greatest potential for success in the treatment of negative symptoms (of schizophrenia)' (p. 1)
- Caddy et al. (2012) found positive correlations between participating in a creative activity group and improved mental health outcomes in an Australian psychiatric hospital. The study examined hospital records between 2004 and 2009 and focused on 403 service users who had received at least six sessions of therapy in a creative activity group.

According to Clift (2011), there is now a vibrant research interest in arts and health, giving rise to the recent launch of three academic journals dedicated to arts/music and health research: *Arts and Health: An international Journal for Research, Policy and Practice*, the *Journal of Applied Arts and Health* and *Music and Medicine*, and the well-established *Medical Humanities Journal* (see Further reading/additional resources, below).

Theoretical Materials Relevant to Creative Activities

It is vital that occupational therapists are able to articulate and justify their rationale for using creative activities as therapy. The choice of theoretical underpinning is informed by the needs of the service user, the demands and opportunities of the environment, and the interests and skills of the therapist (Creek 2009; Iwama et al. 2009). The expert occupational therapy practitioner may incorporate many theoretical approaches, techniques and frames of reference, adapting swiftly to the needs of the service user through the practice of clinical or professional reasoning (Unsworth 2001; Creek 2010). The purpose of this section is to familiarize occupational therapists with some of the theories underpinning the use of creative activities. They are illustrated using case studies later in the chapter.

The Theory of Creative Ability

A South African occupational therapist, Vona du Toit, developed the Theory of Creative Ability during the 1960s and until her death in 1974. Since the 1990s, the theory has been presented as a model by de Witt (1992, 1997, 2005). Known for many years as the Model of Creative Ability, it was renamed the Vona du Toit Model of Creative Ability in 2010. The model is used in the UK and Japan, and widely used in South Africa.

Vona du Toit (1962) used Buber's definition of creativity; that through one's action, 'something arises that was not there before' (Buber 1947, p. 85). This is comparable with Carl Rogers' (1959) view of creativity; that it involves the creation of an original product out of the person's own uniqueness, their human and non-human environment, and the events and circumstances of their life. Therefore, creativity may result in something tangible (a product of some kind) or something intangible – such as new understanding, or an increase in self-esteem. Vona du Toit's notion of creativity relates to the ability to create one's world and oneself (tangible products) and also intangible products such as one's sense of self and intrapersonal change. She proposed that this occurs progressively through levels of creative ability.

Levels of Creative Ability. There are nine levels of creative ability in the model. The first six levels (outlined in Table 17-1) are commonly seen by occupational therapists because they are levels at which people usually seek or need intervention. It is not the norm for people who are on the three final levels to be in need of intervention and therefore they are not usually encountered in occupational therapy practice. Rather,

TABLE 17-1

Six of Du Toit's (1972) Nine Levels of Creative Ability

Level	Motivation	Action
6	ACTIVE PARTICIPATION: for egocentric reasons, to improve on activities or behaviour identified as a problem by the individual	ORIGINAL: able to analyse activities to identify aspects for improvement and can provide original solutions
5	IMITATIVE PARTICIPATION: to behave and perform tasks to standards/expectations; doing as well as others	IMITATIVE: demonstrates behaviours and task performance to socially accepted standards; evaluates; problem-solves
4	PASSIVE PARTICIPATION: to learn behaviours and skills for independent living; doing and being with others; learning socially acceptable behaviours and expectations of task performance	EXPERIMENTAL: experiments with behaviours and tasks in order to identify what is acceptable; experiments with activities to expand knowledge and skills; begins to evaluate performance
3	SELF-PRESENTATION: to develop a sense of self (likes/dislikes; what one can do); exploring the environment, people and situations; constructive doing; learning how to do; relating to others	EXPLORATIVE: willing to try 'to do' but lacking skills; shows interest in surroundings; needs supervision to do tasks and to complete them; tends to do a bit and then stop/feels unsure; communicates with familiar people
2	SELF-DIFFERENTIATION: to differentiate oneself from others and things; making contact with the environment	DESTRUCTIVE: engages with the environment; interacts with objects in a way that they are not meant to be used; limited awareness of/contact with people; brief periods of activity INCIDENTALLY CONSTRUCTIVE: through contact with objects, makes something happen by chance (unplanned)
1	TONE: establishing the will to live and maintaining biological tone as 'the starting point from which all human systems needed in occupational performance develop' (de Witt 2005, p. 21)	PRE-DESTRUCTIVE: little or no awareness of, or response to, the environment

people may have been on a higher level before the onset of their mental health problems, but present on a lower level in health and social care services due to illness, injury or other issues. A detailed description of the levels is provided by de Witt (2005) and du Toit (2006).

du Toit posited that human beings are motivated to relate to the world around them and this occurs through acting on it; through *doing*. Gradual changes in human beings' motivation and actions for doing are described in levels of creative ability. For example, motivation at the fifth level is termed *imitative participation* because there is motivation for occupational performance of a 'good' or socially acceptable standard which imitates, or conforms to, socially accepted behaviours and ways of doing things.

Progression, Regression and Recovery of Creative Ability. Influenced by the environment, progression through the levels of creative ability occurs sequentially, like progression through the stages of human development. However, illness, injury, trauma or difficulties associated with old age may cause a decline or regression in an individual's creative ability to a lower level. In this case, restoration of creative ability is seen as the recovery of the self, albeit a changed self.

The Creative Process: Response, Participation, Product. The decision a person makes in response to each demand, opportunity or challenge of daily life, ultimately determines an outcome. Therefore making decisions is creative. In each decision, 'Man' is determining the quality of 'Being' – becoming Himself' (du Toit 1962, p. 2). Making the decision to participate in life through mental and physical effort is known as a *creative response*, and is a precursor to participation. In mental health practice, service users' responses to life may be affected by a number of factors including reduced motivation, reduced levels of activity, withdrawal or occupational deprivation. du Toit suggested that therapists are more likely to gain a creative response, elicit motivation and engage an

individual if they offer an intervention that attends to the person's level of creative ability which encompasses motivation. Through participation, there is the creation of tangible and intangible products and ultimately there is change – and the 'becoming' or creation of oneself.

Growth in Creative Ability. Participation requires mental and physical effort, but if this is felt (by the individual) to be beyond their abilities, it can result in stress, withdrawal or failure, which is not conducive to achieving growth in creative ability. Similarly, participation that is well within a person's abilities and is felt to be easy or requiring very little effort has limited potential for bringing about growth. Rather, growth occurs through the mastery of 'just right challenges'. That is, challenges which are at the limits of one's ability and require effort. Mastery of challenges through effort results in a person's growth towards, or into, a new level of creative ability (du Toit 1970). Identifying what constitutes the 'just right challenge' for mastery and growth is the therapist's task. To assist with this task, the Theory of Creative Ability provides a guide to intervention for each level.

Intervention: The Creativity of the Occupational Therapist. du Toit (1962) suggested that within the therapeutic relationship 'the patient and therapist very intimately share the problem of the patient's recovery' (du Toit 1962, p. 11). Coming alongside the service user, the therapist uses their own creativity to facilitate a therapeutic process for maintenance, growth, or recovery of creative ability through the use of carefully selected activities. This is informed by the therapist's holistic view of the service user and of what is meaningful and purposeful for that individual. It involves understanding the occupational performance demands the service user faces and an appreciation of the therapeutic potential of the activity. Selected activities are then graded to enable the service user to respond with a decision to participate, to exert effort in the face of the 'just right challenge', to master occupational performance challenges and thus elicit motivation for further participation. In this way, the goals of therapy can be achieved for maintenance of creative ability (particularly for service users with progressive conditions), or the growth of it.

Grading occurs in relation to four principles: handling (therapeutic use of self); structuring (managing session time and environment); presentation (considering how the activity will be facilitated); and activity requirements (analysing activity characteristics to aid selection of the 'right' activity).

Flow Theory

The concept of flow has much to offer occupational therapists working with creative activities. It was developed by Hungarian psychologist Mihaly Csíkszentmihályi, and seeks to articulate the enjoyable, holistic sensation an individual experiences when totally engaged in an activity (Reid 2011). Flow, therefore, attempts to conceptualize optimal human experience (Csíkszentmihályi 1975).

Flow has been associated with happiness (Csíkszentmihályi 2002), creativity (Csíkszentmihályi 1997) and spirituality; particularly the faculty of mindfulness (Wright et al. 2007; Reid 2011). When in a state of flow, a person may feel deep enjoyment, or they may be unaware of any emotion, being completely focused on the task at hand. A person becomes so absorbed by the activity that 'self consciousness is lost and worries or negative thoughts disappear' (Wright et al. 2007, p. 136).

Csíkszentmihályi (2002) identifies five factors which are said to accompany a flow experience:

1. Clear goals and feedback
2. Concentration on the task in hand
3. A sense of control, or an absence of worry about losing control
4. A loss of self-consciousness
5. Changes in the way time is experienced.

According to Csíkszentmihályi (2002), engaging in flow activities leads to growth and discovery:

> *One cannot enjoy doing the same thing at the same level for long. We grow either bored or frustrated; and then the desire to enjoy ourselves again pushes us to stretch our skills, or to discover new opportunities for using them.*
>
> ***(Csíkszentmihályi 2002, p. 75)***

Flow states have been recognized as being relevant to occupational therapy because when a person is fully

participating in an activity with a 'just right challenge', they are likely to experience feelings of pleasure, clarity and a desire to sustain and repeat activity (Rebeiro and Polgar 1999). (See Ch. 20 for additional examples of applying flow theory in practice.)

Narrative

A narrative or story may be understood as a series of events which are linked in a sequence across time, according to a plot (Morgan 2000) and are essential in creating a person's identity (Smith 2008). The unique way people tell stories about their experiences reveals their outlook on life, including their values and beliefs. Understanding this outlook is vital to the formation of a therapeutic relationship (Sumsion and Law 2006). It can be used to enable the person to re-author their life experience (White 2004; Mould et al. 2010) and to reconstruct it in new ways. Indeed, it has been proposed that people derive meaning in their lives by 'locating themselves in unfolding narratives that integrate their past, present and future selves' (Kielhofner et al. 2008, p. 110). Story work lends itself to this because a story has a natural structure (the story arc) with a beginning, middle and end.

The use of creative media adds a richness to any work with narrative. People can speak their story, act it out as a drama, write it down as poetry or creative writing or create a blog. They may tell the story using images or video or animation. It can be distilled into a digital story or sung as a song; it can be drawn, painted or set out in a scrapbook. Time-based media such as video, animation and digital storytelling, are particularly suitable.

During a crisis, telling stories can help a person to make sense of what has happened;

> *Attention to human suffering means attention to stories, for the ill and their healers have many stories to tell. The need to narrate the strange experience of illness is part of the very human need to be understood by others*
>
> ***(Mattingly 1998, p. 1).***

Smith (2008) acknowledges the power dynamics of the mental healthcare system and that service users may feel oppressed, marginalized and stigmatized by the very structures which are intended to help them. Listening to service users' stories can help to deconstruct unhelpful discourses and prevent them becoming internalized (Morgan 2000).

Plot and metaphor are two important features of narratives. They 'synthesize and impart meaning on many elements and episodes of life' (Kielhofner et al. 2008, p. 110). Plot refers to the narrative arc, linking a person's past to their present and to an anticipated future, while metaphors give such stories meaning. They are part of everyday language and 'allow us to express concepts, enabling us to link the abstract to what is already known' (Mould et al. 2010, p. 285).

The Tree Theme method (Gunnarsson et al. 2011) and the Kawa model (Iwama et al. 2009) both provide a framework for the use of metaphor within occupational therapy. In the Tree Theme method, the service user paints trees to represent different stages of their life and the Kawa model uses a river as a metaphor for the life being lived. Additionally, the therapist can also work with whatever metaphors the service user chooses.

CASE STUDIES

What follows is a series of case studies based on the practice experiences of the authors. Each example uses one or more of the theories outlined earlier to underpin the chosen creative activity.

For each case study, an overview of the creative media used is provided. It should be noted that experiential knowledge of any creative medium a therapist might use is essential. It gives the therapist an in-depth understanding of the performance components, enabling them to grade the activity. This is vital to creating the 'just right challenge' and is based on activity analysis. For example, for a simple activity such as tie-dyeing it may take 1–2 days of personal exploration to gain the necessary level of expertise to use this medium in one's own practice, while activities such as knitting require more technical skill in order to produce a reasonable standard of product and thus facilitate service users in doing the same. For other activities such as digital storytelling and stop motion animation, it is necessary for the therapist to have spent time in personal projects and further training is likely to be necessary.

CASE STUDY 17-1

Using Digital Storytelling with Errol

Digital storytelling began in 1993, as an exploration of ideas about cultural democracy; emancipating marginalized groups and giving ordinary people a voice. The idea of digital storytelling emerged from the performing arts/creative writing community in Berkeley California and the advent of desktop computers ensured its widespread use (Lambert 2006).

Digital storytelling can be facilitated on a one-to-one basis but group work offers the additional benefits of building social capital and support by creating the opportunity to be listened to by a supportive group and to communicate and share feelings among peers. Within a facilitated small group process of 6–8 storytellers, each person is supported to distil aspects of their experience into a personal story. This story is expressed as a very short (3 or 4 min) narrated presentation of still images (and sometimes video) using slide show or video editing software. The output is therefore a 'film', which can be burnt to a DVD or stored on a computer. The storyteller remains in control of all aspects of the production of the story and in the process can acquire or enhance personal skills using computers and digital media.

Digital storytelling is best suited to use with people who are able to reflect on past personal experiences and be ready to make sense of them. It can be an intense, immersive process and this should be borne in mind by the therapist.

ERROL

Errol, a 35-year-old man living in the community, was diagnosed with bipolar depression in his early 20s and has had several hospital admissions with severe depression or psychosis. He had been relatively stable for 2 years, having learned self-management strategies for his depressive and psychotic symptoms with the support of his community mental health team (CMHT) and through taking mood-stabilizing medication.

Errol had survived a number of bereavements and losses in his life, including the suicide of his best friend and was struggling to come to terms with the legacy of chaos which his mental health problems had created in his life. Errol lived alone, had a greatly reduced social network, was unemployed (apart from occasional, temporary, low-paid jobs) and spent his time enjoying computer games.

He was referred to the community occupational therapist for an assessment of his daily living skills and to explore his vocational aspirations. The occupational therapy assessment was conducted over three informal meetings where the therapist began to build a rapport with Errol. It became clear that, although he wanted to gain paid employment, Errol was burdened by a sense of failure and loneliness and he felt hopeless about his future. Errol also felt responsible for his friend's death.

INTERVENTION

The therapist shared with Errol her analysis that his sense of hopelessness arose from his lack of a clear occupational identity due to the disruption to his life and his diminished social relationships and roles. She discussed digital storytelling with Errol as a possible starting point for working together and he agreed to take part in a 3-day workshop with six other service users hosted by the CMHT in a local community centre.

The occupational therapy goals for Errol were as follows:

- To re-author an aspect of his experience using storytelling techniques in order to promote recovery and hope for the future
- To engage in a meaningful activity with opportunities for flow or mindfulness experiences
- To re-learn or enhance his computer skills.

Errol played an active part in the workshop, listening attentively to others in the group and as one of the more technically literate members he was able to offer support to others. During the workshop, he made a tribute story about his late friend using some of his own photographs.

After the workshop, Errol decided to show the story to his parents and to the sister of the friend who had died. The therapist kept in close contact with Errol in the weeks which followed to give him the opportunity to de-brief and to allow him to reflect on the experience.

CASE STUDY 17-1 (*Continued*)

EVALUATION

Errol said doing the workshop was like 'five years of counselling packed into three days'. He told the therapist that he no longer felt responsible for his friend's death, and that he felt really proud of the digital story as a tangible achievement. He said the process of making it had helped him to see events in a new less self-critical way. The digital story-telling acted as a springboard for Errol's engagement in a care plan and was a turning point in his life.

Errol later enrolled on a computing course at his local college. He also kept in touch with several of the other workshop participants and, through the shared experience of the workshop, the beginnings of new friendships were formed.

CASE STUDY 17-2

Using the Theory of Creative Ability with Joe

As described earlier in this chapter, the Theory of Creative Ability helps the therapist to identify a person's level of creative ability and to articulate therapy aims for each level. It shapes the course of the therapy process by guiding the selection of activities, and informs professional reasoning regarding the role of the environment and the therapeutic use of self. Joe's case illustrates the *imitative participation* level (see Table 17-1) and the use of group clay mosaic making as a creative activity.

JOE

Joe, a 27-year-old man with a diagnosis of paranoid schizophrenia, had been a service user in a medium secure unit for 5 years. His index offence was grievous bodily harm to a male neighbour who he believed was attempting to poison him.

Joe had progressed through the slow-track rehabilitation service to the fast-track rehabilitation ward, from which inpatients move on to the pre-discharge hostel or are discharged into the community. To this end, the ward focused on enabling service users to perform daily activities and to participate in the community in an effective, satisfying and socially acceptable way, such as by developing skills for independent living. They were expected to keep their bedroom tidy, do laundry, cook with and for others, and engage appropriately in ward-based and community-based activities.

Managing these demands and finding them meaningful relates to both the *passive participation* and *imitative participation* levels (see Table 17-1). The first of these levels involves *experimental* action – trying out and experimenting with differing techniques and differing ways of behaving in a broad range of situations in order to learn how to perform activities and behave to socially defined standards. This level leads to the imitative participation level with *imitative* action, which is characterized by compliance with societal norms (doing the same as/doing as well as others, thus imitating the expected standard). It is the level at which learning gained during the experimental level is put into practice, aiming at effective, independent daily living.

On admission to the ward, the therapist assessed Joe through interview and by assessing his task performance in a range of familiar and unfamiliar activities in differing situations. This assessment was informed by the assessment process described by de Witt (2005).

The assessment showed that Joe was at the beginning of the *imitative participation* level of creative ability, where motivation is broadly directed towards carrying out roles and activities according to general, socioculturally defined norms regarding personal hygiene and dress, behaviour and the performance of activities (de Witt 2005). Meeting these norms requires the ability to self-evaluate occupational performance in order to identify whether meeting norms has been achieved. However, self-evaluation skills are not yet fully developed at this level, but develop with progression through it (de Witt 2005).

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CASE STUDY 17-2 (*Continued*)

Joe's occupational narrative and history indicated that he lacked experience of realistic self-evaluation, compounded by receiving predominantly negative feedback during his youth. Joe perceived that he lacked the experience of success in many areas of his life. For example, he was expelled from school, he had been unable to gain employment, and he had developed unhealthy, abusive and dysfunctional friendships and intimate relationships. However, he expressed a desire to change so that he could live and work in the community. This was significant. A self-improvement motive is implicitly a motive for self-evaluation (Neiss et al. 2006) because it involves comparing oneself against a desired standard (Collins 1996).

Informed by Joe's history and expressed motivation and by knowledge of the imitative participation level, the therapist negotiated the following goals with Joe:

- To increase pre-vocational skills (e.g. problem-solving, planning, working neatly)
- To develop self-evaluation skills
- To develop higher-level social skills (e.g. negotiation, compromise, assertiveness)
- To increase knowledge and skills for meaningful occupational performance.

INTERVENTION

Self-evaluation may lead to the realisation that one has not met a desired standard and this can be a difficult experience (Seaton et al. 2008). Therefore, activities requiring the meeting of standards (such as cooking for others on the ward), need to be balanced with activities for fulfilment of other needs. For this reason, the therapist explored with Joe, creative activities that might achieve therapeutic goals, while also providing an opportunity for the self-expression, relaxation, pleasure or satisfaction not gained through Joe's other activities. From the creative activities suggested by the therapist, Joe was interested in joining the weekly mosaic project group, and did so for 2 months.

The mosaic project involved the design and creation of glazed, clay mosaic panels on the theme 'together we're strong' for a community centre mural. An activity analysis of this project indicated that it placed occupational performance demands that were relevant to Joe's needs, which could also be graded using the principles of the Theory of Creative Ability. For example, there was an expectation on group members to produce a mural of sufficiently high standard for public viewing. The therapist structured the group to create an expectation for collaborative working, assertiveness, negotiation and compromise, and the development of pre-vocational skills such as problem-solving, tool use and planning.

The method for making mosaic pieces was simple and repetitive enough to allow skills to be developed relatively quickly. Achievement of these skills enabled Joe to become free to use his imagination, self-expression and to become immersed in the process of designing, mixing and experimenting with colours; to become absorbed in creativity and develop intrinsic motivation.

EVALUATION

Joe developed the skills for participating fully in this group activity. With guidance from the therapist, he developed self-evaluation skills that enabled him to realize improvements in his ability (as evidenced by the improving quality of the mosaic pieces he created). The positive feedback from the therapist, plus Joe's own realization of what he had achieved through mastery of challenges, meant that the activity was very pleasurable and satisfying, creating a flow state for Joe (Wright et al. 2006).

Joe's evaluation skills transferred to his daily occupational performance, enabling him to improve in a number of activities, such as working with other service users to jointly cook meals at weekends, planning leisure activities, and generally applying problem-solving skills. Further assessment indicated that Joe had progressed further through the imitative participation level.

CASE STUDY 17-3

Using Animation with Tom

The term animation here refers to *stop motion* or *stop frame* animation. This involves arranging objects or people, taking a photograph or still, moving them slightly, taking another photograph, then moving the object or person again. The illusion of movement is achieved by rapidly playing the sequence of still images in real time using animation software (Mason 2009).

TOM

Tom, a 7-year-old boy, was referred to occupational therapy within a Child and Adolescent Mental Health Service (see Ch. 25) by the consultant psychiatrist. He had been given a diagnosis of reactive depression and anxiety following the death of his grandfather.

Tom lived at home with his parents. They reported finding it increasingly difficult to connect emotionally with him, describing him as withdrawn and angry. His teacher expressed concern that Tom was also withdrawn and lethargic in class, preferring to sit alone during break times instead of playing with his friends.

Furthermore, Tom was not engaging with the cognitive behavioural therapist or primary mental health worker. Following an initial consultation with Tom and his mother, Tom was offered weekly occupational therapy sessions over a 12-week period, during which he chose to explore the animation station in free play sessions.

Free or unstructured play is directed by the child and not the therapist. The child is free to choose what they play with and how they play within basic limits set-up by the therapist (Ryan and Wilson 2000). Free play is used within disciplines such as play therapy to support children in working through themes, which arise from the child's unconscious. The process does not involve praising the child, problem-solving or offering interpretation of a child's motivation so the child is therefore 'free' to explore and work towards therapeutic insight at their own pace.

To engage a child in free play, a therapist should have appropriate postgraduate training in free play techniques or supervision from a practitioner (e.g. a play therapist) who has the necessary training. Engaging in child led play sessions can however be useful for occupational therapists interested in observing play preferences, mood, sensory preferences, strengths and functional skills within a relaxed, child-centred atmosphere.

The initial plan agreed with Tom and his family was as follows:

- To explore Tom's existing coping strategies
- To provide a safe space for building new skills
- To encourage re-engagement in valued activities.

INTERVENTION

Animation was part of a wider care package, which included advice to Tom's parents and school about strategies for supporting Tom's mental health and wellbeing. Practical sessions were developed exploring activities of daily living, psycho-education and anxiety management. These were provided by the occupational therapist and the occupational therapy assistant.

Goal Attainment Scaling (GAS) (Kiresuk et al. 1994; Turner-Stokes 2009) was used to measure progress; the goal-setting being done jointly with Tom and his family, and in consultation with the interdisciplinary team. Interdisciplinary team members received systemic family therapy supervision alongside their usual supervision. This enhanced intra-team communication and provided a space to creatively explore hypotheses, models of practice, care planning and any transference issues that arose.

Goals emerged gradually from practice, orientated to Tom's needs, but they are described here in relation to three stages of the therapeutic process: *initial engagement, therapeutic exploration* and *assimilation*.

Stage 1: Initial Engagement

Tom was initially withdrawn and quiet in occupational therapy sessions. The therapist provided a space which facilitated child-led activity choice so Tom was able to engage on his own terms. Once engagement was established, therapist-led play tasks were set. These were simple and gratifying to ensure Tom experienced success. They required short bursts

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CASE STUDY 17-3 (*Continued*)

of concentration, required minimal problem-solving, and were focused on an end-product. Opportunities were provided for Tom to lead the activity as his confidence grew and reflected the activity choices and sensory preferences that naturally arose.

At this stage, the occupational therapy goals were as follows:

- To identify what was important to Tom (his values, attitudes and beliefs)
- To grade activities to build on occupational performance skills, resilience, motivation and locus of control
- To gradually re-introduce activities Tom had previously enjoyed as part of his daily routine.

Stage 2: Therapeutic Exploration

Once comfortable in the environment, Tom began talking about some of his feelings, often while animating an apparently unrelated scene. As Tom's confidence in animating grew, so did his capacity for exploring his thoughts and feelings. Animation became a means of expressing himself when words were unhelpful. The occupational therapist and Tom entered into a triadic relationship encompassing each other and the graded activity.

At this stage, the occupational therapy goals were as follows:

- To explore coping strategies for managing feelings and finding ways of processing loss
- To foster Tom's self-esteem and self-worth through meaningful activity.

Stage 3: Assimilation

To conclude the occupational therapy sessions and to support Tom's new found hobby, he was offered the opportunity to develop his own animation project in a local arts centre. The shared goals were:

- To assimilate what Tom had learned and discovered during intervention
- To build confidence
- To learn additional computer/animation skills
- To practice his hobby in a non-clinical environment.

This graded intervention with Tom included techniques developed as elements of the Re-Animation Approach (Mason 2011). This approach provides a framework for the use of animation in a range of therapies. It is trans-generational and family/community focused, drawing on theory and techniques from occupational therapy, systemic family therapy and positive psychology. The techniques used with Tom are categorized as *Just for fun*, *Animated Exploration* (including animated therapy techniques, therapeutic re-authoring/storytelling, and animated activities complementing psycho-educational work) and *Production-based Animation*.

Just For Fun. The occupational therapist introduced Tom to a range of stop motion techniques including 3-D model animation, 2-D drawn animation, cut-out techniques and pixilation. Pixilation is a stop motion animation technique where real actors or objects are used as living puppets, positioned frame by frame as puppets or props would be, moving position slightly between each frame. The actors/objects can appear to fly or to disappear through walls.

Examples of pixilation include Aardman Animation Studios' 'Angry Kid' and movies such as 'The Secret Adventures of Tom Thumb' by the Bolex Brothers (see Further reading/additional resources, below).

The *Just for Fun* sessions with Tom focused on creating opportunities for assessment and observation, building a therapeutic relationship and facilitating a playful, respectful experience tailored to his level of function. Tom made short 'test' films exploring animation techniques and created a show reel to take away with him.

Animated Exploration. Tom's exploration of his feelings about the loss of his grandfather was combined with psycho-education about managing depression and anxiety. The following activities were used:

Putting Depression in the Room. Tom was asked what his depression looked like and was encouraged to create a model of it, which he later animated, capturing ways of coping with his feelings in animated test films, which he then chose to share with his parents in family-focused occupational therapy sessions.

CASE STUDY 17-3 (*Continued*)

Memory Sands. Tom brought in a bottle that he had found with his mother in a charity shop. He selected and animated different-coloured sands to layer in the bottle to remind him of important memories of his grandfather.

Where in My Body? Tom coloured in and animated a template of a person to show where he felt emotions (such as anxiety, sadness, happiness, anger, love) in his body, and what colour and shape they were.

Therapists should note that films created during explorative animation sessions are treated as confidential case material and service users are advised not to put material onto websites such as YouTube.

Production Based Animation: Family Tribute. To end the therapy sessions, the family chose to work together with the occupational therapy assistant (who was trained in animation) to make a short animated film about Tom's grandfather using photographs, objects and audio from family videos. It was created at a local arts centre to facilitate Tom's transition out of services. As part of Tom's discharge package, Tom and his family were able to share the film with the therapy team as a way of ending the therapy process.

Evaluation

By the end of the intervention, Tom's engagement in the occupational therapy sessions had changed. He joked with the therapist and talked about his plans for the future. He was expressing his feelings with his parents in the sessions and had re-established the day-to-day routines that had been lost during his depression. Tom's school reported that he was participating fully again, engaging in activities with his peers. His mood had improved significantly.

Outcomes and progress were measured using self-rating scales developed by the occupational therapist and animated with Tom. The Model of Human Occupation Screening Tool (MOHOST) (Parkinson et al. 2004) was used during the exploratory stage to discuss daily life skills and set goals. The MOHOST was re-visited during the final session as were Tom's GAS goals. Tom had exceeded these. He could talk more openly about his grandfather's death and his fears that his father would become ill with the same condition.

Tom was discharged from the service maintaining his connection to the arts centre where he had begun attending animation workshops as a new hobby.

SUMMARY

This chapter began by asserting that creativity is an essential part of everyday life and that the role of the occupational therapist is to nurture the creative potential innate in every individual through the use of creative media. A consideration of different historical and cultural contexts explored the resurgence of interest in the therapeutic potential of creative activities both within the profession and outside it. A theoretical underpinning for work with creative activities was then outlined. Finally, three case studies were provided which illustrate the application of theory using three different creative media.

FURTHER READING/ADDITIONAL RESOURCES

Creativity and Health-Related Journals

Arts and Health: An international Journal for Research, Policy and Practice. Taylor Francis. http://www.tandfonline.com/toc/rahe20/current.

Journal of Applied Arts and Health. Intellect books. http://www.intellectbooks.co.uk/journals/view-journal,id=169/.

Music and Medicine. Sage. http://mmd.sagepub.com/.

Medical Humanities Journal. BMJ journals. http://mh.bmj.com/.

Animation

http://www.animationtherapy.co.uk/.

http://www.angrykid.com.

http://www.bbc.co.uk/cbeebies/tree-fu-tom.

http://www.bolexbrothers.co.uk/features.htm.

Theory of Creative Ability

Vona du Toit Model of Creative Ability Foundation (UK). http://www.vdtmocaf-uk.com.

Digital Storytelling

Center for Digital Storytelling. http://www.storycenter.org/.
Patient Voices Programme. http://www.patientvoices.org.uk/.

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SERVICE USER COMMENTARY

After many years, I now believe that my long-standing mental health problems – diagnosed as bipolar disorder – are linked somehow to my drive to achieve 'perfection', largely to please other people. This meant I've needed to be 'in control' as much as possible, and often hyperactive. Losing control increasingly resulted in my collapsing, when I discovered my 'achievement' may have been a psychotic fantasy rather than reality. My collapses meant long periods of depression when I lacked confidence to achieve or even to do anything, or to interact with others, for fear of criticism.

Having been identified as an 'academic' rather than a 'creative' child, adults encouraged me to concentrate on the more analytical subjects I was good at. Though it rarely found expression, I also knew I had a deep emotional response to art and to the possibility of being creative.

I encountered occupational therapy during my first spell in hospital with deep depression. Although my fear of 'failure' made me reluctant, I attended my first OT session after pressure from nurses, and encouragement from other patients. I joined a group batik session mainly to relieve the intense boredom of life on the ward. I was surprised to be able to focus for short periods on the activity, and that it took my mind away from constant negative thought patterns. Although I was then too depressed to experience enjoyment, I became absorbed in what I was doing. During the session I stopped anxiously watching the clock, wishing the time away so I could return to bed. During subsequent sessions I learned to enjoy getting absorbed as I created things. I started to be surprised the sessions had gone so quickly, and to want more time. The description of flow in the chapter conveys well my experience of being present and mindful.

Later, I was able to draw on that skill of finding flow during another depression. At home alone I decided to draw some plants I'd collected, and found myself absorbed and lifted out of my mood both while I was drawing, and for the rest of the day.

Joining other activities in hospital, I was surprised that much of my work looked colourful and optimistic, in spite of my mood. I also discovered that, although things didn't turn out as I had envisaged, they often still looked beautiful or interesting to me and to others. Over the years, this realization has been increasingly significant in my recovery – understanding that I need not be in constant control of what I do, that if I relax and let things happen, leave space for serendipity and trust a process, positive things may (and usually do) happen.

Several years later now, I am a more flexible and adaptable person. I know that being enabled and encouraged to try creative occupational therapy has played a significant role in that change. I am pleased that I was encouraged to try things I was reluctant about, and that hospital OTs made it easier for me to 'have a go' without being crippled by anxiety that I would not 'get it right'. I'm now an occasional member of a weekly Community Art Group, creating pieces together for local festivals and community events. The group has become increasingly autonomous, under the guidance of a skilled community artist, and provides really significant support in the lives of many of its members.

I love the words of the depressed Danish philosopher, Kierkegaard: 'To dare is to lose one's footing momentarily. Not to dare is to lose oneself'. Although daring to be creative causes me anxiety, it definitely heals too.

Ruth Sayers

18 PLAY

ROB BROOKS ■ CAROLYN DUNFORD

CHAPTER CONTENTS

INTRODUCTION

Play is recognized as a universal right for every child in the United Nations Convention on the Rights of the Child (Article 31). Children have the right to rest and leisure, to engage in play and recreational activities appropriate to the age of the child. Participating fully in cultural and artistic life should be respected and promoted through the provision of appropriate opportunities for cultural, artistic, recreational and leisure activities.

Children and young people's play experiences influence their mental health status and overall development. Play is the context for the development of childhood friendships and enables children to learn about, and develop, occupational roles (Bundy 2012). Play deprivation can have a profound, negative effect on development and mental health. The presence of a mental health condition in either the child or parent can also effect the development of play occupations having further effects on the child's mental health. In paediatric occupational therapy and mental health literature and practice, there has been a shift from the developmental significance of play and adaptation towards themes of socialization, play assessment and play as a primary occupation (Dennis and Rebeiro 2000).

The delineation between the constructs of play and leisure has not been adequately defined and they are

often lumped together as a single construct. Very young children are not usually considered to have leisure occupations and play is generally seen as the province of children. However, playing can be a meaningful occupation for adults as well. There is a shift from play to leisure activities with increasing age. Leisure is defined by the American Occupational Therapy Association (AOTA) as non-obligatory activity that is intrinsically motivated and engaged in during discretionary time (AOTA 2002). Townsend (1997) described the purpose of leisure to be for enjoyment, e.g. socializing, creative expressions, outdoor activities and games and sport. Passmore (1998) described three types of leisure: achievement, social and time-out:

- *Achievement leisure*: This involves challenging and demanding activities such as playing sports or music. Achievement leisure is thought to impact on self-efficacy beliefs and self-esteem
- *Social leisure*: The primary purpose of social leisure is to be with others and this supports competencies with relationships and social acceptance
- *Time-out leisure*: The purpose of time-out leisure is relaxation which can have positive benefits in terms of providing rest but too much time-out leisure can have a negative effect as it is socially isolating and generally less demanding.

While leisure occupations sit within the taxonomy of occupations for young people and adults, the notion of play can be seen as the primary occupation for young children. There is no universally accepted definition of play and it could be argued that defining an activity as play can only truly be done by the player themselves; however it has been suggested that there are some critical characteristics which delineate play from other occupations (Rigby and Rodger 2006). These include intrinsic motivation, process-not product-orientated, pretending, not governed by external rules and requiring active participation of the player (Rigby and Rodger 2006). Missiuna and Pollock (1991, p. 883) described free play as 'spontaneous, intrinsically motivated, self-regulated, and requires personal involvement of the child. It includes exploration, mastery, decision making, achievement, increased motivation and competency'. Bundy (1991) echoed the defining aspects of play as being intrinsically motivated and internally controlled but she adds that it should also be free from objective reality. Creativity can be explored through play and is defined as:

> *The innate capacity to think and act in original ways, to be inventive, to be imaginative and to find new and original solutions to needs, problems and forms of expression. It can be used in all activities. Its processes and outcomes are meaningful to its user and generate positive feelings.*
>
> ***(Schmid 2005, p. 6)***

Creativity can be expressed through a wide range of occupations throughout life but for young children, play is the primary vehicle for creativity.

Environment and Play

Participation in play requires interaction with the 'physical, social, cultural, economic and organizational aspects of the environment' (Ziviani and Rodger 2006, p. 41). As well as facilitating play, the environment can be a barrier; it is necessary to consider the environment at different levels including individual, family, neighbourhood, community and society (see Table 18-1).

Children are often most aware of their physical environments and these have been of interest to researchers for some time. Susa and Benedict (1994) identified that the design of the outdoor play environment was an influencing factor in play. This study examined traditional playgrounds (slides, swings, seesaws) opposed to contemporary playgrounds (aesthetically pleasing timber connected to provide space for social interaction and graded challenges). It was found that contemporary playgrounds created more complex play including rockets, boats, castles and bridges. A further aspect of the play environment is the availability of toys or materials (Pellegrini and Smith 1998). The toys in Western culture are reported to include kitchen utensils, stoves, irons and ironing boards, toy phones, dress-up clothes, and toy miniatures (Johnson et al. 1999). Haight et al. (1999) provided a cross-cultural example of children in the Marquesas' Islands pretending to paddle, canoe, hunt and fish using objects from the natural environment, while European-American children used superhero toy miniatures influenced by children's movies. The social and economic environment can result in reduced play opportunities and,

TABLE 18-1

A Summary of the Environmental Influences on Play Occupations

Environment	Definition/Example
Physical environment	The natural environment such as the terrain and climate; the built environment including the design of buildings and objects within it such as toys
Social environment	Expectations and attitudes of social support including family, friends and care-givers
Cultural environment	Societal norms including beliefs, customs, social behaviours, attitudes and expectations
Economic environment	Availability of resources such as finances at both a local and societal level
Organizational environment	Structures that mediate resources including the government, policies, managers

studies in orphanages in Romania showed that all the children had delays in cognitive and social functioning due to an impoverished environment (Kaler and Freeman 1994). The introduction of play sessions in such environments has been shown to significantly improve children's development (Taneja et al. 2002).

In the last decade, family environments have undergone significant changes with more mothers working, caregiving by grandparents, increased structured play and less free-time, financial pressures and parental separation and reconstituted families (Darlington and Rodger 2006). Parents' and caregivers' mental health status can also lead to reduced play opportunities for children and young people, for example persistent maternal depression has been associated with less time spent reading with a child, taking outings and trips to the park and playing indoors (Frech and Kimbro 2011). It is important when working with children and families to appreciate the family context and use family-centred practice. At the centre of family-centred practice are the beliefs that the family is the constant in the child's life, knows the child best, wants the best for the child and will know the child in a way that a therapist will never be able to. This approach favours a collaborative parent–therapist partnership, where the therapist has technical expertise and the parents are experts on their child (Darlington and Rodger 2006).

Culture and Play

Play is universal, yet culturally determined and contextualized representing the values, beliefs, ethics, history and society that the individual belongs too (Roopnarine and Johnson 1994). Play both maintains and develops a culture's identity and what is seen as play by one culture may not be by another. Through play, children learn to master their environment, learn society's rules, practice skills, rehearse adult roles and understand cultural norms, symbols and attitudes (Drewes 2009). With the changing ecology of childhood, it is imperative that occupational therapists become conversant with the meaning and relevance of play in diverse cultures. There is a growing body of evidence to suggest that there are cultural differences seen in children's play across Mexico, Africa, Asia, China, India, Korea, Japan, USA and Europe, as well as with indigenous populations (Drewes 2009). Haight et al. (1999) examined the differences in European-American and Chinese children's play themes. They found that European-American children's play emphasized individuality, independence and self-expression, while Chinese children's play emphasized harmonious social interaction obtained through obeying, respecting and submitting to elders as well as adherence to rules and cooperation. A further example of Western and Eastern differences can be seen in a study by Farver and Shin (1997) who compared pretend play in preschool Korean-American and Anglo-American children. Theses authors found that in Korean-American society, it is culturally valued to be ready for school and therefore play had a greater number of teacher-directed activities and fewer opportunities to interact with peers during play. Anglo-American children were observed to wander free, interact and play with a greater range of toys, materials and curriculum. Further, cultural values can be seen in the link between play and gender. Early literature from Sutton-Smith et al. (1963) identified boys playing

with soldiers, cowboys, spacemen and hunting, while girls played dolls, dress-up, school and actresses. Paley (1986) identified nursery as a place where sexual stereotypes begin.

THEORETICAL UNDERSTANDINGS OF PLAY

A theory is an explanation or understanding of a natural phenomenon; just as there are numerous definitions of play there are multiple and diverse theories of play. Classical understandings of play from the 19th and early 20th centuries were predominantly grounded in sociological and psychological theory and attempted to explain the existence and purpose of play.

Classical Play Theories

There are three classical theories of play: surplus energy, practice and recapitulation.

- *The surplus energy theory*: arose from the work of Schiller and Spencer in the late 1800s and proposed that, as children were not responsible for their own survival, they had left over energy which was directed into play
- *The practice theory of play*: was formulated by Groos (1901). Groos posited the idea that play existed in children so that they could practice the instinctive behaviours necessary for survival. Groos also recommended forms and functions of play, which were experimental play, including sensory and motor activities and socioeconomic play, which included fighting, chasing, social and family games
- *Recapitulation theory*: is about rehearsing activities of the child's ancestors (Hall 1920). Hall viewed the function of play as cathartic rather than mastery and that during play, children played out the history of humankind, for example the throwing, running and hitting of cricket reflects a summary of hunting activity.

These classical theories of play have been widely critiqued but form the basis from which the contemporary study of play has evolved.

Contemporary Play Theories

Contemporary accounts of play developed after the 1920s have been drawn from a range of knowledge bases but have often endeavoured to explain the role of play in child development. There are too many modern theories of play to discuss in detail in this chapter but they include Freud, who believed play had a role in children's emotional development; Sears, who saw play as part of personality development; and Piaget, who proposed a theory of intellectual development through play (Johnson et al. 1999). These theories have served to further our understanding of child development and form important foundation knowledge for occupational therapists working with children and young people (Case-Smith and O'Brien 2010).

OCCUPATIONAL THERAPY AND PLAY

In the early years of the occupational therapy profession, the 'play spirit' was considered essential for worthwhile life (Slagle 1922). Reflecting the prevailing trend in occupational therapy during the mid-20th century for a more medical and reductionist approach, Knox (2010) described how:

> *Play in the early years of occupational therapy was used for a variety of purposes such as diversion, development of skills and remediation*
>
> ***(p. 543)***

In the late 20th century, occupational therapy scholars started to reclaim play itself as an essential part of occupational therapy (Crepeau et al. 2009). Play is a primary occupation of childhood and is seen as having a unique value for its own sake beyond acquiring skills (Rigby and Rodger 2006; Bundy 2012). Play and play activities are not synonymous (Tobias and Goldkopf 1995). Play has to be child- rather than adult-directed, whereas occupational therapists often direct play activities to enable acquisition of specific skills, such as making choices or developing fine motor dexterity.

Occupational therapy theory tends to group occupations into the broad categories of self-care, productivity, play and leisure. The Canadian Model of Occupational Performance and Engagement has a category of leisure which it describes as being for enjoyment, such as socializing, creative expressions, outdoor activities and games and sport (Townsend 1997; Townsend and Polatajko 2007). The Model of Human Occupation has a play and

leisure category described as activities undertaken for their own sake (Kielhofner 2007). Recently, it has been suggested that these categories focus on the purpose of the occupation but do not capture the meaningfulness of the occupation (Hammell 2004). Hammell suggested we should consider the schema of doing, being, becoming and belonging, as conceptualized by Wilcock (2006). By *doing* play children acquire new skills and explore different experiences. This has the potential to build self-esteem, which is integral to mental health. Play can engender a sense of belonging to different social groups such as family, peers and wider society. Through play, children and young people can learn how to develop mastery over their environment, which gives it the potential to be a powerful therapeutic medium. 'If play is the vehicle by which individuals become masters of their environments, then play should be the most powerful of therapeutic tools' (Bundy 1991, p. 61).

Passmore and French (2003) concluded that participating in leisure occupations has a significant and positive relationship with mental health, including self-efficacy beliefs. It has also been suggested that there may be a correlation between depression and participation in play and leisure activities, with engaging in active leisure activities having a potential protective factor against depression (Desha and Ziviani 2007). When children and young people are involved in setting goals for occupational therapy intervention, they frequently identify participation in specific play or leisure activities as a desired goal (Dunford et al. 2005).

Play and Leisure as Occupations

Occupational therapists believe that participation in meaningful occupations, including play, can promote health and wellbeing (WFOT 2012). Play has even been described as the work of children. Children tend to view tasks as work when they are directed to do the activity by an adult, if the skill is thought to be too difficult, or when the task is inhibited play (Chapparo and Hooper 2005). There are a whole range of occupations involved in parenting a child: being a playmate for your child could be viewed as one of the occupational roles. Parents need to learn how to play with their children and facilitate play as an occupation through providing suitable opportunities. A variety of factors can influence a parent's ability to offer occupational opportunities for their child, including their own mental health status, experiences of being looked after as a child, parenting style, financial and time resources (Jaffe et al. 2010). Occupational therapists can enable parents to learn how to play with their child and provide appropriate play and leisure opportunities. This enables the child to explore their occupational role as a *player*, which is discussed further later in this chapter. Larson and Verma's (1999) time use study found that adolescents' time spent in various occupations was fairly consistent throughout Europe but contrasted with time use in developing countries. Children in many developing non-industrial countries spent more time performing household chores and work and consequently, less time in play and leisure activities. In Europe, the average time adolescents spent sleeping was 8–9 hours per day; TV viewing 1.5–2.5 hours per day; playing sports 20–80 minutes per day and other active leisure 10–20 minutes per day (Larson and Verma 1999). Time use studies are useful in providing some guidance around typical occupational balances for children and young people.

Developing as a Player

Children develop the role of player alongside the roles of daughter/son, sibling, friend and student. The term *player* refers to a child's engagement in different types of play over time and which reflect the context. For example, parallel play with a peer at the sand pit or constructional and solitary play with blocks at home (Rigby and Rodger 2006). Through the role of player a child engages with family and peers, learns to problem solve and uses their imagination. The role of player unfolds throughout childhood and adolescence as developing physical, cognitive and psychosocial skills enable them to expand their play repertoire.

The development of play and the occupational role of player begins with sensorimotor exploration of their own bodies. Children discover their hands and feet. Then they start to explore their immediate environment and learn that they can cause things to happen around them. They will repeat actions to elicit pleasurable responses. Functional play enables children to explore the purpose of objects and their relationship to them. Social play initially occurs alongside others with cooperative play and turn-taking emerging during the second year. The number of other children they can play with increases with age. Once in school, peer relationships become important and friendships develop.

Children learn to regulate their behaviour and consider others. They engage in games with increasingly complex rules and have competitive relationships. Learning the behaviours associated with different occupational roles is part of the socialization process and children develop social skills through play. As children grow older, they widen the number of occupational roles they have, including formal roles with specific expectations, such as being a member of a sports team. Development of player role behaviours can be a vehicle for testing and experimenting with different roles in preparation for adult life (Case-Smith and O'Brien 2010).

Occupational Play Theories

Since the last edition of this book, occupational therapists have challenged the assumptions and relevance of existing play theories (see above). Occupational science has facilitated an occupational perspective of play, which embraces the complex nature of play (Stagnitti 2004). Occupational therapists acknowledge a range of theoretical understandings about play but are identifying the limitations of interpreting play only through its physical, cognitive and psychosocial components. In accordance with this view, Humphry (2005) reported that there has been an over-reliance on play theories that provide an organismic subsystem view. Occupational therapists need to appreciate the multiple understandings of play which take into account the occupational nature of people. An occupational perspective of play requires an evolutionary, ecological and humanist approach (Wilcock 2006). The use of occupational science helps occupational therapists to consider play as a dynamic interaction between the child, their environment and the occupation. Occupational therapists have begun to develop a holistic understanding of play from an occupational perspective. An example of this is the concept of playfulness.

Playfulness Theory

Bundy, an Australian occupational therapist, proposed an interactionalist perspective called playfulness, which is 'the disposition or tendency to play' (Cordier and Bundy 2009, p. 46). In this theory there are four key concepts:

1. *Intrinsic motivation* refers to an element of the activity itself, not an external reward that motivates involvement. Participation occurrs because of enjoyment rather than an outcome. For example children play with dirt, sticks and stones with no goal in mind but for pleasure
2. *Internal control* concerns the control that players have over their play. Children make decisions during play such as what the rules are during a game of tag. This gives them a sense of being in charge
3. *Freedom from the constraints of reality* means how close to object reality the play will be. For example children use boxes to represent cars and houses when they play families with dolls and teddies
4. *Framing* refers to the ability of players to read social cues and interact. This aspect of playfulness reflects how a child expresses cultural knowledge, framing it within a common understanding of what is play and what is happening during the play.

Bundy also utilized the environment in her model suggesting that this can either impede or facilitate play with optimal environments being safe, allowing adaptation, promoting involvement and supporting motivation and mastery (Cordier and Bundy 2009). Playfulness can be disturbed when any of the key elements are not present or when the environment does not support play. Children with autism can have difficulty with the suspension of reality and are therefore susceptible to deficits in playfulness.

DEVELOPMENT OF PLAY OCCUPATIONS

Children and young people's play occupations occur within their own unique context through a dynamic interaction between the person, the play occupation and the environment (Law et al. 1996; Wiseman et al. 2005). Children engage in different types of play; exploratory, functional, social, pretend/symbolic, dramatic, constructive, imaginative, creative, rough and tumble, games with rules and sports-related. Child development can be seen as emerging from the dynamic interaction of multiple systems and sub-systems within the child such as biomechanics, central nervous system, physiology, cognition, motivation, experiences; the environment – physical, social, cultural and occupational (Thelen 1995). Developmental changes

in motor, cognitive and psychosocial domains interact dynamically with the child's experiences to influence their play development.

However, occupational therapists need to understand development in a way that goes beyond milestones and developmental norms to development of the knowledge and skills required to enable children to fulfil their occupational roles. Play needs to be viewed from the child's unique perspective that is shaped by their environment and culture. Occupational therapists should also consider all aspects of the environment as important when understanding children's play. Although less obvious, home, neighbourhood and community environments have a significant impact on play, including the expansion of sedentary play activities, increased urbanization, demise of playgrounds, growth of apartment living and concerns about safety. Writing about the loss of a neighbourhood pond in Canada, Manuel (2003) used an occupational science perspective to describe how the physical pond environment facilitated play occupations including ice skating, frog catching and fishing. Manuel also highlighted the impact of the social and cultural environment including neighbourhood skating parties and community spectators.

Occupational Development in Children and Young People

There are a number of proposed models or theories of child occupational development.

Humphry (2005) has proposed the Model of Processes Transforming Occupations (PTO) as a way to understand how children's occupations develop, rather than how children's abilities develop. The PTO can be applied to children's occupations, which are described as 'activities that children find interesting or pleasurable and want to do or do because others manifest value in their doing so' (Humphry 2005, p. 38). The PTO applies dynamic systems theory to play, meaning that a child's intrinsic capacities (physical, cognitive and psychosocial skills) self-organize into a performance pattern for that play situation; these intrinsic capacities are interdependent and dynamic, so should not be separated (Humphry 2002). The focus is on the interaction of the child, the environment and the occupation, which reflect the occupational meaning. The PTO has three clusters which can be used to explain participation in play occupations:

1. *Construction of occupational opportunities*: This first cluster considers the influence of community, societal and cultural environments. Communities have shared cultural practices which are reflected in the nature of children's play, for example the use of manufactured toys
2. *Social transaction in developing occupation*: This second cluster refers to the idea that being involved in a co-occupation contributes to the development and adaptation of the occupation. Two children bring different performance patterns and skills to a joint play occupation, such as playing dress-up, which creates a new co-constructed occupation and new meaning
3. *Self-organizing processes underlying transformations in occupation*: This final cluster applies dynamic systems. Intrinsic capabilities within the child are assembled to enable occupational performance for that play occupation. These capabilities are reorganized as an occupation changes but repeated use through occupation enables enhanced performance.

The Process for Establishing Children's Occupations (PECO) (Wiseman et al. 2005) is a further example of a theory of occupational development in children. The PECO was developed from a qualitative study of children and young people's engagement in occupations and focuses on the development of childhood occupations rather than the development of the individual. The authors described two themes which emerged from 12 in-depth interviews. The first theme includes the reasons why children do the things they do (opportunities, resources, motivations, parental views and values), and the second theme identifies a process by which children's occupations become established (innate drive, exposure, initiation, continuation, transformation, cessation and outcomes). The PECO was developed from an exploratory study but offers an initial representation of how, and what, influences the development of occupations in childhood. Case-Smith (2010) has also detailed the development of children's occupations. Table 18-2 is a quick reference guide to play occupations at different ages.

TABLE 18-2

A Developmental Guide to Play

Age	Typical Play
0–6 months	Sensorimotor play predominates Social play focused on attachment and bonding Repeats actions for pleasurable experiences Coos, squeals, smiles, laughs
6–12 months	Exploratory Sensorimotor play evolves into functional play Functional Uses toys according to functional purpose Looks at picture book Social Attachment relating to parent Plays give and take Interacts briefly with other infants Plays contently when parents in room
12–18 months	Exploratory Explores all the spaces in the room using rolling and crawling Functional Simple pretend play directed towards self (pretend eating/sleeping) Imitative play from immediate model Social Begins peer interactions Parallel play Shares toys with parent
18–24 months	Functional Performs multiple related actions together Social Participates in parallel play Imitates parents and peers Group play Watches other children Begins to take turns Enjoys solitary play, e.g. colouring, building Pretend/symbolic Inanimate objects perform actions (dolls eating, dancing, hugging) Pretends objects are real and/or symbolize other objects Matches pictures to real things
24–36 months or 2–3 years	Social Associative parallel play predominates Cooperative play, takes turns Interest in peers, enjoys having companions Begins cooperative play and in small groups Shy with strangers especially adults Makes messes Matches red and yellow (3 years) Pretend/symbolic Uses toys to represent animals or people Plays out drama with animals or imaginary friends Constructive Drawing and puzzles Imitates adults using toys

TABLE 18-2

A Developmental Guide to Play (*Continued*)

Age	Typical Play
3–4 years	Social Participates in role play and dressing up Tells stories Continues with pretend play that involves scripts with imaginary characters Enjoys clowning Sings whole songs Role play based on parents' roles Construction Takes pride in products Shows interest in goal of art activity Constructs complex structures Games with rules Begins group games with simple rules Engages in organized play with prescribed roles Participates in organized gross motor game
4–5 years	Social play Understands taking turns Will take turns with 8–9 other children Plays with 2–3 children for 20 min in cooperative activity, e.g. project or game Pretend/dramatic play Dressing up Pretend play with scripts/imaginary characters Construction play Takes pride in products Interested in goal of art activity Constructs complex structures Games with rules Begins group games with simple rules Organized play with prescribed roles Sports Pedals tricycle turning corners Climbs on playground equipment swinging from arms or legs
5–6 years	Social Plays with 4–5 children on cooperative activity without constant supervision Pretend/dramatic play Acts out part of story playing part or using puppets Construction play Builds complex structures Plans and builds using simple tools (inclined plane, fulcrum, lever, pulley) Games with rules Explains rules of game/activity to others Board games Sports Swings on swing Rides bicycle Can jump rope by self Skates forward 3 metres Hits ball with bat or stick Walks or plays in water waist high in swimming pool Hangs 10 seconds from horizontal bar bearing own weight on arms

Continued on following page

TABLE 18-2

A Developmental Guide to Play (*Continued*)

Age	Typical Play
6–10 years	Social
	Play includes talking and joking
	Peer play predominates at school and home
	Has best friend
	Plays with consistent friends
	Is part of cliques
	Cooperative, less egocentric
	Tries to please others
	Less impulsive and able to regulate behaviour
	Has competitive relationships
	Games with rules
	Card games
	Computer games
	Has collections
	May have hobby
	Sports
	Cooperative and competitive play in groups/teams
	Winning and skills emphasized

> *Shifting from an organismic view to a contextual, occupation-centered perspective of development reframes the issue from understanding the development of children to one of understanding the ways children take on societal knowledge of how to use objects and carry out daily activities – those they want to do or carry out because of others' expectations.*
> (***Humphry and Wakeford 2006, p. 260***)

Occupational development is supported or constrained by other developmental components such as movement, cognition and psychosocial abilities.

- *Movement* is an integral part of many play activities. The emergence of motor milestones is widely variable and all charts indicating the ages at which children achieve skills should be viewed with caution, especially when conducting developmental assessments. Cultural differences have been noted and many milestones are reached earlier now than they were at the turn of the century (Herbert 2003)
- *Cognitive development* includes intelligence, attention and problem-solving, all of which can be explored during play. As children's understanding of the world increases, their play becomes more complex. As they develop emotional intelligence they are able to link behaviours with feeling and develop a theory of mind, which enables them to place themselves in another's position
- *Psychosocial development* includes dealing with emotions, social cognition and self-management and a child with poor social skills finds it difficult to join in games with their peers, which reduces the opportunities for physical play, as well as social interaction. A child's development of temperament includes confidence and motivation with a confident child being more likely to be motivated to try a new task and risk failure than a child who lacks confidence.

Infancy (Birth–2 Years)

In the first 6 months of life, sensorimotor play predominates and social play is focused on attachment and bonding, which often co-occurs with self-care occupations. Attachment theory was proposed by Bowlby (1969), a psychiatrist, and refers to the emotional bond between a child and the care-giver. The relationship between attachment and occupation is discussed by Whitcomb (2012) who highlights the need for co-occupation, particularly between mother and child, as a facilitator to attachment.

Sensorimotor play develops into functional play with toys being used for their purpose. Interest in picture books emerges. The child expresses their emotions through verbalizations to indicate whether they are enjoying play or not and they will repeat actions that give them pleasurable experiences many times.

By the end of the first year they can play 'give and take', showing an emerging ability to take turns. They play contently when their parents are in the room and will interact briefly with other infants. As the child's motor skills develop, they are able to explore their environment using crawling and rolling initially. They engage in simple pretend play, such as eating or sleeping. They will engage in parallel play and basic peer interactions. As they approach their second birthday, they show more interest in their peers and begin to take turns. Initially toys are used for their functional purpose but at 12–18 months, simple pretend play starts to emerge. By the age of 2 years, the child can perform multiple related actions together.

The play environment in these early years is usually home- or childcare-based, with interaction taking place primarily with parents, family members and a small number of others, which may include a paid carer. Outside play is weather-dependent and in extreme climates may be challenging for young children.

Early Childhood (2–5 Years)

For many children, early childhood is the time when their social contacts widen as they mix with similar-aged peers, friends and family members. At 2–3 years, their play is primarily parallel but associated to what is happening around them. They are able to cooperate with others and play in small groups and understand taking turns. At 3–4 years they will tell stories and sing whole songs. By 4–5 years they can take turns with 8–9 other children. They will play with a group of two to three children for up to 20 minutes cooperatively on a project or game. Towards the end of this stage they can play group games with simple rules. In early childhood, symbolic or pretend play emerges with the child showing imagination through play (Case-Smith and O'Brien 2010). Toys are used to represent animate objects and they will act out stories with real or imagined friends. Constructive play starts to emerge, including drawing, painting, building and doing puzzles. By the age of 4 years, they start to take interest in the end-product of their creative activities and can build complex structures.

Middle Childhood (6–10 Years)

Play during middle childhood includes construction, crafts and hobbies, games with rules, media and technology use (e.g. CDs, DVDs, and other devices), organized sport, social and dramatic play. Constructive play involves building complex structures with blocks or interlocking shapes, including puzzles. Crafts and hobbies include drawing and collecting things, such as stamps, cards and stickers. Games with rules that are played include playground, computer, board and card games that require abstract thinking. Media and technology use is common in this age group, such as watching TV and DVDs. A variety of devices enable children to play video games, listen to music and use the internet for online activities. Sporting activities undertaken outside school commonly include swimming, football and cycling. Organized sporting activities are influenced by local cultures, such as whether football or rugby is popular in the UK. Social play includes talking and joking with peers and simply hanging out. During this time, children's play takes on more social and cooperative forms compared with younger children's play.

Adolescence and Adulthood

Adolescents describe leisure time as providing enjoyment, freedom of choice and time out (Passmore and French 2003). Passive leisure activities provide few benefits beyond providing resting time, as too much can lead to boredom. Boredom is associated with higher risks of leaving school early, misusing drugs or alcohol and youth offending activities (Widmer et al. 1996). Sexual play emerges with puberty. Regardless of disability, common interests include listening to music, communicating and spending time with friends and watching television. In early adulthood, the focus shifts to establishing balancing leisure occupations such as socializing, dating, team sports and other interests with other aspects of life. In middle adulthood, leisure interests are generally established, often with a focus on family activities.

Although an appreciation of play as a catalyst for child development is important knowledge for

occupational therapists, the issue of play as an occupation is our unique perspective. So far this chapter has considered the role of play in occupational therapy, play as an occupation, the development of the occupational role of player and occupational theories of play. Having considered the theory, the focus is now on practice, including the range of play assessments available, the play interventions used by occupational therapist and the impact of play on specific conditions.

ASSESSMENT AND INTERVENTION

Play is the primary occupation of children and young people, making it a domain of concern for the occupational therapist. Play should be embedded in occupational therapy assessment, intervention and outcome measurement. By facilitating play, occupational therapists can assist children and young people to achieve positive mental health and wellbeing.

Play Assessments

The absence of a universal definition of play and what should be assessed has also impeded the development of play assessments and it is only recently that occupational therapists have realized a range of occupation-focused assessments (Stagnitti 2004).

Wendy Coster, a notable occupational therapist, significantly contributed to the re-examination of assessments used by occupational therapists working with children and young people (Coster 1998). She called for occupation-centred assessment of children, describing how occupational therapy assessment had traditionally concentrated on the physical, cognitive and psychosocial components that may impede the child's abilities. These component parts were often assessed in isolation. The impact on occupational functioning was a secondary consideration and not directly assessed, for example in the areas of self-care, school and leisure. In mental health settings, the dominance of psychodynamic theory and lack of appropriate tools constrained occupational therapists from accessing and utilizing play assessments that reflect the core values of the profession. As an alternative approach, Coster (1998) explored the concept of a top-down approach to assessment, recommending assessment of performance within typical occupations, such as participating in a school lesson or riding bikes outside with friends.

An assessment of play may be made for a number of reasons, for example: establishing a baseline of performance; intervention planning; or as an outcome measure or for research (Brown and McDonald 2009). The reason for the assessment should guide the therapist's assessment tool selection. It is important that assessments are considered carefully and an informed evaluation of psychometric properties, such as validity, reliability and clinical utility, is conducted (see Chapter 5). As many assessments were developed using limited normative samples, occupational therapists should appraise whether an assessment is culturally appropriate. There are a range of assessment tools available, which specifically examine play or leisure occupations including for example:

- The Symbolic and Imaginative Play Developmental Checklist (Stagnitti 1998)
- Play Skills Self Report Questionnaire (Sturgess 2007)
- Test of Playfulness (Bundy et al. 2001)
- Revised Knox Preschool Play Scale (Knox 1997)
- Kids play profile (Henry 2000)
- Preteen play profile (Henry 2000)
- Adolescent leisure interest profile (Henry 2000)
- Children's Assessment of Participation and Enjoyment (CAPE)
- The Preferences for Activities of Children (King et al. 2004).

Table 18-3 shows a range of available play assessments and their uses. Three occupation-based play assessments are now discussed in further detail.

Child-Initiated Pretend Play Assessment

The Child-initiated Pretend Play Assessment (ChiPPA) was developed by Stagnitti (2007), an Australian occupational therapist. This norm-referenced standardized assessment of spontaneous pretend play is suitable for ages 3–7 years 11 months. The ChiPPA takes between 18 and 30 minutes to administer and requires the therapist to construct a play house before sitting with the child to complete a conventional imaginative play session followed by a symbolic play session. The items for the first session comprise common play items, including dolls, a teaset, animals and a truck. The second session utilizes unstructured items, such as a tin, piece of wood, stone and a cloth. The assessment

TABLE 18-3

A Summary of Play Assessments for Occupational Therapists

Reason for Assessment	Example of Play Assessment
Establish a baseline of performance	Revised Knox Preschool Play Scale (Knox 1997)
Show change over time	Test of Playfulness (Bundy et al. 2001)
Supplement clinical observations	Play Skills Self Report Questionnaire (Sturgess 2007)
Assist with intervention planning	The Symbolic and Imaginative Play Developmental Checklist (Stagnitti 1998)
Outcome measure	Child Initiated Pretend Play Assessment (Stagnitti 2007)
Research	Penn Interactive Peer Play Scale (Fantuzzo and Hampton 2000)

is child-centred and non-directive and is scored by recording every action the child uses and assigning a code (Stagnitti 2009). Analysis of the codes shows the play process, themes and repetitions which highlight typical or deficient pretend play. Stagnitti has completed two studies that have shown that the ChiPPA has good reliability and validity (Stagnitti et al. 2000; Stagnitti and Unsworth 2004).

Test of Playfulness

The Test of Playfulness (ToP) (Bundy et al. 2001) provides an objective measure of engagement in play activity. It is based on Bundy's Model of Playfulness (1991) and evaluates free play for children 6 months to 14 years of age. The ToP is administered by observing the child in a familiar natural environment for 15–20 minutes, both indoor and outdoor if possible and appropriate. It has 24 items that reflect the domains of intrinsic motivation, internal control and freedom to suspend reality. The examiner rates the extent, intensity and/or skill of the observed behaviours. Overall playfulness is determined by the combined scores in each domain (Cameron et al. 2001; O'Brian and Shirley 2001). A number of studies have confirmed the validity and reliability of the ToP for children with and without disabilities (Okimoto et al. 1999; Bundy et al. 2001; Harkness and Bundy 2001). Additional research by Cameron et al. (2001) found that the ToP is clinically useful for occupational therapists with children with a variety of disabilities. It has helped therapists examine the interaction of the child and the environment, and address the product of play rather than just play skills. It was also seen as a useful tool to highlight a child's strengths rather than the weaknesses.

Play Skills Self-Report Questionnaire

Sturgess (2007) identified the need for an evaluation of play in middle childhood. The Play Skills Self-Report Questionnaire (PSSRQ) has been developed for 5–10-year-olds who have a problem with play or social skills; or have another concern such as illness or disability which could have an effect on play and/or social skills. Sturgess (2007) based the assessment on the premise that playing and playfulness are beneficial to children; take place in many areas of a child's life; occur alone and with others; and facilitate physical, cognitive, language and social skills. The purpose of the PSSRQ is to gather a child's self-perception of their ability on 29 play skills from a range of contexts – home, school, community. There is also a parent/carer version of the PSSRQ. It is designed to enable self-comparison over time and therefore does not have meaningful summative scores. The PSSRQ takes 15 minutes to complete. It has been developed from occupational therapy principles but can be used by a range of health and education professionals who have an understanding of child development. Earlier studies have confirmed face and content validity and test–retest reliability (Sturgess and Ziviani 1996). The PSSRQ is a useful child- and family-centred assessment tool that could be used with children with a range of mental health difficulties, including attention deficit hyperactivity disorder (ADHD).

Play Interventions

As well as progress with play assessments for occupational therapists, there have also been developments in play interventions. Play interventions either use play as therapy with play outcomes or use play as therapy with non-play

outcomes. The latter has historically been used by occupational therapists working in mental health settings, often using non-directive play interventions or, with additional training, play therapy. Play therapy makes use of play to help a child play out feelings and problems and experience growth (Axline 2000). Play therapy utilizes eight basic principles: developing a friendly relationship; accepting the child; permissiveness; recognizing feelings; respect; non-direction; allowing a natural process; and limitations. Play therapy is supported mainly by case study research and is often used with children who have been traumatized or abused (Cooper 2009). Play therapy is not an occupation-based intervention but due to the paucity of alternatives has often defined occupational therapist role in mental health settings.

Increasingly, occupational therapists are using occupation-based play interventions. These use play as therapy and as an outcome. In this type of intervention, the therapist is aiming to see an improvement in play as an outcome of the play intervention. The numbers of interventions that meet these criteria are limited but *Learn to Play* and *Cognitive Orientation to Daily Occupational Performance* are two good examples of occupation-focused interventions.

The Learn to Play Programme

The Learn to Play programme by Stagnitti (1998) is a specific play intervention that uses play as a therapeutic medium and play as an outcome. This practical programme develops the imaginative play skills of children aged up to 6 years of age and is therapist-facilitated and family-centred. Learn to Play addresses the area of play themes, sequences of play actions, object substitution, social interaction, role play and doll/teddy play. It is suitable for use in a practice or home setting. Following assessment using the Symbolic and Imaginative Play Developmental Checklist (Stagnitti 1998), the occupational therapist demonstrates developmental-appropriate play activities with the child and encourages the parent/carer to carry out the same. The play activities are supported with handouts and should be incorporated into the family play routine. The programme is regularly reviewed by the occupational therapist and the level of skill increased over a 3–6-month period (Stagnitti 1998). The Learn to Play programme can be used with children who have a range of difficulties, including autistic spectrum conditions and attachment disorders.

Cognitive Orientation to Daily Occupational Performance

Cognitive Orientation to Daily Occupational Performance (CO-OP) is an intervention based on a dynamic system or cognitive neuroscience approach, where there is an emphasis on the interaction between the person and the environment (Polatajko and Mandich 2004). CO-OP can be applied to play but is not a play-specific intervention. The approach can be used with older-age children in mental health settings with conditions such as ADHD. CO-OP is a person-centred, performance-based, problem-solving approach, where the therapist guides the child to discover and learn strategies to achieve their chosen goals. The occupational therapist establishes goals with the child, for example to kick a ball in football, and measures their current performance and satisfaction with the activity. Following this, there are ten sessions with the child, where the global strategy – goal/plan/do/check is used, together with domain-specific strategies to improve performance of the activity itself (Polatajko and Mandich 2004).

Occupational therapists working with children and young people will commonly work with those who have a range of conditions, including Attention Deficit Hyperactivity Disorder (ADHD); Autistic Spectrum Conditions (ASC); depression; anxiety; obsessive compulsive disorder (OCD); behavioural difficulties and eating disorders. All of these conditions can have an impact on play and leisure occupations. Occupational therapy for ADHD is presented in the next section, as an example.

PLAY AND ATTENTION DEFICIT HYPERACTIVITY DISORDER

Attention Deficit Hyperactivity Disorder (ADHD) is a common condition seen in children and young people in mental health settings and is characterized by the symptoms of inattention, hyperactivity and inattention that impair everyday life. ADHD diagnosis and intervention in the UK is typically completed by a multidisciplinary team (NICE 2008); the occupational therapist is a specialist in understanding the impact of ADHD on daily occupations, including play. Recent studies have highlighted that children and young people with ADHD engage in less cooperative play and sharing, dominate play, lack interpersonal

empathy, struggle with transitions between activities and are involved in more negative behaviours compared with typically developing peers (Leipold and Bundy 2000; Cordier et al. 2010b, c). Cordier et al. (2010a) also found that children with ADHD commonly use siblings as playmates who are thought to be more accommodating of ADHD play behaviours. The occupational therapists working with a school-aged child with ADHD could complete the Test of Playfulness to understand the child's play behaviours at home and at school, along with discussion of any concerns with the child and their family. Following the assessment the occupational therapist could use the CO-OP approach or the play-based intervention model proposed by Cordier et al. (2010c). The latter integrates the symptoms of ADHD with concepts from Playfulness Theory (see earlier) to improve intrinsic motivation and empathy. Both interventions are occupation-focused and can support children in their role as player within the family, school and social contexts.

SUMMARY

Play has always been an intrinsic part of occupational therapy practice. Occupational therapists have been influenced by the study of play in related areas such as psychology and sociology. This knowledge provides a foundation but considering play as an occupation is unique to the occupational therapy domain of concern. Occupational therapists have developed an understanding of play as an interaction between the person, their environment and the occupation. Play occupations reflect societal and cultural roles, are influenced by the built and natural environment, and transform through shared meaning. Play can therefore support healthy mental and physical development. Play deprivation has serious consequences for emotional development and behaviour. Mental health difficulties in children and young people can impact on play and leisure occupations and therefore have further impact on health and wellbeing. Furthermore, parents with mental health issues can influence the child's development of a healthy range of play occupations. Occupational therapists working in this field have available an increasing range of play assessments and interventions that are occupation-focused. Research into play and occupational therapy is establishing the important role occupational therapists have in maintaining or establishing play occupations for children and young people's with mental health difficulties.

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19 LIFE SKILLS

KEVIN CORDINGLEY ■ HANNAH PELL

CHAPTER CONTENTS

INTRODUCTION

Occupational therapists work with individuals with mental health problems to facilitate their recovery (see Ch. 2). For any occupational engagement and participation, biological health and physical safety needs must be met (Matuska and Christiansen 2008). For example, the ability to identify appropriate foods, locate, purchase, prepare, cook and eat, underpins fundamental life skills, without which other participation potentially would not occur. Recovery involves managing the practical and social aspects of life, such as shopping, eating meals with friends or paying bills. These aspects of life are called life skills, which are associated with building and maintaining relationships with others. This makes for a complex array of skills required for recovery and for functioning effectively in life, which can be developed through occupational engagement and for which occupational therapists have a clear role (Kelly et al. 2010). In this chapter, the place of life skills in occupational therapy is explored by defining and describing life skills; considering ways to assess; and examining the interventions for developing life skills. Throughout, discussion of key issues draws on theory, practice and current evidence underpinning the approaches used by occupational therapists.

WHAT ARE LIFE SKILLS?

The term life skills has been used to broadly describe a range of tasks and activities that support occupational and role performance. Life skills have been defined by Mairs and Bradshaw (2004) as 'the skills required to fulfil the roles required of individuals in

the setting in which they choose to reside' (p. 217). In a Cochrane review, Tungpunkom and Nicol (2009) described life skills as managing money, organizing and running a home, domestic skills, personal self-care and interpersonal skills. A later update of this review also included therapeutic recreation (Tungpunkom et al. 2012). Life skills have been classified as self-maintenance (Reed and Sanderson 1999), which includes personal and domestic activities of daily living (Hagedorn 2001). Also they can be labelled as instrumental/activities of daily living (I/ADL) (American Occupational Therapy Association, AOTA 2008).

This broad-based view of what can account for life skills is problematic. Indeed Reed's (2005) historical review of the concepts of self-maintenance and self-care highlighted the diversity and lack of consistency. In some instances, categories in their own right being sub-categories in other literature.

Before settling on a definition of life skills for this chapter, it is important to consider the place that life skills have within occupational engagement and participation as a whole. Life skills are one aspect of occupational therapy, relating to the occupations of individuals and the communities they belong to and live with.

LIFE SKILLS, ROLES AND BELONGING

The performance of life skills may well involve doing tasks and activities that one may enjoy or one has an obligation to do (Wilcock 1998, 2006). This performance of life skills is accompanied by an implicit sense of purpose and meaning (Creek 2003, Jonsson 2008).

Life skills form blocks of performance that are part of a set of tasks performed in sequences that make up activities supporting occupation (Creek 2003). Life skills are also required to perform occupational roles for which occupational engagement is integral. A given role has an internalized social and personal outlook, attitudes and specific actions. These are expressed in associated and expected behaviours and relationships to others (Kielhofner 2008). However, Creek (2010) also makes explicit the relationship to performing occupations within a role. A role example is being a mother, who has her views on parenting and understands expected behaviours (Creek 2010) associated with the IADL of child-rearing (AOTA 2008). Having a work role or even just functioning in life today would require the IADL of communication management (AOTA 2008). This may require the use of technology. It is important to note that the same or similar life skills could be required for a number of different roles in ADL, such as dressing and meeting personal hygiene and grooming needs (AOTA 2008). A combination of life skills therefore helps to meet role needs and expectations.

Roles and the life skills required to fulfil them are also linked to social activities and relationships, where the psychological and emotional needs for belonging and support are met (Rebeiro et al. 2001). Communication and interaction skills are not discussed in this chapter, but they are often required as a part of other life skills, such as shopping when speaking to shop assistants. Life skills and roles also relate to cultural, spiritual and religious aspects of occupation discussed later in the chapter. Meeting occupational needs is believed to have an effect on health and wellbeing (Doble and Santha 2008) and may, in part, be addressed by life skills.

For many people, maintaining life skills and roles, and gaining a sense of belonging, can be a daunting prospect. A person may have to manage many aspects of their mental health problem and the reaction of others, as well as the impact on their own participation. This can mean being stigmatized by the wider community and feeling alienated as a result (Townsend and Wilcock 2004). The challenge in managing these different elements of life can make it difficult to develop effective and socially valued roles which increase the sense of belonging (Wilcock 2006).

Categorizing Life Skills

In the mental health setting, addressing life skills means helping people to manage a range of occupations within the category of self-maintenance. This category is related to and may influence effective engagement in productivity and leisure. This focus forms part of the broader aim of occupational therapy to enable people to participate in occupations and associated roles. These categories are regularly used by occupational therapists (Jonsson 2008; see also Chs. 18 and 21). Categorizing occupations is important, not

only to distinguish them but also to understand how they relate to each other.

Individuals categorize occupations differently, depending on how the occupations are perceived in relation to personal interests, needs and meanings (AOTA 2008). Implicit within the categories of occupation are two concepts: occupational engagement and participation. Each concept denotes slightly different aspects and they are defined here. Engagement is 'a sense of involvement, choice, positive meaning and commitment while performing an occupation or activity' (Creek 2010, p. 166). This sense of involvement is linked to the internal emotional and psychological world of the individual and is experienced when performing an activity or occupation (Creek 2010). Participation is 'involvement in life situations through activity within a social context' (Creek 2010, p. 180). In this definition, the emphasis is placed on doing as influenced by, and performed within, the norms and expectations in a given culture and social milieu (Creek 2010), of which roles form a part. This demonstrates the complexity and multidimensionality of each occupation for each individual (AOTA 2008) within a social context.

Addressing life skills in the mental health setting means helping service users to manage a range of occupations within the category of self-maintenance that also are related to, and may influence, effective engagement in productivity and leisure. All form part of the broader role of the occupational therapist to enable service users to participate in occupations, associated roles and develop a balance in occupational engagement and participation (Wilcock 1998).

It is clear that the term 'life-skill' has no one definition. For the purposes of this chapter, life skills will be regarded as activities of daily living (ADL) and instrumental activities of daily living (IADL) as AOTA (2008) defines, i.e.

- *Activities of daily living* are basic or personal and are 'fundamental to living in a social world; they enable basic survival and wellbeing' (AOTA 2008, p. 631)
- *Instrumental activities of daily living* are 'activities to support daily life within the home and community that often require more complex interactions than self-care used in ADL' (AOTA 2008, p. 631). They are complex multistep activities requiring the integration of higher-level cognitive skills (McCreedy and Heisler 2004).

Table 19-1 summarizes these activities. The ways in which life skills problems can manifest are discussed next.

Individual Needs

People may have a variety of life skills problems. The occupational therapist needs to build a picture of the individual's constraints and strengths, considering how occupational limitations are related to the signs and

TABLE 19-1

A Summary of the Activities Categorized as Activities of Daily Living and Instrumental Activities of Daily Living

Activities of Daily Living	Instrumental Activities of Daily Living
Bathing and showering	Care of others (including selecting and supervising care-givers)
Bowel and bladder management	Care of pets
Dressing	Child-rearing
Eating	Communication management
Feeding	Community mobility
Functional mobility	Financial management
Personal device care	Health management and maintenance
Personal hygiene and grooming	Home establishment and management
Sexual activity	Meal preparation and clean up
Toilet hygiene	Religious observance
	Safety and emergency maintenance
	Shopping

AOTA (2008).

symptoms of the person's mental health problems. Undertaking an activity analysis is important to help understand in what aspects of the particular life skill the individual has problems with. This is used as a basis for discussion when intervention planning (see Ch. 6).

This section uses the example of schizophrenia and the associated difficulties identified in the occupational therapy and psychology literature. (The signs and symptoms of schizophrenia are not specified here, and the reader is directed to familiarize themselves with a psychiatric textbook for details). Schizophrenia has been found to affect the balance of an individual's occupations; it can result in engagement in passive activities and a low level of daily structure (Bejerholm and Eklund 2004). Under-activity may lead to a sedentary lifestyle (Bejerholm 2010a). This can lead to limited experiences of accomplishment (Bejerholm 2010b) and may affect the ability and wish to initiate life skills.

It must not be assumed that all of these problems will be apparent for every person with schizophrenia. It is also important to note that some life skills may not be considered by some to be meaningful occupations. A person-centred approach (Sumsion, 1999) is therefore required to understand the individual's perspective of their occupational capacity and their sense of meaning in performing life skills. This has to be balanced with the possibility of vulnerabilities such as self-neglect and its impact on health and wellbeing. When valued life skills are identified and risks are known, the occupational therapist may decide to use specific assessments (see below).

People can experience limited societal acceptance due to stigma, impacting on their sense of belonging within a community (Andonian 2010). This can lead to barriers in participation (Yilmaz et al. 2008) and therefore difficulties maintaining and developing roles. The attitudes of others can limit opportunities to develop friendships. A lack of a close and reliable friend has been found to limit occupational engagement (Bejerholm 2010b). However, an acute phase can impact on this. At this time, the need to make new friends may be less of a priority (Bejerholm 2010a). The physical environment and the location of occupations can also impact on social connections and participation (Yilmaz et al. 2008).

There are cognitive difficulties with real-world daily life task functioning (Rempfer et al. 2003) for people with schizophrenia. Learning and memory can be affected (Green et al. 2000). Executive function problems impact on initiating and performing tasks and solving new or conflicting problems in complex or unfamiliar situations (Green et al. 2000). Awareness (insight) problems, such as lack of knowledge or recognition of deficits, lead to lack of initiation of activities and limited success in rehabilitation (Katz and Hartman-Maeir 2005). This may lead to a withdrawal from performing life skills, which may lead to boredom (Bejerholm 2010b), stagnation and emptiness permeating occupational patterns and time use (Bejerholm and Eklund 2004). This can also lead to an impaired sense of meaning of the activity for the person, which limits participation (Yilmaz et al. 2008).

Culture and Religion

Participation and engagement happen within an environment with social and community aspects, as well as physical (architectural and natural) space (Baum and Christiansen 2005; Kielhofner 2008). The sociocultural and religious aspects of life skills that form a part of participation need to be explored by the occupational therapist. This section can only briefly introduce the huge diverse range of cultural and religious differences in occupational performance.

Cultural beliefs influence occupational patterns, choice of activity level, perceptions of value of occupations influencing engagement in them (Chiang and Carlson 2003; Bonder et al. 2004). The occupational therapist has to consider cultural values in relation to what people do. For example, Fair and Barnitt (1999) explored a range of different ways in which a cup of tea was made by 15 students and colleagues from South Asia, Africa, Europe and Australia. The ways of making tea, the meaning of doing this and the purpose for doing it varied between and within cultures and across generations. This suggests that occupational therapists need to be open to reviewing their existing and traditional practices of using hot drinks for assessment when working with people from different cultures (Fair and Barnitt 1999; see also Table 19-2).

In research about service users' perspectives of their experience of mental health inpatient rehabilitation, some participants felt the focus on independence and life

TABLE 19-2

Making a Cup of Tea – Checklist

Making a Cup of Tea	1. Independent	2. Able with Verbal Prompts	3. Able with Physical and Verbal Assistance	4. Unable to Complete	Comments
Aware of use of equipment					
Organizes task in sequence					
Aware of safety factors					
Fills kettle appropriately					
Turns on gas/electricity switches					
Puts tea in pot/cup appropriately					
Pours boiled water in appropriately					
Uses sugar/milk appropriately ...					

Adapted from Finlay (2004).

skills was not necessarily culturally relevant (Notley et al. 2012). Gibbs and Barnitt (1999) explored four aspects of self care (dress, diet, bathing and toileting) in a study involving 19 Hindu elders. The concept of independence was not understood by the participants, who valued and expected family members to care for them. As elders, they were central to and supported by an extended social group. Sensitivity must be shown to these situations and expectations in assessment and intervention planning.

Religious observance is an IADL (AOTA 2008). Participants in a black and ethnic minority focus group identified that the consideration of spiritual and religious needs may be a focus for occupational therapists. Returning to the community could involve church and faith groups: understanding and exploring how people wish to express their spirituality may be very important (College of Occupational Therapists 2006).

These examples provide a sense of cultural and religious aspects that need to be considered in relation to life skills. Therapists also need to be aware of their own cultural beliefs and behaviours and how that impacts upon their understanding and sensitivity to others from a different background (Chiang and Carlson 2003). Even within a single society, people have different backgrounds and therefore attach different meanings to the occupations they value (Darnell 2009). Culture also has an emergent nature and the therapist must recognize whatever cultural issues are established, they need to be seen as a means of generating preliminary hypotheses to be tested for the specific person (Bonder et al. 2004). This leads into a consideration of how to assess life skills.

ASSESSING LIFE SKILLS

Assessment of life skills for mental health service users should be holistic and starts with observation (see Ch. 5). The therapist must have completed an activity analysis of the life skill to guide assessment of the person's strengths and constraints. This analysis includes psychological/emotional, social, cognitive, sensory and physical aspects of performing life skills, as well as the environment in which these will be performed. It may also be useful to know the educational background and level of achievement in other areas of occupation. Beyond this point, decisions can be made about what form of assessment would be required. However, it is also important to know for what purpose the assessment is required. For instance, the life skill needs of a person returning to live alone are different to one going to live in a group home.

In the mental health setting, relevant initial observations can indicate problems an individual may be experiencing in relation to life skills areas and include the following:

- *Environment*: Influences of noise, silence, interruptions, temperature, health/social care setting, home- and community-based observations and assessments
- *Mood and affect*: Levels of anxiety and discomfort
- *Appearance*: The state of clothing and whether dressed appropriately for weather conditions, malodorous smells, body weight, and application of make-up and hair and nail condition
- *Cognition*: Attention and concentration during discussion prior to, and during, observations of I/ADL.

Non-Standardized Assessment Tools

The assessment can take the form of a checklist of aspects of the activity that would be required to perform it effectively. For example, the checklist might focus on making a cup of tea (see Table 19-2). Here, a person would be observed and a tick placed at the appropriate score and descriptor box; making additional comments as required. This may also be constructed for a different activity, such as making a sandwich, or occupations such as shopping for groceries.

Whatever assessment is used, it is important to give the person the fullest opportunity to complete all or as much of the assessment as they can before the occupational therapist intervenes. As soon as the occupational therapist alters the way an assessment is performed, the clearest picture of strengths and constraints for the person is altered. The therapist must not alter the progress unless the possibility of harm arises and the person appears unable to deal with this possibility. For example a pan has some oil that is over-heating, producing a lot of smoke and could catch alight. Should the therapist need to intervene, this should be recorded as part of the assessment. It may be that the person lost concentration, lacked knowledge or was distracted in some way. These may indicate the impact of their mental health problem on their occupational functioning. However, it is also important to get feedback from the person about their perspective of what happened.

Tools to measure life skills may be linked to a specific model of practice, or they may stand alone, but there should always be a theoretical basis underpinning the assessment. The following section therefore considers some new developments with stand-alone assessments.

Assessing Activities of Daily Living

A sensitive approach is required for assessment by discussion or observation of personal activities, such as bathing, showering, bladder and bowel management, and personal hygiene and grooming (see Case study 19-1 for an example from practice). The initial observations of mood and appearance can be helpful in assessing some aspects of these activities. All attempts to prevent or minimize the person's embarrassment should be made. Discussion may be better than a full observational assessment. However, if the person is unable to fully verbalize their abilities in these areas, asking someone who regularly assists with these activities, with the person's consent, can help the therapist to understand the needs. Ultimately,

CASE STUDY 19-1

Personal Hygiene and Grooming

Bob has a diagnosis of paranoid schizophrenia. He is currently an inpatient on a rehabilitation unit.

ASSESSMENT FINDINGS

Bob has not been attending to some of his activities of daily living, particularly his personal hygiene and grooming.

ANALYSIS

Bob does not think he has a problem with his personal hygiene and grooming.

INTERVENTIONS:

- Occupational therapist to build a therapeutic rapport with Bob
- Help him develop self-awareness of his issues with personal hygiene and grooming
- Feedback to him prior to individual sessions
- Teaching strategies to check his personal care needs and manage them effectively
- Take him to the barbers and encourage him to take pride in his appearance.

observation may be the only way to assess fully the specific difficulties.

Assessing Instrumental Activities of Daily Living

The Test of Grocery Shopping Skills (TOGGS) was developed in North America and is undergoing validity and reliability procedures (Hamera and Brown 2000; Rempfer et al. 2003). There is potential for its use in other countries, provided the validity and reliability are established for the relevant population and context. The theoretical base for this assessment uses information processing from cognitive psychology, along with occupational therapy models and a focus on the environment.

This assessment is used with people with schizophrenia and schizoaffective disorder. It is an observational measure of the person's ability to identify the correct type of groceries, on a given list, in the correct location in a shop. The environmental aspect of the assessment refers to where the shopping is carried out, which is a medium-sized shop unfamiliar to the person being assessed. There are three aspects for assessment by observation: accuracy, efficiency and timeliness. The person has to locate the correct type and size of an item, at the lowest price. This is an assessment designed to deal specifically with grocery shopping. Other assessments measure occupational engagement. From observation, discussion and assessment, the occupational therapist may gain a picture like the example from practice described in Case study 19-2. Following the process of observation, assessment, interview and discussion, life skill intervention plans need to be established.

INTERVENTIONS FOR DEVELOPING LIFE SKILLS

> *If you give a person a fish, they will have a single meal. If you teach them how to fish, they will eat all their life.*
>
> ***Kwan Tzu, Chinese Poet***

The intervention plan should be based upon the holistic and person-centred assessment of the specific and individual strengths and constraints of the service user. Allied to this is the application of relevant research evidence and practice experience to inform the intervention plan. This means that the interventions and approaches will vary for each person. To plan interventions, basic requirements should be considered. Different methods include teaching methods and occupational therapy approaches.

CASE STUDY 19-2

Cookery Skills

Building on the case of Bob, the team are concerned that Bob was not eating healthily prior to his admission.

The occupational therapist needs to establish why Bob wasn't cooking for himself. Is this reduced motivation, lack of ability, few routines or limited knowledge of healthy eating? Has his condition impacted on him cognitively? Can he concentrate on the task? Is he easily distracted? The therapist meets with Bob who says that he doesn't know how to cook and would like to learn. He was previously eating only take-away food and ready meals. He has a limited understanding of healthy eating and the impact of an inadequate diet on his long-term physical health. He reports spending a lot of his money on the take-away meals and so is often short of money. Bob is keen to participate in individual cooking sessions.

BASIC REQUIREMENTS FOR LIFE SKILLS INTERVENTIONS

The following aspects of planning and developing life skills interventions are the basic preparations required to provide the optimal approach for each person. It is at this stage that the information gathered about the person informs the therapist about how best to organize the environment and build on existing life skills to promote learning.

Environment

Environmental considerations include the social and physical aspects. At all stages of the therapeutic process the therapist must be aware of therapeutic approaches to life skills training. This includes their therapeutic use of self, person-centred practice

and the use of core occupational therapy skills. Emotional and psychological support will be indicated by showing a genuine interest, a caring attitude, therapist confidence and boundaries in their behaviour (Berkeland and Flinn 2005, pp. 436–437). This helps to build on the therapeutic relationship and develop the person's trust in the therapist. The observations about the environment from the initial assessment are relevant in preparing and choosing an appropriate area to work with the person. The interventions may start in a hospital or rehabilitation unit and develop towards working in the person's home in the community. However, the person's level of ability and needs will dictate the location of intervention.

TEACHING METHODS

There are a variety of teaching methods for developing life skills that can be applied to therapeutic settings, including:

1. Written instructions: these need careful planning for readability and design (Hoffmann 2009)
2. Verbal instructions: these also require clarity. There should be short descriptions of what is required of the person. Also one concept should be presented at a time, in order of least to more complex. This allows the person to understand each one and to provide a firm basis for moving onto the next issue
3. Photographs, pictures and illustrations may be useful to indicate clearly what is being aimed at
4. Demonstrations by the therapist (or others) and the use of video and DVD can be much more effective than trying to use written or verbal directions. Practical life skills can be taught effectively this way, for example peeling and chopping onions and safe handling of kitchen equipment
5. Checking the person understands: questions can be asked to clarify the level of understanding that has occurred, allowing the therapist to make alterations and repeat as necessary. The person must also have the opportunity to ask questions too. Key points can also reinforce their learning
6. Feedback and monitoring progress: the person needs to understand how well they are proceeding, and this requires sharing and exchanging information.

Finding out the person's perspective of their performance is important. The therapist must be aware of the accuracy of immediate feedback at any point in the session (Berkeland and Flinn 2005), as this may be based on emotional reactions if the person is upset or elated in mood. Immediate review of a situation and support is important for people who lack confidence and self-esteem, or for those who may have difficulty perceiving their capacity and performance constraints in realistic terms. An example of this would be that a service user has achieved a specific method for preparing a vegetable for the first time.

Feedback and monitoring progress needs to be considered carefully as to when, and how often, this is provided. Feedback would be particular to each person's needs and stage of the occupational therapy process. Feedback can take a variety of forms; the simplest and most direct form is verbal. The occupational therapist can also share the results from standardized assessments or written reports on the person's progress. These could be used to inform discussions about a plan for the life skills that still need to be developed. Later on, if group work is used, feedback can include comments from peers. If appropriate video can be used to show the person exactly how they performed. This needs to be managed carefully due to possible sensitivity to the experience of seeing oneself on video. However, the video can provide a clear record of how the person progresses and can be presented as before and after reviews of achievements.

The following suggestions about constructive feedback are from education, but are relevant in the mental health setting:

- Learner has first say
- Praise before criticism
- Limit the feedback
- Specific, not vague
- Concentrate on what can change
- Time for learner to think and respond
- Explore possible alternatives
- How is the feedback received?

- Think of the language you use
- End on a positive note (Neary 2000).

The process of making sense and understanding these experiences may well include challenging the person's beliefs if they do not match with what can impact upon their health and wellbeing. This can be a delicate process and the therapist needs to manage this with therapeutic approaches. These feedback methods may be used independently of each other, or more often a combination of them is applied in life skills interventions.

TEACHING LIFE SKILLS

Providing life skills interventions may require that some skills are taught. This need may arise for several reasons: the person may have never developed the skills at all; they may have forgotten some aspects; their mental health problems may have impacted on their performance and capacity for learning life skills; or there may be a new or more effective way of performing a life skill. Learning to adapt to doing occupations in a different way or in a different social or physical (geographical, architectural) environment could also be required.

In mental health service provision, the occupational therapist uses teaching techniques and so practice is a blend of these therapeutic, teaching and learning approaches. Berkeland and Flinn (2005) and Hoffmann (2009) give details of teaching methods for further reference.

Learning a skill or knowledge occurs whenever an individual adopts new behaviour patterns or modifies existing ones in a way which has some influence on future performance or attitudes (Neary 2000, p. 95). The use of the word attitudes makes an explicit reference to a change in an aspect of cognition. So learning can involve changes in skills, knowledge and belief systems. It is 'the ability of the teacher to set up a learning experience which brings about the desired educational outcome' (Neary 2000, p. 91). This indicates that the teacher has responsibility for establishing the learning environment to enable the learner to achieve specific learning requirements. One related but key difference in education in the health and social care setting would be to 'influence [peoples'] knowledge and health behaviour' (Hoffmann 2009, p. 159). From this perspective there may need to be specific teaching for health promotion, for example smoking cessation programmes. This would relate to the IADL of health management and maintenance (AOTA 2008).

Teaching in mental health services can also involve psychoeducation.

> *The purpose of psycho education (or patient education/teaching) is to increase patients' knowledge and understanding of their illness and intervention. It is supposed that increased knowledge enables people with schizophrenia to cope more effectively with their illness. Psycho educational interventions involve interaction between the information provider and the mentally ill person* ***(Pekkala and Merinder 2002, p. 2).***

This quote suggests a strong medical focus on mental illness and its intervention. However, psychoeducation can encompass a broader perspective about the various aspects of mental health problems, their impact and interventions to improve these.

Part of the therapeutic process linked to learning and education is also about helping a person to understand what they have learned and how this might fit into their life and influence their health and occupational performance. This is another example of health-based education about how life skills limitations can impact upon occupation, health and wellbeing. The person may not know about these and so the therapist would be in a position to teach the person about them and ways to improve life skills that would then improve health and wellbeing.

OCCUPATIONAL THERAPY APPROACHES

This section considers life skills interventions in occupational therapy in mental health settings.

A decision has to be made about the overall approach to be followed, for example, a remedial or compensatory approach may be needed (see Ch. 4). Underlying deficits, such as limited concentration, which impacts upon life skills, may indicate a remedial method is needed to improve concentration.

Compensatory approaches use occupational therapy core skills to adapt the activity or environment to enable effective life skill performance. For example if a person is struggling to organize their kitchen, and then finds it difficult to find items in cupboards in the kitchen, the cupboards could be organized in a logical manner. It needs to be determined how far the person is able to effectively complete life skills and what other types of occupational therapy core skills may be required to enable life skill development and performance, such as: changes to the sequencing of tasks; grading the complexity of the activity; individual and group-based interventions. See Case study 19-3 for an example from practice that focuses on individual cookery and an approach to intervention planning. The teaching of performance skills is one aspect in this work, but there may also be a need for group work (see Case study 19-4 for an example from practice which considers a group intervention for cookery). Life skills groups require knowledge of group work theories (see Ch. 16).

Life Skills Training

Life skills training was designed to enhance the ability of people with long term mental health problems to live independently (Tungpunkom and Nicol 2009). The emphasis is on learning and re-learning skills. Life skills approaches can be highly structured to develop required skills (Mairs and Bradshaw 2004) and can include behavioural methods. Stern (2009) explains behavioural methods and how occupational therapists can use them in practice.

Part of the therapeutic process is concerned with applying learning, to enable a person to see what they have learned and how it might influence their health and occupational performance. This is another example of health-based education about how life skills limitations can impact upon occupation, health and wellbeing. If required, the occupational therapist could teach or share information which would enable the person to appreciate the link between their life skills and their health and wellbeing.

The Effectiveness of Life Skills Programmes

Brown et al. (2001) studied the effectiveness of a 12-week pilot community living skills group to develop home management, community living, personal care and safety, and social and interpersonal functioning. The Canadian Occupational Performance Measure (COPM) (Law et al. 1990) and a satisfaction questionnaire were completed pre-group and post-group. The post-group COPM revealed a decrease in participants who perceived occupational performance deficits in cooking, shopping and structuring the day (Brown et al. 2001). A questionnaire identified a number of life skills that were of most help, including cooking, healthy eating, safety in the home, kitchen hygiene, household chores, shopping and budgeting. The skill transfer from group to the home environment was also evaluated, by direct observations in a home visit by the therapist. The study findings indicated an improvement in ability to manage tasks more effectively at home (Brown et al. 2001).

Mairs and Bradshaw (2004) focused on life skills training for individuals with schizophrenia. These life skills sessions were developed by Mairs and were

CASE STUDY 19-3

Individual Cooking

This example develops the information given in Case study 19-1.

Discuss with Bob what meals he likes. This will help motivate him to cook. Start to plan the first session, consider more basic meals, e.g. omelette or a jacket potato and filling (something that will be successful and easily achievable). This will give Bob a feeling of achievement and motivate him to cook again.

Breakdown the cooking task into simple steps; encourage Bob to consider each step but be prepared to advise him when he is unsure. Get him to think through:

1. What equipment is needed?
2. What ingredients are required?
3. What order do the ingredients need to be cooked in and for how long?

FUTURE SESSIONS:

Build on Bob's skills in cooking a range of basic meals. Provide education on healthy eating and the long-term impact of eating an inadequate diet. Organize a food shopping trip with Bob to help him plan the ingredients required and budget for them appropriately.

CASE STUDY 19-4

Group Cookery

Louise is an inpatient in an acute mental health unit. She has a diagnosis of bipolar affective disorder and is currently depressed in mood. Prior to her admission, Louise was living at home with her young daughter and was able to cook for them both. Since her admission, Louise has found it difficult to get motivated to cook or look after herself. She has made some improvements in her mental state but has lost confidence in her abilities and is worried that she will not be able to cope at home. She agrees to attend the group cooking sessions in the occupational therapy department.

Louise would benefit from group cooking sessions to help her gradually complete small tasks as part of a team. There would be less expectation and pressure to complete an entire meal, as in an individual cooking session. The group environment allows her to engage with others and receive praise on her skills from her peers.

Group cooking session plan:

1. Group members are given individual tasks in preparing the ingredients for cooking and different cooking and meal responsibilities are given.
2. Interaction between group members is encouraged.
3. The occupational therapist works as a group member and acts as a role model.
4. Positive feedback is given to each member when observed by the occupational therapist.
5. The group all eat the meal made, together. The occupational therapist ensures that a good end-result is achieved.

provided to participants over a maximum of 12 individualized life skills sessions, based on the participant's identification of the goals they wanted to work on, as well as usual interventions. Techniques of psychoeducation, activity scheduling, modelling, shaping and reinforcement were used. The findings indicated that the results were unclear regarding social and community functioning, as measured by the Social Functioning Scale. However, there was some support for the reduction of negative and overall symptoms as measured by the positive and negative symptoms of schizophrenia (Mairs and Bradshaw 2004).

A systematic review of life skills by Tungpunkom and Nicol (2009), which has been updated (Tungpunkom et al. 2012), highlighted that the evidence of efficacy for life skills is inconclusive. The reviewers suggested that further research is required to establish the efficacy of life skills interventions and given the limited evidence, that people should not be pressured to engage in such interventions.

Although there is limited evidence for the effectiveness of life skills interventions, research involving service users has indicated the value of a focus on life skills (see below). See Case study 19-5 for an example from practice, which provides an overview of the range of issues that might need to be considered with one person.

Physical Fitness and Activity

Physical health needs are also considered by occupational therapists as life skills. This fits into a holistic approach which considers physical, social and mental health needs within the sociocultural context. The ability to participate in physical fitness impacts upon an individual's health and wellbeing and is covered under the heading IADL, as health management and maintenance (AOTA 2008). However, occupational therapists are adopting a broader approach to physical fitness, which includes a range of physical activity that can improve health and wellbeing. These include gardening (York and Wiseman 2012) and dance (Froggett and Little 2012).

In purely physical fitness terms, it has been suggested that occupational therapists need to be careful about using guidelines for physical fitness as a directive. The existing guidelines do not take into account service users' needs in the context of mental healthcare (Handcock and Tattersall 2012). There has been a comparison of the physical health status of people with serious mental health problems and the general population of North Queensland, Australia (Northey and Barnett 2012). Those with mental health problems had reduced physical health and lower physical activity levels, but further research is required with more internationally representative participants (Northey and Barnett 2012). Perham and Accordino

CASE STUDY 19-5

Preparing to Move Back to the Community

Adam is resident at an inpatient mental health rehabilitation unit. The plan is to assist him towards discharge back to his home, with some community support.

ASSESSMENT FINDINGS

Adam is aware he needs help with developing his cooking skills and that he needs support with budgeting.

Adam is not managing in the home environment and may need further support in the future.

ANALYSIS

Strengths:

- Adam is motivated to meet with the occupational therapist and expresses a wish to learn to cook and is able to identify that he needs support with managing his finances
- Adam has some insight into his skills and has a willingness to work on these areas
- Adam is keen to return to his home
- Adam is aware that he may need more support in the future.

Constraints:

- Adam has few life skills and has been mainly eating take-away meals
- Adam is not coping in the home environment, which is in an unclean and untidy condition.

INTERVENTIONS

Weekly cooking sessions:

- Start with smaller more manageable meals (to build confidence through task achievement)
- Graded support to build up skills
- Build up slowly to more complex meals
- Practice meals several times to increase confidence and learning.

Finances:

- Go through a budgeting form of basic outgoings and benefits received
- Help Adam to set up weekly/daily budget and monitor this regularly
- Help Adam set up direct debits to pay his bills
- Add in basic everyday tasks, e.g. taking medication, managing personal care, laundry.

Occupational Therapist to Arrange a Home Visit with Adam

- Assess the home environment, establish what equipment does he have or need
- Look at support options and discuss these with Adam
- Work out a route to the local shops and travel options
- Incorporate cooking/shopping sessions into his home environment.

(2007) compared two groups of participants with mental health problems and the effects of exercise on their functioning; one group did not participate in exercise and the other did. The results demonstrated that those that did exercise had significantly improved in their functioning on hygiene and in their pursuit of independence in comparison to the non-exercise group.

Exercise can also support other areas, such as providing a means for building social relationships. Football in particular has developed as a therapeutic medium for occupational therapists in recent years. Mynard et al. (2008) looked at a community-based football team run in Australia and noted how three major themes were identified from their research findings; a spirit of inclusion, team-building and meaning

of involvement. In Case study 19-6, as an example from practice, Hannah describes an aspect of her work as an occupational therapist working in adult mental health rehabilitation, which includes working regularly with young men who are interested in sport (see also Ch. 14).

SERVICE USERS' PERSPECTIVES ON LIFE SKILLS

The findings from research about life skills interventions have been variable (Brown et al. 2001; Mairs and Bradshaw 2004) and inconclusive (Tungpunkom et al. 2012). It is important to consider the views of service users and what they believe to be their life skills needs. The research literature, and service user perceptions of life skills, can then be reviewed one in light of the other. The practical focus to life skills development was valued by research participants (Di Bona 2004; Lim et al. 2007; Notley et al. 2012). The studies used forms of group work (Brown et al. 2001) and individual approaches (Mairs and Bradshaw 2004) for interventions for life skills. Skills-based groups, particularly cookery, were seen as positive by participants (Di Bona 2004; Lim et al. 2007). Also the opportunity to re-learn (Di Bona 2004; Notley et al. 2012), learn and practise new skills helped service users' functioning in daily life, improving their confidence (Lim et al. 2007). Being offered choices which were relevant to the participants' needs was also valued (Notley et al. 2012). The importance of developing self-efficacy has also been emphasized, so volition for occupational engagement and participation can be enhanced (Law 2002).

SUMMARY

Different ways of conceptualizing life skills and explanations about their relationship to categorizing occupations, and engagement and participation for people in mental health settings have been presented. The associations between instrumental/activities of daily living (AOTA 2008), roles and belonging, health and wellbeing, and life skills have been clarified. Various interventions from education and the occupational therapy evidence base have been provided, along with examples from practice to illustrate how occupational therapists can work in this area of occupation.

CASE STUDY 19-6

Football Team

Football particularly has been noted to be a focus for the young men in the rehabilitation unit where I work. Three years ago, a sports technician colleague and I decided to set up a football team with regular training sessions for service users. The sessions gradually became more popular with both men and women. The team developed and service users were encouraged to play an active role in choosing a team name, kit and designing a team badge.

The training sessions have been particularly noted for the development of social opportunities. Social networks have started to build up and service users were observed to exchange contact details and spend time socializing together during and after training. This has been especially important for this service user group; loss of social networks and the social stigma of mental illness have impacted on all their lives to various degrees. Joining a competitive football league helped them to connect and work together as a team. The players also gained meaningful accomplishment through task achievement. At the end of the season, awards are given out for achievements and players are encouraged to contribute to recognizing positives in others within the team.

The training sessions take place in a local University's sports park where other football teams also meet regularly to train. This is important, as it helps service users to feel socially included in their local community. The team has played non-mental health teams in friendly matches to help increase their profile within the local area. Service users have been encouraged to attain qualifications in coaching skills and use these within the training sessions. This could lead to the possibility of paid employment in the future. Team members are given different responsibilities within the group, such as team captain or being in charge of looking after the kit.

The occupational therapy process has been highlighted with information on the observation and assessment of life skills needs and ways to work with people that are meaningful, person-centred, and sensitive to their cultural and religious needs.

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20 GREEN CARE AND OCCUPATIONAL THERAPY

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CHAPTER CONTENTS

INTRODUCTION

The term *green care* describes a variety of health and social care interventions that intentionally harness nature in their approaches. The word *green* in this context, therefore, refers to using the natural green environment as a context for human occupation. It should not be confused with other uses such as in *green politics* or being *environmentally friendly*, for example; although there are overlaps as this chapter will show.

There are many different types of green care intervention, including horticulture-based approaches, care farming animal assisted interventions, facilitated green exercise, and wilderness therapy (see Fig. 20-1); each of which has its own pedagogy, recognized practices and processes.

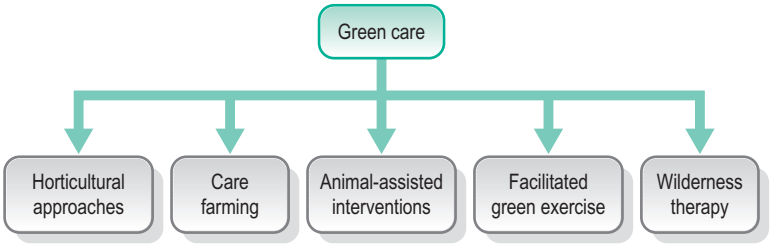

FIGURE 20-1 ■ An overview of the main intervention types comprising green care.

In green care, nature is an integral component of an active intervention and not merely a pleasant backdrop to care (Haubenhofer et al. 2010; Sempik et al. 2010). This distinguishes green care from passive encounters with nature, such as when sitting in a garden, seeing a landscape view from a window or through the greening of the built environment. Furthermore, green care means designed, intentional, *occupation*-based therapeutic intervention, not just *being active* in natural settings. The distinction between certain nature-dependent phenomena that people experience as therapeutic and bona fide green care interventions is shown in Fig. 20-2.

Green Care and Occupational Therapy

Green care provides many opportunities for occupational therapists to use the natural green environment and the occupations associated with it in their practice. Many of the principles, theories and frameworks used in green care are derived directly or indirectly from occupational therapy or have a bearing on it, and many occupational therapists use green care approaches within their practice (perhaps even being unaware that green care exists and that they are a part of it). Therefore, there is a need to provide theoretical knowledge to many green care practitioners who have an occupational therapy background.

Chapter Aims and Structure

This chapter introduces specific green care interventions, describes their underpinning constructs and theories, grounds these within an occupational therapy framework to inspire practitioners' professional reasoning, and highlights the growing evidence-base for green care. The reader is also directed to further resources to explore certain issues in more depth. Woven throughout the chapter are five illustrative case studies derived from practice. They show how green care operates within contrasting health and/or social care contexts: a forensic inpatient unit, a day service, a therapeutic community, a care farm and a vocational rehabilitation social enterprise.

GREEN CARE INTERVENTIONS

Like occupational therapy, green care is a complex intervention (Sempik et al. 2010); its efficacy is multidimensional and based on a *synergy* between the service user, the occupation they engage in, and the natural green environment.

Horticulture-Based Approaches

From an international perspective, there is no consensus on terminology for either the practice of horticulture-based green care or for its practitioners. These terms are all used: *horticultural therapy*, *therapeutic horticulture*, *garden therapy*, *social and therapeutic horticulture*. The latter term has emerged recently (particularly in the UK) to describe participation, by a range of vulnerable people, in groups and communities whose activities are centred on horticulture and gardening, but which differs from domestic gardening because it is formally structured as an intervention (Sempik and Spurgeon 2006). This shift in terminology highlights the importance of the social context. It emphasizes that the overall efficacy of the intervention comprises restorative processes arising from the natural, green environment *and* from the social milieu created through collective participation (Haubenhofer et al. 2010). It underlines the value of social and therapeutic horticulture as a route into the social capital of communities. In several countries voluntary professional registers exist or are being created in order to professionalize and assure the quality of practice (see Fieldhouse and Sempik 2007), with an associated regulation of job titles.

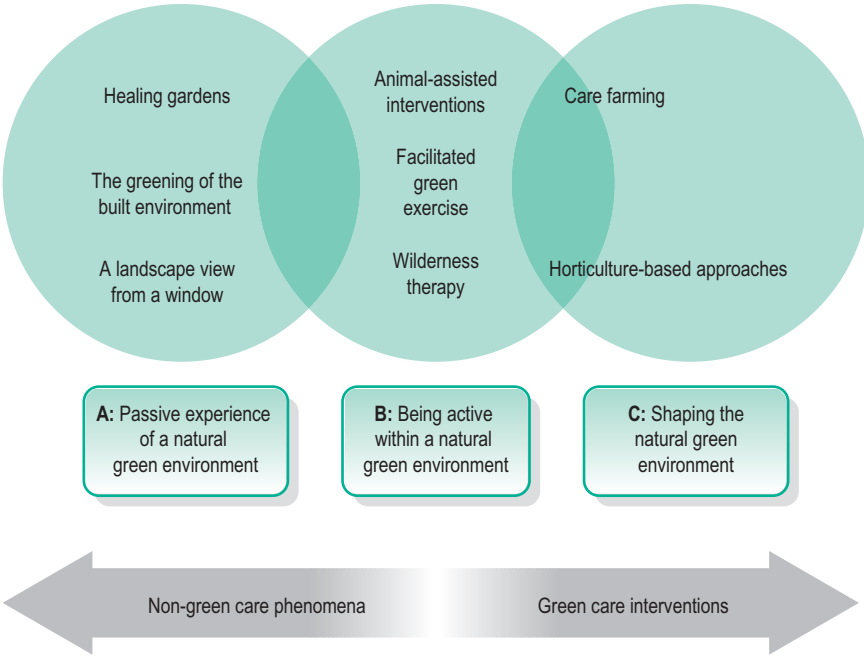

FIGURE 20-2 ■ Nature-based phenomena and their association with green care.

CASE STUDY 20-1

Green Care in a Forensic Inpatient Unit

Jan is an Occupational Therapy Horticulture Technician, serving acute and rehabilitation wards in a forensic unit. She works in small gardens attached to each ward, and in a larger occupational therapy garden, where vegetables, fruit and flowers are grown. The sessions are pre-booked and service users are risk-assessed and escorted by one or more members of staff. Jan's aims are to enable service users to build relationships, increase their sense of role and responsibility, and have opportunities to be creative and nurturing in a clinical environment that limits such opportunities. She also sees gardening as a leisure, training or vocational activity for individuals once discharged.

Neil is on an acute ward with a diagnosis of schizophrenia. He is highly aroused and thought disordered. He is unable to remain still and spends his time pacing the corridors. He is seen as a high risk in terms of violence and has been physically restrained frequently. He has access to 'outside' once every hour into a secured garden for a 15-minute smoking break. Neil is offered half an hour of gardening, as he is unable to attend other therapeutic activities. The use of metal tools, breakable plastics or toxic plant material (such as bulbs) is not permitted, so Jan engages Neil in planting up a container with summer bedding plants.

As the session starts, Neil speaks rapidly. He appears to be speaking through different personalities, and dances round the room. However, when Jan puts the plant material into his hands he stops, sits down and begins to focus on it. He talks about his experiences of gardening and handles the bedding plants with care. Although he needs to be drawn back to the task, he plants up the container, organizing colour and design, and choosing materials. By the end, he has produced something with which he is clearly pleased.

Care Farming

Care farming (also known as social farming or green care farming) is the use of commercial farms and agricultural landscapes to promote mental and physical health through ordinary farming activities (Hine et al. 2008). The notion of *multifunctionality* has been adopted by many care farmers, whereby farms serve at least two different functions through their usual activities – that is, agricultural production and health/social care. While activities may be tailored to the abilities of participants, there is no separate facility on the farm for the provision of care.

Care farms serve the needs of people with mental health problems, learning disabilities, addictions, dementia, and other challenges. There are different models, reflecting different national healthcare contexts (Haubenhofer et al. 2010).

Animal-Assisted Interventions

Animal-assisted therapy is a therapist-directed intervention evaluated in relation to specific therapeutic goals (Berget and Braastad 2008), while *animal-assisted interventions* refer to a more generalized approach using livestock, for example, within a care farming context (Kruger and Serpell 2006; Sempik et al. 2010).

The rationale for these approaches is that caring for an animal, responding to its needs and learning to communicate with it develops psychological wellbeing and self-esteem. Animals show affection in response to the attention they receive and are not judgemental (Katcher 2000). A randomized controlled study by Berget et al. (2008) showed that working with farm animals improved coping ability, self-efficacy, symptomatology and quality of life for participants diagnosed with schizophrenia, anxiety, mood and personality disorders.

Facilitated Green Exercise

'Green exercise is activity in the presence of nature' (Barton and Pretty 2010, p. 3947) and derives its efficacy from the synergistic benefits of physical activity and exposure to nature (Pretty et al. 2006). Walking, cycling, gardening and conservation are widely facilitated to address specific therapeutic goals. A meta-analysis of 10 UK green exercise studies showed that green exercise improved mood and self-esteem, with individuals with mental health problems showing one of the greatest changes for self-esteem (Barton and Pretty 2010). In the UK, MIND (2007) have argued that GP referral for facilitated green exercise sessions could be as effective as prescribing antidepressants for people with mild to moderate depression.

Wilderness Therapy

Wilderness (or nature therapy, or adventure therapy) uses outdoor activities – such as rock-climbing or canoeing – in their natural settings to distance people from customary stressors and to create challenging situations with controlled risk for participants, whose experiential learning and self-reflection forms the basis of positive change (Hine et al. 2009).

Wilderness therapy can help individuals (often adolescents) with anxiety and depression and/or behavioural problems and can also improve trust and communication within families and groups. It can adopt a specifically psychotherapeutic approach based on the premise that wild nature evokes positive coping behaviours (rather than defensive ones) because of the risk involved, the immediacy of the consequences of one's actions, and through cooperation within one's peer group (Berman and Davis-Berman 1995; Itin 1995; both cited in Haubenhofer et al. 2010).

In addition to the five green care intervention-types described above, a brief overview of ecotherapy is provided. Ecotherapy is not, strictly speaking, a green care *intervention-type* but it is often discussed within a green care context.

Ecotherapy

Ecotherapy sees personal health and healing as being directly related to the health of the natural ecosystem of which humans are a part (Davis and Atkins 2009). Ecotherapy integrates health-promotion activities that serve individual, community and global goals (Burls 2007), highlighting that the natural world is an inextricable element of our community and social system, and that 'the mind-body-world web contains its own freely available healing potentials' (Buzzell and Chalquist 2009, p. 20).

In this sense, *ecotherapy* is not so much an intervention-type, as an approach to any or all green care interventions (Sempik and Bragg 2013). For example, Chalquist (2009) notes that, in addition to benefitting individuals, horticulture:

> *'helps the community too, particularly when it involves growing fruit and vegetables locally, thus decreasing dependency on chemically treated food products seized from exhausted, nitrate-singed soils and trucked or flown in from thousands of miles away.'*
>
> ***(p. 68)***

This macro-level perspective on human occupation and environmental degradation identifies ecotherapy as an ecological issue, overlapping with green politics and the sustainability agenda.

These diverse interventions are all underpinned by the natural green environment. What follows is an overview of how the human relationship with this environment has been conceptualized, and how these theories can inform occupational therapy.

GREEN CARE CONSTRUCTS AND THEORIES

The key constructs and theories associated with green care can be understood as conceptual *psycho-evolutionary perspectives* or a more empirical exploration of the *human relationship with the natural world*.

Psycho-Evolutionary Perspectives

The Biophilia Hypothesis

The biophilia hypothesis suggests that people have an innate desire to connect with nature and that this is strongly determined by survival instincts established early on in our species' evolution (Wilson 1984; Kellert and Wilson 1993). It sees this affinity as being integral to people's physical, psychological and social development. In short, it proposes that an attachment to the natural world is hard-wired into humans and is adaptive.

Particular aspects of personal development are associated with certain values that nature is seen to possess, such as:

1. *An aesthetic value* – whereby the beauty of nature fosters human curiosity, exploration, and adaptability
2. *A dominionistic value* – whereby mastery of nature and/or adversity builds self-esteem
3. *A humanistic value* – whereby a shared emotional attachment promotes trust, cooperation and sociability
4. *A moral value* – whereby an appreciation of the wholeness and integrity of the natural world generates feelings of harmony and belonging
5. *A naturalistic value* – whereby immersion in natural rhythms promotes mental acuity and physical fitness
6. *A negativistic (or resisting, questioning) value* – whereby a healthy respect, for the power of nature and the sense of wonder it fosters, promotes positive attitudes to fear, risk-taking and self-management
7. *A symbolic value* – whereby the figurative and metaphorical significance of natural objects, processes and rhythms encourages greater understanding of one's own life
8. *A utilitarian value* – whereby one's dependence on nature's finite material resources is appreciated, as food, for example.

(Kellert and Derr 1998; cited in Burls 2007).

The utilitarian value underpins the human ethic of nature conservation and care for biodiversity and is at the core of an ecological perspective of life, as Shoemaker (1994) notes:

> *The green plant is fundamental to all other life. Humankind could perish from this planet and plants of all kinds would continue to grow and thrive. In contrast, the disappearance of plants would be accompanied by the disappearance of all animal life, including humankind.*
>
> ***(p. 3)***

The biophilia hypothesis also theorizes that humans attune to the condition of nearby animals and plants because it is a way of deriving information about their shared environment. An animal at rest signals wellbeing and safety, and this impression is then transmitted to the person. Similarly, healthy plants and flowers convey a relaxed feeling of being in a bountiful natural setting, beneficial for humans (Melson 2000; cited in Sempik et al. 2010).

An Overload and Arousal Perspective

It is estimated that in industrialized nations, people spend between 1% and 5% of their time outdoors; the lowest amount of time at any point in human history (Chalquist 2009). The health implications of this are

wide-ranging. Wilcock (2006) suggested that cultural values and norms are disconnecting people from the natural world that shaped our evolutionary path, so that modern life is less orientated to the older biopsychosocial capacities necessary for maintaining health. This offers fewer opportunities to recover from mental stress (Pretty et al. 2005). Modern living can subject people to a bombardment of sensory overstimulation that may lead to damaging levels of psychological and physiological arousal, whereas natural green environments that include plants contain patterns that reduce stress levels (Ulrich et al. 1991). This makes accessing the natural outdoors environment a potentially important issue for mental health service users, whose contact with nature may be limited by hospital admissions, urban living and/or low income.

Attention Restoration Theory

The most widely quoted theory in the context of green care (particularly in relation to horticultural interventions) is Attention Restoration Theory (Kaplan and Kaplan 1989; Kaplan 1995). It posits that natural environments offer respite from the mental fatigue that results from having to constantly inhibit competing influences when trying to direct one's attention towards a specific task. It argues that the presence of nature is inherently interesting or stimulating and requires no effort in order to engage with it, and describes this phenomenon as *fascination*.

Fascination has a positive impact on individuals' cognitive ability and restores the ability to focus attention. It is an essential feature of a *restorative environment*, which is said to comprise the following:

- *Fascination* – the ability to maintain attention effortlessly, so that directed attention can be rested and attentional fatigue eased
- *Being away* – the subjective sense of having escaped, or feeling removed (physically or conceptually) from situations that would normally be stressful, or place a burden on directed attention
- *Extent* – a sense that the environment is 'rich enough and coherent enough so that it constitutes a whole other world' (Kaplan 1995, p.173) which the individual can become immersed in
- *Compatibility* – the individual's inclinations to become active are matched by the opportunities for action which the environment affords. In other words, an individual may feel *inclined* to weed a patch of earth, or pick a ripe apple – which has obvious implications for their motivation.

Kaplan and Kaplan (2011) note how easily people are impaired by becoming overloaded with information. They use the term *reasonableness* to describe the kind of wellbeing derived from enhanced information-processing (including better concentration, greater capacity for reflection, and enhanced planning and problem-solving). They contrast this with the irritability, impulsiveness, impatience, distractibility and error-prone performance associated with attentional fatigue.

Occupational forms associated with green care (such as gardening, conservation work or bushcraft), which simultaneously foster fascination and offer a range of compatible activities, can promote instinctive engagement and enhance motivation. Studies consistently show people prefer environments where they anticipate they will be able to function effectively (Kaplan and Kaplan 2011). They respond unconsciously to cues for such environments, preferring those that have *coherence* (that is, they can be made sense of, have some degree of predictability, and are knowable) but which also have *complexity* (that is, they are alluring and offer the possibility that there is more to be learned). This is typified by the human attraction to 'the bend in the path' (Kaplan and Kaplan 2011, p. 312). This is explored more fully later as an occupational science phenomenon.

The Human Relationship With the Natural World

This section focuses on phenomena and constructs with an empirical basis, in that they are all drawn from close observation and inquiry into people's experiences, as they engage with the natural world. Such experiences may be considered as 'here and now' manifestations of the evolutionary viewpoints presented earlier.

Maller et al.'s (2002) systematic review of anecdotal, theoretical and empirical evidence showed that simple human contact with nature fostered recovery from mental fatigue, restored concentration, was recuperative, increased capacity to cope with stress, improved productivity and enhanced people's life satisfaction and general outlook on life. Chalquist's (2009)

CASE STUDY 20-2

Green Care Within a Day Service

Jo is an Occupational Therapy Horticulture Technician. Her weekly allotment gardening group is one of a network of community-based groups – *New Directions* – within an NHS support and recovery service. She has an annual budget (£100) to buy equipment and seeds and rents the allotment from the council for £40 per year. The NHS Trust indemnifies staff working in community-based venues on the basis of routine risk assessment. The group helps service users build their confidence and their social and employable skills.

Abby is diagnosed with depression and anxiety. She is often agitated and avoids social situations, spending much of her time at home in bed. On joining the allotment group, Abby is initially tearful and seeks out Jo to talk to, but as she engages in tasks, she becomes calmer and more reflective. She says the allotment work stops her ruminating on her problems, and helps her engage with group members. After a few months, Abby takes on her own plot so she can go more frequently and grow produce for her family.

Two years later, Abby tells Jo she has learned to accept help for the first time and now feels she has something worth offering people. She gains a Royal Horticultural Society Certificate in Horticulture at a local Further Education college and works with a local charity. Following discharge, Abby addresses over 100 people at a recovery conference, describing how the allotment group gave her hope that there was something inside her that was still alive and worth nurturing, when everything else in her life seemed dead. She now sources funds from *Rethink* (mental health charity) and is setting up a peer support group and often brings the group to her allotment. She also (by arrangement) visits the New Directions group occasionally, providing support to others.

overview of the research-based evidence for nature-based *interventions* underlines that reconnection with the natural world can impact on and alleviate anxiety, frustration, and depression – and bring a greater capacity for health, self-esteem, self-relatedness, social connectedness and joy.

What follows is an overview of some of the processes through which this kind of impact is seen to occur. The aim is to encourage thinking about how green care occupations can be translated into occupational therapy.

Sensory Processing

Sensory processing refers to the way messages from the senses are processed by the nervous system, so they can inform motor and behavioural responses (Dunn 2009). Individual differences will influence a person's *sensory diet*, the combination of preferred sensorimotor experiences that optimize individuals' functioning in a given environment. Green care settings offer a potentially rich, nourishing and varied sensory diet. Plants and flowers may be cultivated specifically for their shape, colour, scent and texture, for example in sensory gardens. Green care settings also encompass the visual appeal of landscape and light, outdoor smells and sensations (such as hearing birdsong) and a wide range of sensory experiences related to changing seasons and the weather. There are other sensations too, such as the feeling of excitement and exhilaration associated with a sense of adventure on taking positive risks and having fun.

Sensory-based approaches are particularly relevant in mental health practice. People living with schizophrenia may have sensory processing difficulties in processing motion, decoding facial information, and recognizing and conveying emotion in the voice, for example, which are likely to have a significant impact on social and vocational participation (Champagne and Frederick 2011). Similar sensory problems may arise for people living with dementia, or with a learning disability (see Ch. 26).

Information can be extracted quickly from natural green environments, enabling individuals to function effectively. Therefore, green care settings may be conducive to achieving a balance of sensory stimulation to promote optimal cognitive functioning (Dunn 2009; Kaplan and Kaplan 2011).

An essential therapeutic advantage of green care is that the physical act of doing – such as digging, sowing, weeding or watering – amplifies the existing cognitive benefits of simply being in a natural green environment through its sensory integrative function. The fact that rich sensory experiences are abundant, uncontrived and naturally integrated through occupation is crucial to green care outcomes.

Temporality

Green care activities heighten people's awareness of time in terms of seasonal change or daily rhythms (such as a regular time for milking the cows). Clark (1997) has called this *temporality*, suggesting that the pace of life not only bombards the senses but can dislocate the temporality of occupations, resulting in 'doing without being' (Clark 1997, p. 86), or a disconnection from self. Simo (2011) offers this perspective:

> *Gardening enables human beings to reconnect with nature and emerge from their immersion in a cyber-world dominated by the instrumental reasoning which orders people to fit the rational economy of its design and the consequent ethics of the machine society.*
>
> ***(p. 358)***

Green care can restore a sense of being, relocating an individual in relation to past and future events and developing awareness of the possibilities of the present time. This, in turn, orientates behaviour to the fulfilment of hopes, the formulation of goals, and the re-connection with (or reconstruction of) personal narratives.

Personal Narrative

Human beings instinctively strive for coherence and create narratives or stories in order to make sense of their lives (Mattingly and Fleming 1994; Hasselkus 2011; see also Ch. 17). The kinds of stories people create for themselves are important because stories shape behaviour. Individual narratives can emerge readily in natural green environments and can be shaped by metaphors of nurturing and growth drawn from the environment itself. For example, attention restoration theory suggests that an individual can pass through a succession of levels, or depths of experience, from clearing the head to reflection on personal issues and goals (Kaplan 1995). This reflective process, when combined with a connection to, and contemplation of, the natural world, can foster patience and optimism:

> *Horticultural therapists – individuals who put seeds in the ground and expect plants to emerge – are accustomed to operating with a full measure of hope.*
>
> ***(Schwebel 1993, p.11)***

This mirrors recovery-oriented practice (see Ch. 2), as green care may be regarded as a positive metaphor made real:

> *The garden is a metaphor for the process of recovery. During the winter months we must work hard although we do not see the results, in the hope that they will arrive in the spring.*
>
> ***(Simo 2011, p. 358)***

Spirituality

Existential crises are often associated with mental health problems, when individuals may question the meaning, purpose and value of life (Warner 2000; Koslander et al. 2009). Significantly, in the context of green care, people often express their feeling of being part of nature and having a purpose within it (Sempik et al. 2005, pp. 46–51). This suggests green care can promote spirituality, where spirituality is defined as the secular experience of finding meaning and purpose in life through absorption in occupations (Egan and Delaat 1994; Urbanowski and Vargo 1994; Howard and Howard 1997; Wilding et al. 2005). This spirituality is often associated with the 'presence or soul of place', as a facet of identity and finding oneself, a centre of belonging and kinship, and a focal point for stories, image and metaphor (Chalquist 2009, p. 70).

Gardens may also have a theist (religious) spiritual significance for some, such as older people (Heliker et al. 2000) and those experiencing life-limiting illness (Unruh et al. 2000; Unruh 2004). The evidence suggests that, for some people confronting their own mortality, natural spaces have a particular resonance by linking nature to creation and ultimately to a creator.

Flow

Flow experiences arise from a subjective psychological state characterized by enjoyment, self-motivation, and feelings of self-worth and competence (Czikszentmihalyi 1992; Emerson 1998). The self-motivating aspect of green care occupations (Kaplan and Kaplan 2011), combined with the resulting cognitive change, suggests green care occupations may be conducive to flow. Such experiences may be associated with exploration (see Kaplan and Kaplan's (2011) notion of complexity, described earlier), navigating between feeling skilful and feeling challenged (see Ch. 17).

During flow, absorption in doing (see spirituality) generates a strong sense of personal agency, and of an integrated self, and prompts a forgetting of worries or

negative thoughts (much like attention restoration) leading to increased happiness, self-esteem, work productivity, and life satisfaction (Wright 2004). So, in addition to new learning, it strengthens the identity of the learner and excludes competing thoughts that might obscure this. Like temporality, flow increases awareness of the present and thus has strong therapeutic potential.

Wright (2004) has noted that an occupation is likely to be most therapeutic when it has the full attention of the individual, can provide clear, immediate, unambiguous feedback, takes place in an uncontrived real-life environment, and occurs when the individual is in a relaxed state. Green care occupations can meet all these requirements.

Production

The care of animals and plants may attract and engage people for aesthetic reasons (Czikszentmihalyi and Rochberg-Halton 1981) but there is also the immediate appeal (related to survival) of growing food. Production or productivity (see Glossary) is integral to cultivation in green care and has many therapeutic applications. Taking home fresh food to share reinforces a provider role for individuals who may otherwise primarily be cared for, and opens up avenues for further exploration such as healthy eating and cooking. Harvesting produce collectively can become a symbolic means for a group to reinforce its own identity and the working partnerships that contributed to the end product:

> *Alex: I had those runner beans that me and you planted … and they were nice.*
>
> ***(Fieldhouse 2003, p. 293)***

Green care occupations have many of the characteristics of work. They can enable participants to be productive, to develop skills and status, to have social contact and make friends, to transfer to paid employment (staff at projects are frequently drawn from former service users), and to develop structure in their daily lives. Added to this is the cultural ambiguity of many green care occupations, in that they may be regarded (and experienced) as therapy, leisure, a hobby, education, training, voluntary work, or employment – depending on the context.

On this basis, green care can provide a therapeutic milieu that is non-stigmatizing, inclusive, and acceptable. It can support individuals' recovery journeys by presenting an occupation (gardening or farming, for example) as a continuous pathway from occupational *therapy* towards ordinary mainstream *occupation*. The case examples in this chapter illustrate how green care can be adapted to different care settings to facilitate this journey.

CASE STUDY 20-3

Green Care at a Therapeutic Community

Alun is land manager for a therapeutic community, which is a registered care home for adults with a range of mental health problems. They live as residents and members of the community for up to two years as part of their care plan under the Care Programme Approach. Their stay is funded, in most cases, through local mental health trusts. The community lies within 20 acres of land, much of which is used for fruit, vegetable, and meat production. Working on the land is part of the life of the community; both in terms of the food produced and because the activities of production, cooking and preserving give structure to the community's day-to-day life. The natural landscape also inspires therapeutic activities such as painting, drawing, pottery, sculpture and crafts.

An appreciation of the land, as a central feature of the residents' environment and the source of their seasonal organic food, fosters a connection between the residents and the world around them. Residents may become involved in land, livestock and plant care, in groups or as individuals. This work is tailored to residents' needs but exists within the wider context of necessary tasks that are essential to the community's life.

Yakubu has a long history of psychosis and substance misuse. He enjoys living and working in the community because it helps him rediscover his identity and build up his interpersonal skills. He works on the land two mornings a week – helping with seasonal tasks such as wheel-barrowing compost, digging vegetable beds, planting out seedlings, weeding, watering and animal care. The physical exercise grounds him and helps him feels more alive, he says. His commitment to the community ensures he gets on with his work, even when he appears to be feeling low, and this new-found self-motivation has helped his recovery.

Production is important because it is a dimension of social inclusion (see Glossary). In green care, this involves acknowledging individual capacities and adapting occupations within a range of democratic projects, which are amenable to many different service models, such as social enterprises (Sempik 2010; Pollard 2011). This focus can shift the power dynamic of the service provider/service user relationship in positive ways (Wilson et al. 2010), thus fostering citizenship.

The Human Relationship with Plants and/or Animals

Green care is unique among therapeutic interventions, in that it creates relationships between people and other living things. The direct and obvious response of plants and animals to care or neglect provides immediate, non-judgemental reinforcement of an individual's sense of agency

> *In nature there are neither rewards nor punishments. There are consequences.*
>
> ***(Ingersoll, cited in Jiler 2006, p. 91)***

Furthermore, such relationships also offer non-discriminatory, non-threatening, positive returns for the carer without imposing the emotional burden of an inter*personal* relationship – which the individual may not want, or not yet feel ready for (Fieldhouse 2003). Some therapeutic applications derived from this close relationship are explored later.

A Totality of Experience

Green care offers a holistic experience which integrates a wide range of psychological social and physiological processes. A single green care experience could involve any or all of these, working together synergistically. To highlight any single process would be arbitrary given that the lived experience does not differentiate between them. Simo (2011) highlights this synergy eloquently:

> *It [gardening] enables the capacity of introspection, to connect with oneself as well as promoting a feeling of relaxation and wellbeing, developing motor skills as well as cognitive and affective … gardening is a social occupation that allows people who may have acquired a sick role and may feel socially excluded to adopt the new roles of carer and gardener. It is an aesthetic experience, a ritual of creation of beauty and life, which confers an artistic gaze or perspective on the participant, to work listening to the water falling, seeing the colours of the plants, smelling the scent of the flowers, touching the bark of the trees.*
>
> ***(p. 358)***

The natural green environment, the occupations it generates, and the relationships that emerge from collective participation are mutually reinforcing; operating as a coherent whole – referred to by MIND (2007) as a 'winning combination' (p. 7). The benefits of green care may be due to the totality of the experience; one that envelops people completely.

GROUNDING GREEN CARE PRINCIPLES WITHIN OCCUPATIONAL THERAPY

There are many ways in which green care and occupational therapy are interwoven. There is much shared history, a common link with occupational science, frequent close working relations between practitioners, and a grounding in person–environment–occupation models of practice. Furthermore, there are extensive opportunities for shared professional reasoning around the applicability of therapeutic approaches and practical skills, such as group work. Each of these will now be examined in turn.

A Shared History

Historically, there has been a strong connection between green care and occupational therapy. Observing the improved outcomes for patients who worked in the market gardens and farms of the old psychiatric asylums was a formative influence on the emerging occupational therapy profession in the UK (see Ch. 1). These institutions were often located in natural landscapes because this was presumed to be recuperative (Wilson et al. 2010), albeit away from society. Significantly, these resources were not replicated in the move from institutional to community-based care that has been unfolding in the UK since the 1970s (Leff 2001). However, arguably, as a response to the acknowledged shortcomings of community care, they are now re-appearing as an intervention for the same service user groups as before (MIND 2007).

Occupational Science and Green Care

Occupational science is discussed in Chapter 3, offering theories to inform practice including green care. Biophilia falls within the domain of occupational science because it shapes human occupations and has been consistently adaptive for our species over evolutionary time. Psycho-evolutionary perspectives emphasize how change at a human genetic level is much slower than the transformation of our society and lifestyle; 'our genes do not change so quickly' (Cox 1995, p. 36). Consequently, we are drawn to natural environments resembling the ones we evolved within, on the basis of their perceived restorativeness (Wilcock 1995; Kaplan and Kaplan 2011).

Early humans, endowed with an enlarged brain – an *occupational* brain (Wilcock 1995) – and faced with an environment that could sustain or threaten survival, developed the capacity to analyse situations and make decisions about the prospect of food, water and shelter (Lewis 1994). This history is partly responsible for our present-day attraction to savannah-like vegetation (Balling and Falk 1982; cited in Relf 1998) and to certain tree shapes (Orians 1986; cited in Relf 1998). Kaplan and Kaplan (2011) underline how humans still show strong preferences for natural environments with, for example, a 'brightly lit area that is partially obscured by foreground vegetation' (p. 311) and the presence of water and/or trees.

The impact of the phenomena presented earlier (such as temporality, narrative, spirituality and flow) are, arguably, underpinned by Wilcock's (2007) notion that $d + b^3 = survival\ and\ health$; where d is *doing* and b^3 refers to *being*, *becoming* and *belonging*. Wilcock (2007) suggested that *doing* (where it involves a sense of *being* in a real world of passing time and physical space) can foster in an individual, a sense of their own capacity for self-transformation (*becoming*), and can therefore connect individuals with their sense of self, with their community and with their culture (*belonging*). Wilcock's theory acknowledges the evolutionary and ecological dimensions of green care's processes and how these anchor and reinforce a sense of being. It underlines, for example, that an ongoing personal narrative is simultaneously being reviewed, lived and unfolded forwards into the future.

Practice Partnerships

While an occupational therapist offers a unique depth of understanding of people's occupational challenges (understood from physiological, psychological and sociological viewpoints), and of strategies to transform occupations such as gardening (through activity analysis, for example) into a therapeutic experience, there are a number of benefits to be derived from collaboration with green care practitioners. Their approaches can blend, yet their respective skill sets are sufficiently different that each can benefit from the other's specialism. For example, a social and therapeutic horticulture practitioner has a unique technical knowledge of horticulture and additional skills in therapeutic applications, group dynamics, garden design, and project management which can extend the scope of projects throughout the year with gardening work (such as winter crops) and horticulture-related art and craft activities (linked to cultural festivals, perhaps) including cooking, poetry or photography, for example.

For the green care practitioner, the advantages of collaboration may include a greater awareness of activity analysis, occupation-focused outcome measures and occupational therapy professional reasoning, including using models of practice.

Applying Occupational Therapy Models of Practice to Green Care

Green care shares with occupational therapy an acute awareness of the influential role of the environment as a context for performance, and an appreciation of the therapeutic power of engagement with the environment through occupations.

Within occupational therapy, the term *environment* has a particular resonance. It comprises the physical, social, cultural, economic and political features of a person's context that have an impact on the motivation, organization and performance of their occupations (Kielhofner 2008). It is a multifaceted phenomenon and green care operates across all of these facets. For example, farming and gardening activities lend themselves to being carried out within a social milieu and are implicitly valued by those social groups and by society at large.

A significant example of cross-pollination between green care and occupational therapy is the

adoption of an occupational therapy model – the Person-Environment-Occupation-Performance Model (PEOP) (Baum and Christiansen 2005) – by an international group of green care practitioners to develop a European conceptual framework for green care (Sempik et al. 2010). This was used to conceptualize the dynamic relationship between the service user, the natural environment, occupation, and performance. Clearly, the connection between green care and occupational therapy is not just a practical one, but a conceptual one too. Occupational therapists can bring the changing perspectives on this dynamic person–environment–occupation relationship into their green care practice.

Turpin and Iwama (2010) have noted a conceptual shift within occupational therapy models, away from a notion of *mastery* of the environment and towards a greater appreciation of *participation* within it. This shift widens the therapist's focus on the *service user* to include families, groups, communities, organizations and populations. It accommodates a *socioecological* model of health; one that emphasizes the complete interconnectedness of the person and their environment and concentrates attention on the very close person–environment–occupation fit at the heart of green care interventions.

A socioecological model endorses green care as a total experience, because of the natural, uncontrived, interconnectedness of its component parts. Interventions can be focused on the person, the environment or the occupation, because change in one area will stimulate change in the others. This offers multiple starting points and pathways for promoting change when working with individuals who have complex and/or enduring needs, thus highlighting green care's versatility. A socioecological model also supports innovative practice by forging links with a wider sphere of practice partners such as farmers, gardeners, landscape designers, human geographers, architects, town-planners and public health agencies. This has been called for widely within green care (Barton and Pretty 2010; Haubenhofer et al. 2010) and within occupational science (Wilcock 2006). It encourages thinking about how green care might serve contemporary inter-agency agendas of community development, health promotion, social inclusion and recovery.

CASE STUDY 20-4

Green Care on a Care Farm

Paul runs a commercial mixed arable and dairy farm that engages people who are recovering from serious mental health problems, providing a structured working environment and training in organic agriculture and horticulture. Paul (like many care farmers) feels committed to organic food production and compassionate animal care. He sees the health of the land, the quality of the food produced, and people's health and wellbeing and sense of community as a natural whole.

Service users are referred and funded by social services. Paul employs three staff with expertise in education, training and psychotherapy. They provide support for around 20 people who work on the farm for up to 3 days a week. The care farm is also well known in the local community, and enjoys the support of several retired volunteers, most of whom previously worked in education or healthcare.

The average length of placement is around 2.5 years, by which time service users are at a stage in their recovery when they feel able to move on – either to employment, training or other goals or activities that had been interrupted by their mental health problems.

John is typical of many former service users when he says that working on the farm has boosted his self-esteem and self-confidence through acquiring new skills, making new friends and being part of a mutually supportive team. He is no longer a 'patient' but a 'farmer'. His bipolar difficulties had caused him to lose his job but John is now back at work as an architect and feels part of society again. Being in the open air, watching things grow and getting his hands dirty, says John, gave him the space to reflect on his strengths, what he wanted in life and where he really wanted to be.

Therapeutic Approaches Applicable in Green Care

Comparisons made between the therapeutic interpersonal relationship and qualities of the human relationship with plants and/or animals (see earlier) highlight the suitability of green care as a medium within which

various therapeutic approaches can be used *in situ* – that is, in the natural green environment, beyond their traditional clinical settings (Schwebel 1993; Unruh et al. 2000; Grut 2003; Chalquist 2009; Haubenhofer et al. 2010).

A Cognitive-Behavioural Approach

A cognitive-behavioural approach harnesses an individual's ability to acknowledge the automatic connection between their thoughts and behaviour, to modify the relationship between these, and thus to bring about changes in performance (Duncan 2008; and see Ch. 15). As described earlier, green care can enhance an individual's capacity for reflection and offers much reinforcement of an individual's sense of personal agency. It can enable an individual to experience themselves differently and unlearn habitual patterns of thinking and doing.

A Humanistic Approach

The humanistic approach focuses on the individual's sense of self. It aims to reinforce a person's sense of agency and (by facilitating reflection on the experience of *being* that individual) to achieve greater congruence between the actual self (how one is) and the ideal self (how one would like to be) (Finlay 2004). It is implicitly about self-creation as people search for meaning in life and relates closely to aspects of personal narrative, spirituality and flow, as previously discussed.

A Psychodynamic Approach

Individuals often describe the emergence of strong feelings while working in natural, green environments. The latter stages of attention restoration include contemplation of accumulated matters on one's mind and of oneself in relation to these (Kaplan and Kaplan 1989; Kaplan 1995). In green care, these thoughts and feelings can become woven into an occupation that is a fundamental expression of care for living things. This can connect individuals with the fact of life, with growth, and with the broadest issues of oneness with a natural order and a life/death cycle, so it is understandable that psychodynamic processes (such as projection and transference) may flourish and generate positive intrapersonal change – as shown empirically by Unruh et al. (2000). Projective identification, when infused with positive natural metaphors and social coherence associated with green care, can lead to a strengthening of a person's identity and attachments; generating an internalized sense of belonging in the world and within a social group.

For example, psychotherapist Jenny Grut (2003) harnesses the connectedness people feel with their allotment environment to address the painful and traumatic sense of loss experienced by victims of torture:

> *Nature provides a metaphor to help integrate all aspects of life. The psyche is reflected in nature. … This means we are in connection with a reality that reflects our inner landscape. We can see there, before us, what is happening inside us and when we realize this we become part of the vastness of nature and of the universe.*
>
> ***(p. 188)***

Group Work in Green Care

Many of the occupations associated with green care – such as horticulture, conservation, adventure and wilderness pursuits – occur in groups. Group work principles can be used to amplify the existing therapeutic potential of the green care activity, promoting social functioning and group cohesiveness. For example, Gonzalez et al. (2011) showed that, for a group of adults with depression, a horticulture group's effectiveness was related to group cohesiveness arising from horticultural as well as group psychotherapeutic factors. Group members' sense of shared experience – termed *universality* (Yalom and Leszcz 2005) – is an important therapeutic factor in group psychotherapy and has much in common with the humanistic implications of biophilia described earlier. The net result is that 'group cohesiveness serves beneficial change' (Gonzalez et al. 2011, p. 126). In other words, the group is the mechanism by which the green care is delivered *and* an active ingredient in the therapeutic process. There is a synergy, echoing the notion of a totality of experience (see also Chapter 16 on groups).

THE GROWING EVIDENCE BASE FOR GREEN CARE

Green care embraces many different interventions all of which are conducted with a range of service user groups, and each of which comprises a variety of activities. This presents any researcher with a complex challenge: a heterogeneous group of participants and

no standardized intervention. Hence, research methods such as randomized controlled trials (RCTs) are difficult to conduct. No large-scale trials of effectiveness have been carried out in this area. Researchers have therefore approached the issue of effectiveness, in many cases, by exploring the perceptions and feelings of service users, and understanding the reasons why they feel better as a result of green care. Thus, within green care, qualitative research methods have proved to be particularly useful.

The research output has increased substantially since the review by Sempik et al. (2003). A recent analysis by one of the authors (JS) of the bibliographic database *ArticleFirst* showed that the majority of research has explored horticulture-based approaches (44% of publications) and animal-assisted interventions (34% of publications).

Despite the challenges of such work, researchers have addressed the issue of effectiveness and there have been small number of controlled studies within green care. Studies have shown, for example, that animal-assisted therapy on a farm can increase individuals' self-efficacy (Berget et al. 2008) and reduce depression (Pedersen et al. 2012). Pedersen and colleagues also showed that different farming activities were associated with different levels of change in depression and anxiety scores. For example, more time spent milking the cows was associated with significantly lower levels of these; while time spent mucking out and cleaning was associated with significantly higher levels. This suggests that contact with the animals is important and that the benefits are not merely related to occupational engagement. While these studies are limited because of a low number of participants (and hence have low statistical power), they do show that RCTs can be used to study green care interventions and that effects can be noted through careful observation.

Gonzalez et al. (2009) showed a statistically significant fall in Beck Depression Inventory (BDI) scores for people with depression who received therapeutic horticulture. Gonzalez et al. (2010) also showed that therapeutic horticulture increased Attentional Function Index (AFI) scores, which are a measure of attention restoration, demonstrating a significant association between the changes in these scores and perceived levels of *being away* and *fascination* which are key components of restorative environments (see earlier).

The growing number of quantitative research findings within green care has enabled Annerstedt and Währborg (2011) to conduct a systematic review of controlled and observational studies of nature-assisted therapy, concluding that:

> *a rather small but reliable evidence base supports the effectiveness and appropriateness of NAT [Nature-assisted Therapy] as a relevant resource for public health. Significant improvements were found for varied outcomes in diverse diagnoses, spanning from obesity to schizophrenia. These findings highlight the importance of considering nature as an important resource in mental and public health care and the value of putting further efforts into research of this subject.*
>
> ***(Annerstedt and Wahrborg 2011, p. 385)***

Qualitative research has explored the views and perceptions of both service users and practitioners and has proposed mechanisms and frameworks for explaining the benefits of green care (Sempik et al. 2010). For example, Sempik et al. (2005) concluded that social and therapeutic horticulture projects promoted social inclusion through the dimensions proposed by Burchardt et al. (2002) of *production* (see earlier), *consumption*, *social interaction* and *political engagement*.

Research has also served to highlight the similarities between green care and therapeutic communities (Sempik 2008; Sempik et al. 2010, p. 54). Both approaches rely on creating cohesive communities that provide support and therapy through their group identity and activities. Some therapeutic communities are also green care communities (see Case study 20-3). For example, Hickey (2008) described the Lothlorien Therapeutic Community where cultivating the garden is an important part of the therapeutic process. Echoing the earlier descriptions of positive natural metaphors and personal narrative, he observed:

> *Residents often find metaphorical links between the garden and their own journey, with the garden offering readily available metaphors which reflect their inner process. One person found that there was a parallel between being part of the cycle of nature and her own life.*
>
> ***(Hickey 2008, p. 268)***

CASE STUDY 20-5

Green Care in a Vocational Rehabilitation Social Enterprise

Liz manages *New Blooms*, a social enterprise providing a supportive real work environment for people referred by local community mental health and learning disability teams. The project has 20 trainees who attend for 1–3 days per week to develop their work skills, self-esteem and social contact, and to forge a path into mainstream employment, education or training. Staff include horticulturalists, florists and support workers all of whom train and accredit City and Guilds and National Proficiency Test Council qualifications.

With the increasing awareness of air miles associated with cut flowers, *New Blooms* caters for a niche market, devoting its 4-acre rural site to the cultivation of organically grown English country cottage flowers which are sold at farmers markets, to individuals and businesses, and through a weddings and events service. Each commercial task can be accomplished by most people, whatever their skill-level – from seed sowing, to planting, watering or picking – which means trainees are fully involved in the business. The large volume of flowers produced means the work involves much repetition, so skills and confidence grow quickly.

The project has become a focus for social cohesion locally. Liz is overwhelmed with offers from local people who want to help with cultivation or with markets; and the financial viability of the business has enabled *New Blooms* to recruit five of its staff from former trainees, modelling inclusive employment to local businesses.

Hamzah left his job as contracts manager in a construction business following depression, which left him feeling anxious, isolated, housebound and despondent. After a busy summer in the flower nursery, he embarked on a National Vocational Qualification (Level 2) in Amenity Horticulture. This involved work placements in local parks and gardens arranged with the council. He later gained employment as a Horticultural Support Worker with *New Blooms* and now draws on his own experience to help trainees.

Hence, research into green care has addressed the subject from a number of different viewpoints – using quantitative (Gonzalez et al. 2009) and qualitative approaches (Sempik et al. 2005), through the exploration of personal experiences (Unruh 2004), and through the creation of models and frameworks (Sempik et al. 2010; Sempik and Adevi 2013). The research findings contribute to a growing and coherent evidence base, characterized by a notable rarity of potentially disconfirming studies (Chalquist 2009), which has helped green care to become established.

SUMMARY

This chapter has presented the natural green environment as an integral component of therapy with many proven benefits. It has explored green care on the premise that a cross-pollination of theoretical and practical ideas between occupational therapy and green care will be mutually beneficial.

It is important to remember, however, that green care is not a panacea for all problems nor will it be suitable for everyone. The notion of compatibility, or the personal inclination to engage with a natural green environment (as described earlier in relation to attention restoration theory), is important in understanding the impact of green care. However, from another perspective, when considering who attends green care projects, it may also be regarded as a kind of selection bias. Those individuals who participate in green care have chosen to do so and, importantly, they have usually committed a significant amount of effort and time to this endeavour. Consequently, it should be recognized that not everyone will find green care appealing. Some may simply not enjoy being outdoors, or getting their hands dirty, or dealing with the emotional impact of farm animals being sent to slaughter, or of plants dying. However, some individuals who are reluctant to engage with it in the first instance may subsequently find it enjoyable and beneficial. The occupational therapist should explore the preferences of the service user and guide them towards green care if they feel it is appropriate for them.

Green care is an emerging practice with ancient roots. Its potential is, as yet, largely untapped and its activities are still comparatively marginal within statutory health and social care services. It is hoped that this

chapter will encourage occupational therapists to discover and use green care, work closely with other green care practitioners, and evaluate, research and disseminate that work.

FURTHER READING

Sempik, J., Hine, R., Wilcox, D., 2010. Green Care: A Conceptual Framework; A Report of the Working Group on the Health Benefits of Green Care. Loughborough University. Available at: http://www.cost.eu/library/publications/10–26-Green-Care-A-Conceptual-Framework-A-report-of-the-Working-Group-on-the-Health-Benefits-of-Green-Care.

A report from the European Cooperation in Science and Technology (COST) programme establishing a conceptual framework for green care.

MIND, 2007. Ecotherapy: The Green Agenda for Mental Health. MIND, London. Available at: http://www.mind.org.uk/assets/0000/2139/ecotherapy_executivesummary.pdf.

The executive summary of report by MIND (a UK mental health charity) calling for a new green agenda for mental health.

Townsend, M., Weerasuriya, R., 2010. Beyond Blue to Green. Deakin University, Australia. Available at: http://www.hphpcentral.com/wp-content/uploads/2010/09/beyondblue_togreen.pdf.

A report commissioned by Beyond Blue, the national depression initiative in Australia, which reviews existing Australian and international literature on the links between mental health and well-being and contact with nature, especially through green spaces.

USEFUL RESOURCES

There is a vast range of websites covering a wide diversity of green care topics. Below is a small selection, many of them national associations, which may be of interest and from which you can explore further links.

American Horticultural Therapy Association. www.ahta.org.

Association of Social and Therapeutic Horticulture Practitioners (ASTHP) in England, Wales and Northern Ireland. http://asthp.org.uk/.

Canadian Horticultural Therapy Association. www.chta.ca.

Care Farming UK. http://www.carefarminguk.org.uk/.

The Center of Anthrozoologys (Norway). http://azs.no/english.html.

Cultivate New South Wales (Australia). www.cultivatensw.org.au.

Gesellschaft für Gartenbau und Therapie (Society for Gardening and Therapy) a Germany-based organization. www.ggut.org.

Horticultural Therapy Association of Victoria (Australia). www.horticulturaltherapy.com.au.

Horticultural Therapy South Australia. www.htsa.org.au.

International Plant-People Interaction Resource Centre (University of Hawaii). http://www.ctahr.hawaii.edu/hih/therapy.asp.

Internationale Gesellsschaft Gartentherapie (International Society of Garden Therapy) – an umbrella body of organizations involved in horticultural therapy in Germany Switzerland and Austria. www.iggt.eu.

Plants for People – an international initiative, spreading knowledge of the benefits of plants in a working environment. http://www.plants-for-people.org/eng/aboutus/u.htm.

Schweizerische Gesellschaft Gartentherapie (Swiss Society for Garden Therapy). http://www.gartentherapie.ch/.

Society for Companion Animal Studies. http://www.scas.org.uk/.

Thrive – a UK charity working to help people living with a disability or mental health problem to transform their lives through gardening. http://www.thrive.org.uk/.

Trellis, Scotland – a charity supporting health through horticulture. www.trellisscotland.org.uk/.

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SERVICE USER COMMENTARY

As an employee of a peer-based mental health organization, this chapter confirmed the benefits we have witnessed through our organization's own 'green care' activities, and it provided me with a vocabulary that we can use as we develop our green programming. The overview of what comprises 'green care' was comprehensive and useful. It showed the wide range of activities and settings in which therapy can take place. While I was surprised to see livestock care included with gardening activities, it made sense once I considered how participants are asked not only to witness but to participate in the life cycle.

I am a service user who is not immediately drawn to green care activities, instead finding more satisfaction in the crafting of products; however, I have seen first-hand, the benefits of our organization's community garden, our greenhouse activities and our summer camping excursions. My peers have developed confidence, pride, camaraderie, inner peace and new skills through these activities. The annual summer harvest is a time for celebration, and the gardeners show pride in their success. The harvest provides opportunities to share skills in canning, preserving and food preparation. As mentioned in the chapter, these activities offer one a sense of purpose and insist on personal responsibility and commitment. They do lead to discussions about social responsibility and personal health.

In particular, I agree with the chapter's emphasis on the 'uncontrived setting' for therapy. As peers, we try to offer programmes that are not 'too programmed', activities which offer an opportunity for growth without being overtly didactic or scheduled. (Service users' time is already dictated by their medical, counselling and mental health appointments.) A garden influences the schedule and activities, not the programme manager, and the gardeners must self-organize to make sure its needs are met. For instance, without watering, the leaves will droop, and there will be no fruit. As described in the chapter in *Attention Restoration*, our gardeners become part of the decision-making on how much of their time is needed, and they choose how much to participate. They must learn to live with and respond to weather systems, learning that some decisions will never be in their hands. The garden space teaches coping skills, without anyone lecturing about it.

Absent in this chapter, however, was a discussion about creativity. It is touched on somewhat in the discussion about *Sensory processing*, but not fully. A community garden offers an ideal space to explore creativity. The plot itself has physical limits, but the garden is open to imagination during the planning stages, and it can be as simple or as ambitious as the gardeners wish it to be. It requires visualization.

The theories and constructs provided by the chapter's authors were successfully presented so that, as a layperson, I was able to understand and appreciate the perspective of the occupational therapist. The case studies were useful, although I wished for more specific details. The links to related organizations will be useful to many readers. All in all, it is a very good resource for anyone planning green care activities, whether they are occupational or horticultural therapists, recreation leaders or peers in mental healthcare.

Dinah Laprairie

21 WORK AND VOCATIONAL PURSUITS

ELLIE FOSSEY ■ SALLY BRAMLEY

CHAPTER CONTENTS

INTRODUCTION

Work is a defining feature of everyday life in human communities and a major occupational role of adulthood; indeed, many aspects of sustaining life and meeting human needs depend upon the income and relationships sustained through work (Grove et al. 2005). Consequently, work powerfully shapes people's lives socially and economically, as well as affirming a sense of productivity and valued identity within society.

> *'What do you do?' Having an answer to that question gives us immediate entrée to the normal flow of life …. Work gives us the opportunity to develop relationships in which we can feel good about ourselves. When our relationships develop out of shared respect for the unique talents we all have, it is much harder to sink and destroy them with feelings of not being worthwhile enough …. We know deeply that we are being taken seriously and respectfully by someone who is depending on us to complete a job.*
>
> *(Vorspan 1992, p 52)*

That access to decent and productive work, with fair pay in conditions of freedom, equity, security and human dignity is also considered the right of all men and women (International Labour Organization 2004) and underscores the importance of work. Not surprisingly then, illness-related disruptions to people's working lives, prolonged unemployment or exclusion from work are profoundly felt by affected individuals, their families and communities. People with

mental ill-health are among the most excluded from the workforce, experiencing very high unemployment rates and many barriers to participation in paid work. This is despite people consistently reporting their wish and preference to work; the central importance of meaningful occupation in supporting recovery and promoting social inclusion; and the existence of effective ways to support people to access employment and pursue vocational goals. Thus, this chapter addresses:

- What is meant by work and productivity
- The restrictions and barriers to participation in education and employment and the importance of addressing these issues in relation to recovery and social inclusion
- Approaches to supporting people to pursue their vocational goals and gain access to jobs and careers that enable social and economic participation and inclusion
- How occupational therapists can bring a vocational focus to mental health practice.

WORK AND PRODUCTIVITY

The term *occupation* is often understood as one's work, vocation or employment. Work is a sufficiently commonplace idea that its meaning may be assumed, even taken-for-granted, yet defining the concept of work is not straightforward (O'Halloran and Innes 2004; Jarman 2010). Paid occupations may be the most readily recognized and categorized as work. Indeed, the terms work, jobs and employment are frequently used interchangeably. In comparison, child-rearing, caring and domestic activity might be experienced as work, but are not necessarily remunerated.

In considering what is meant by work and productive occupations, Ross (2007) suggested distinctions between paid work, unpaid, hidden and substitute work may be useful:

- *Paid work* – some form of employment or job, including self-employment, that typically takes place within contractual arrangements, whereby a person's labour is exchanged for a specified remuneration. Paid work is generally highly socially valued; nevertheless the types of paid work that people do and people's experiences of working vary widely.
- *Unpaid work* – work that sustains and enriches society but does not attract individual remuneration. Often undervalued, its economic contribution in society is substantial if the financial cost of the paid work necessary to replace the unpaid contributions of domestic work, caring and volunteering in communities is considered. Much unpaid housework and caring work is not highly visible, being typically carried out by women within the domestic sphere. Volunteering usually occurs outside the home, where particular interests or concerns may be pursued, social connections made and vocationally relevant skills developed or used. Some people choose to participate in volunteering as a meaningful occupation in its own right, while for others it offers opportunities for personal development, skills and experiences relevant to gaining employment. Education and learning too are unpaid but, like paid work, typically impose structure on one's time and, like volunteering, provide avenues for personal and vocational development.
- *Hidden work* – some types of work may include goods and services provided in exchange for cash or other services, but are not formally counted as income. Hidden work may involve illegal activities, such as trading illicit drugs, or exploitation through forced labour for little or no money without safe and decent working conditions.
- *Substitute work* – a segregated form of work, also referred to as sheltered work, traditionally organized to provide daily structure and work-like activity for disabled people as a substitute for employment, but without access to the same rights and working conditions as the mainstream workforce. Once deemed prevocational training, this type of work often created segregated substitutes for, rather than pathways into, jobs that afford the social and economic benefits of community life (Warner 2004; Schneider 2005). Many now consider substitute work to be discriminatory and exclusionary (Ross 2007).

As illustrated above, work is not readily distinguished from other forms of human activity and effort merely based on whether or not it is remunerated. Nor is work easily defined in contrast to leisure: for instance, people may pursue occupations like cooking, gardening, painting and so forth, as paid work or for leisure. Leisure is also often thought of as more freely chosen, discretionary and pleasurable than work, yet leisure may lose these meanings when people are out of work, so that work and leisure appear to derive meaning from each other (O'Halloran and Innes 2004; Ross 2007). Therefore, how the concept of work is understood is shaped by the meanings and values attached to different occupations by individuals, communities and cultures over time (O'Halloran and Innes 2004; Ross 2007; Jarman 2010).

Sociological, psychological, economic and occupational perspectives of the nature and purpose of work overlap somewhat but they also differ (Ross 2007; Jarman 2010). These literatures are extensive; the following offer examples of their differing emphases. First, the division of labour that characterizes industrial societies offers one way to understand the role of occupations in society from a sociological perspective. Originating from French sociologist, Emile Durkheim, the sociological perspective has drawn attention to: the relative value and status in society of different types of work; the differing class, race and gender compositions of occupations; and how these relate to broad patterns of social inequality and disadvantage (Jarman 2010). Second, studies of unemployment and employment from a social psychological perspective have identified positive latent benefits of employment for health: that it imposes time structure and a demand for activity; involves regular shared experiences; links individual goals to collective purposes; facilitates access to social networks; and is important in defining identity (Jahoda 1981).

Third, from an occupational perspective, work is typically viewed as an adult occupation encompassing a range of productive roles. For instance, productivity as described by the Canadian Association of Occupational Therapists (2002) refers to 'occupations that make an economic and social contribution or that provide for economic sustenance' (p. 37), so that this view of work is inclusive of paid employment, study, volunteering and unpaid domestic, parenting and caring work, as ways of being productive and contributing. The occupational perspective also seeks to understand these occupations in terms of their temporal, meaning, contextual and performance dimensions (Christiansen and Townsend 2010). Put another way, an occupational perspective leads us to ask questions about people's occupations such as: how are they integrated into regular patterns and routines of time use? Why are they chosen, and what meanings do they hold? Where are they done? How are they done? How does context influence what is done?

Furthermore, an occupational perspective differs from the aforementioned perspectives in its focus on the dynamic relationships and extent of fit between persons, their occupations, and the environments in which they are enacted (Christiansen and Townsend 2010). For occupational therapists, this notion of fit may be considered in relation to jobs and careers when working with people whose vocational options or working lives have been disrupted. For instance, when considering a person's job, our focus will be the fit between the person, the demands of the job and the specific workplace environment. In turn, this focus may lead to identifying work adjustments to improve this fit. In comparison, to consider a person's employment in terms of a career means focusing on the person's vocational interests, preferences, skills and experiences and the match between these and possible employment options, a process referred to as job matching or career planning (O'Halloran and Innes 2004).

Of interest too, from an occupational perspective, is the balance among the full range of work-related and other occupations in which people engage in daily life and the implications for their health, wellbeing, and participation in society (Backman 2010; Eklund et al. 2010). So, occupational therapists are concerned with the impacts of individuals' occupations on their health, and the ways in which recovery and wellbeing may be supported through participation in personally and socially valued occupations.

UNEMPLOYMENT, EMPLOYMENT BARRIERS AND MENTAL ILL-HEALTH

There are many economic, social and health-related reasons for being concerned about employment and mental health. In high-income countries internationally, mental ill-health is a leading cause of sickness absence.

Unemployment among people with mental ill-health is very high: reported figures from English-speaking and European countries range between 60% and 90%; extensive across all relevant diagnostic categories; and higher for people with mental ill-health than other people in society (Lloyd and Waghorn 2010; Waghorn and Lloyd 2010). Mental ill-health also accounts for a substantial proportion of disability payments at a population level (Cai et al. 2007; Harvey et al. 2009). This means significant economic costs are associated with not adequately supporting people to retain and return to their jobs following sickness absence due to mental ill-health, and not addressing the vocational issues of unemployed people with ongoing mental ill-health.

Paid employment is considered beneficial for health and wellbeing when it provides opportunities for control, using skills, pursuing goals, variety, physical security, money, social contact and a valued social position (Ross 2007), although insecure jobs and poor-quality working conditions may also undermine mental health (Butterworth et al. 2011). In comparison, unemployment has many reported adverse effects for those who personally experience job loss and lack of work: loss of income, purpose, structure, identity and social status, as well as poorer health (Ross 2007).

For people with enduring mental ill-health, the stresses of working were traditionally thought to outweigh the disadvantages of being unemployed, yet the constant strains imposed by prolonged unemployment, poverty, isolation, and losses of self-respect, identity, purpose and routine are actually likely to worsen their circumstances (Marrone and Golowka 1999; Warner 2004). Their low levels of workforce participation should also not be taken to mean that people with mental ill-health are incapable of or do not want to work. To the contrary, the majority of people experiencing mental health issues report wanting access to work opportunities or to pursue vocational aspirations and, with the right supports, can and do engage in education, employment and other productive occupations (Fossey and Harvey 2010). Internationally recognition of these issues, along with the profound employment and social inequalities faced by people with mental health issues, has increased acknowledgement that their employment issues and social exclusion are inextricably linked (Grove et al. 2005).

Paid employment or other ways to be productive and contribute in one's communities, along with a decent standard of living and inclusive relationships, are considered key elements of social inclusion (Bates 2002; Repper and Perkins 2003). Similarly, people often report working and opportunities for meaningful occupation are central to the process of recovering (Davidson 2003; Krupa 2004; van Niekerk 2009). Qualitative studies of employment-related experiences from the viewpoints of people with direct experience report that gaining employment creates a sense of wellness, improved relationships, more positive self-appraisals, and greater optimism (Fossey and Harvey 2010). Other wide-ranging benefits of being employed identified in these qualitative studies include remuneration, more structured time use, greater autonomy, status and acceptance within society, a sense of purpose, feeling productive and useful to others, affirmation of ability and opportunities for social contact and personal development. Many of these are the same benefits reported by other employed people (Fossey and Harvey 2010). So, while their desire for work should hardly be surprising, people with mental ill-health face an extensive range of challenging barriers to finding and maintaining meaningful employment due to systemic, employer and job-related factors, in addition to personal factors.

BARRIERS TO VOCATIONAL OPTIONS AND EMPLOYMENT

The availability of jobs in the labour market influences the likelihood of being employed, but those generally most at risk of losing jobs, job instability and unemployment include: the young and inexperienced, those with least vocation-related skills and qualifications, older workers, those in poor health and disabled people in society (Ross 2007). Hence, people experiencing mental health issues may be particularly vulnerable to difficulties obtaining jobs, losing jobs and to prolonged unemployment on health grounds. Their completion of formal education or vocational qualifications and gaining of work experience have also often been disrupted. Contributing factors are: the common onset of mental health issues in adolescence or early adulthood; the fluctuating nature of

many mental health conditions; and attempts to return to study or work that fail due to inadequate support. These factors make jobs difficult to obtain and sustain, restrict career paths and earning potential, and can result in long-term exclusion from the mainstream workforce (Megivern et al. 2003; Lloyd and Waghorn 2010).

Other wide-ranging barriers to participation in education and employment have been reported by people with direct experience: (Megivern et al. 2003; Blitz and Mechanic 2006; Thornicroft 2006; Forbess et al. 2010; Lloyd and Tse 2010; Waghorn and Spowart 2010), including:

- prejudice and discrimination in educational and employment settings (e.g. related to language use, performance expectations, social interactions, performance management and training practices)
- inflexibility in working practices and educational course structures that respectively limit paid work and study choices particularly for those with fluctuating or episodic conditions
- limited knowledge among employers about how to accommodate people with mental ill-health in the workplace, resulting in a reluctance to hire
- low expectations or limited knowledge of mental health staff about opportunities to study/work, meaning that they either do not attend to vocational issues or convey pessimism about study/work prospects
- views, held by mental health staff and/or carers, that work or study is too stressful/harmful, especially when it is identified as a trigger factor for a person's ill-health, meaning that they discourage return to study or work
- inadequate supports both within and outside the workplace or educational setting
- ongoing dilemmas related to management of personal information and illness disclosure, including its potential for adverse consequences in job-seeking, on return to study or work following sick leave, and whilst engaged in education or employment
- limited income and resources to enable job-seeking or study, such as transport, clothing and equipment
- subjective concerns regarding the impact of medication effects or illness-related factors on managing study/work demands or performing well enough, and fears of becoming unwell and its consequences for study or employment and income
- employment disincentives, such as risks to, or loss of, welfare entitlements and difficulties regaining them if a job is lost
- the complexity of systems to navigate to access education, job-seeking assistance and financial entitlements
- varying availability of effective vocational services, career advice and financial counselling, through which some of the above issues regarding support, disclosure, performance and finances might be addressed.

Despite these barriers, it is increasingly recognized that addressing vocational aspirations serves to achieve key goals in supporting recovery (Slade 2009; Lloyd and Waghorn 2010); solutions to these issues are thus a priority.

ACCESS, OPPORTUNITIES AND SUPPORTS TO FIND AND SUSTAIN EMPLOYMENT

The provision of substitute work has a long history in psychiatry. Initially it was widely associated with the moral treatment methods of William and Samuel Tuke at The Retreat in York, and Philippe Pinel at Bicetre and La Salpetriere in Paris (see also Ch. 1). Substitute work subsequently became widespread in mental institutions, with people working in kitchens, laundries, gardens and workshops as part of their treatment. Their (often) unpaid labour also actively contributed to running these institutions (Wilcock 2001). Later, industrial therapy workshops provided substitute work in protected environments for those discharged from institutions. This practice that has declined for various reasons notably including that the working conditions were restrictive, with limited work choices, few opportunities for vocational development, and little access to mainstream employment (Schneider 2005). Current approaches have shifted towards supporting people to find and sustain mainstream employment of

their own choosing, more in keeping with recovery-oriented practice and fostering self-determination (Slade 2009). This more directly tackles working conditions and practices that perpetuate employment disadvantage or exclusion, consistent with a social model of disability (Burchardt 2004). A focus on resources and support issues across individual, workplace and societal levels is essential to advancing knowledge and best practices for supporting work transitions (Kirsh et al. 2009; Shaw and Sumsion 2009).

Employment Support

Supported employment refers to an approach where the primary goal is to secure employment in a mainstream setting, on an equivalent wage. It aims to help individuals find mainstream employment through rapid job search, job placement and on-the-job support, without lengthy prior prevocational assessment or training. Job searching and placement are tailored to individual preferences, with further support to retain employment (Bond et al. 2008). A further key characteristic for the success of supported employment programmes is the integration of vocational specialists into mental health teams, enabling vocational and mental health staff to regularly meet and interact formally and informally. These principles, originally defining Individual Placement and Support (IPS), are now considered more general principles for evidence-based supported employment (Bond 2004).

Supported employment, based on IPS principles, has been extensively researched over the past two decades and substantial evidence supports its effectiveness for assisting people with persistent mental illnesses to get jobs, and promising outcomes for young people with psychoses (Bond et al. 2008; Waghorn and Lloyd 2010). Psychological interventions may be more often used to assist return-to-work of people with other conditions (Corbiere and Shen 2006; Harvey et al. 2009). However, research suggests that this approach has been less successful in assisting people to keep jobs. There are many ways of enhancing supported employment and potentially job outcomes, for example better job-matching processes, support for problem-solving, attention to work adjustments, natural supports in the workplace and employer education (Kirsh et al. 2005; Bond et al. 2008; Waghorn and Lloyd 2010). Qualitative studies involving people with mental health problems indicate helpful elements of ongoing support that might also include: support to develop personalized self-management strategies for maintaining one's job and wellbeing; attending to disclosure and its consequences as an ongoing process in work settings; access to financial counselling and career advice; and opportunities for weighing the benefits and drawbacks of vocational options so as to make choices in an informed way (Johnson et al. 2009; Fossey and Harvey 2010; Blank et al. 2011). It is also recommended to have more involvement of people with expertise grounded in experience of mental ill-health and employment issues to further develop solutions and strategies that will improve career options and vocational success (Boeltzig et al. 2008; Shaw and Sumsion 2009).

Supported Education

The success of supported employment in helping people get work has largely been based on securing entry-level job positions with limited opportunities for career development. Improving career pathways and options is one of the goals of supported education, an individualized approach based on similar principles to supported employment but focused on supporting people to access and successfully participate in educational courses of their choosing within mainstream settings (Murphy et al. 2005; Lloyd and Tse 2010). Supported education operates in a number of ways. For example, supports may be individualized to enable students to attend mainstream classes and to use on-campus learning supports available to all students. Alternatively, separate classes may be offered to accommodate the specific learning needs of people returning to study in educational settings. Since supported education provides a means to transition back into studies so as to gain qualifications, pursue personal development or vocational aspirations, and enhance employment options, it is also considered a promising approach to improve employment outcomes (Rudnick and Gover 2009; Lloyd and Tse 2010).

Creating New Employment Options

To improve the vocational choices of people disadvantaged in the labour market, another approach is to actively promote the development of new

employment options within communities (Krupa et al. 1998). Such initiatives include social firms and affirmative businesses that adopt a systemic economic development approach to create employment options, whereby working conditions that perpetuate employment disadvantage are eliminated (Krupa et al. 2003). These workplaces are designed with built-in adjustments that can make employment accessible, sustainable and support recovery for those who struggle, while offering equitable working conditions for all workers (Svanberg et al. 2010; Williams et al. 2010).

Mental health services offer a unique work context for the employment of people with direct or lived experience of mental health issues. This expertise becomes a positive qualifying attribute or quality for work, rather than an experience to be hidden and not disclosed, for fear of discrimination. Individuals who choose to work in mental health services may do so to 'put something back'; to 'help others out in the same situation'; or to make a difference to services. However, a range of practices related to employment, human resources and organizational culture need to be in place to ensure safe, sustainable and equitable employment within the mental health workforce (Wolf et al. 2010).

Further, self employment is an under-considered option, which can provide flexible, self-managed work that suits some people experiencing mental health issues (Hamlet Trust et al. 2007). Examples include people choosing to provide expertise as advocates, educators and researchers within the mental health sector on a consultancy basis, and people using their creative, artistic or other talents to develop their own businesses.

Volunteering

Volunteering provides a potentially meaningful way to contribute to community life. Being a volunteer is valued socially and offers a positive role in contrast to that associated with being a mental health service user (Rebeiro and Allen 1998). Volunteering needs to be actively chosen to have these benefits. There are many avenues for volunteering that provide scope to explore interests (art, animals, conservation, spirituality, political activism and so on), as well as opportunities for personal development and social connections within one's community. Peer support initiatives also often offer volunteering opportunities in settings among others who understand mental health issues. Volunteering may also support a sense of competence and accomplishment in a work-like environment that is supportive of staying well, without the perceived stressfulness of paid work, and enable exploration of potential interests and career options (Rebeiro and Allen 1998; Braveman 2012a). However, its effectiveness as a route to paid employment is less clear and it does not redress economic disadvantage, but may support recovery for those who choose and find meaning in volunteering as an occupation (Farrell and Bryant 2009). Services designed to facilitate service users' involvement in volunteering as a means of vocational development are illustrated in Boxes 21-1 and 21-2.

BRINGING A VOCATIONAL FOCUS TO MENTAL HEALTH PRACTICE

A vocational focus in mental health practice can be supported by an occupational perspective. With this perspective, occupational therapists can appreciate and investigate participation in occupations: for example, by using the Model of Human Occupation (MOHO) (Kielhofner 2008). This model provides a framework for appreciating how personal and environmental factors contribute to disruptions or problems in occupations that may occur in life transitions, when capacities change or participation is restricted (Kielhofner 2009). Specifically in relation to work, MOHO guides the therapist to address:

- How a person's values, interests, and view of his or her own capabilities, may support or undermine choosing a work-related occupation, sustaining work participation and developing a positive work identity
- The person's daily routines, roles and habits that may support or constrain involvement in work
- The particular skills and demands of a specific work role
- Features of the workplace environment, such as its physical characteristics and employer and/or employee relationships, which may be supportive or create barriers to participation and success in the workplace (Braveman 2012b).

BOX 21-1

THE WORKS APPROACH TO SUPPORTING MENTAL HEALTH AND EMPLOYMENT

The WORKS (Bramley and Mayne 2010) was developed through active mental health service user and worker collaboration in Sheffield, England, with service users involved throughout in shaping its development into a workshop approach and fully resourced computer and paper-based package. Its initial premise about what an individual needs is not based on diagnosis, prognosis, severity or duration of illness, or where the individual is receiving care in the mental health service. Instead, it acknowledges that individuals have different skills, experiences and preferences; face different opportunities and challenges in identifying and achieving their vocational aspirations; and place themselves at varying starting points in relation to these aspirations.

The WORKS suggests that mental health service users generally find themselves at one of three starting points in relation to their vocational aspiration:

- *Starting Out*: Some people do not believe they could ever achieve employment due to the barriers that they face. Challenges can include a lack of belief that they have any skills and abilities, poor self-esteem and confidence and/or attitudes of others that people with mental ill-health should not or are unable to be employed.
- *Moving Forward*: People may have some experience of employment and/or some vocational preferences. They want to explore their options/choices but lack the confidence in their skills and abilities and/or the information about the next step. They may also want to try some things out in a stepped way to ease the transition.
- *Keeping Going and Growing*: People who are moving into employment but who want to identify how to meet their ongoing support needs to ensure their employment is sustainable and that they continue to develop.

The WORKS provides a framework for conceptualizing support in relation to these starting points (Cassinello and Bramley 2012), as illustrated in Fig. 21-1.

Further, the WORKS provides activities that can be undertaken in workshops facilitated by service user experts in paid and voluntary roles, and by individuals using the computer or workbook-based resource independently, for these points on vocational pathways:

- *Starting Out* builds the foundations of aspirational thinking, hope and confidence. It focuses on identifying

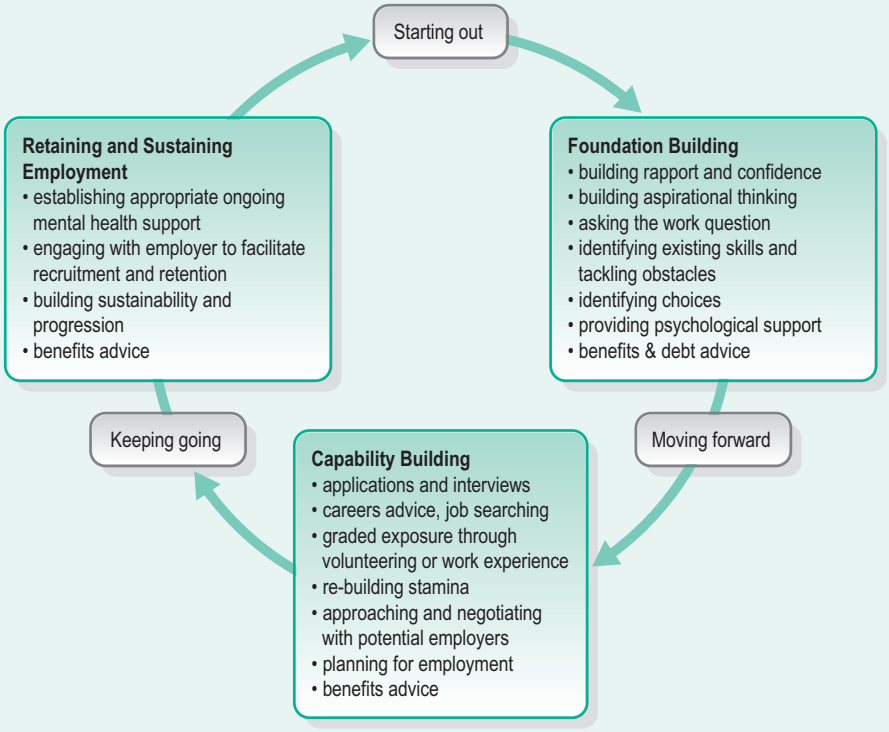

FIGURE 21-1 ■ The WORKS framework. *(© Sally Bramley. Sheffield Health and Social Care NHS Foundation Trust.)*

Continued on following page

BOX 21-1

THE WORKS APPROACH TO SUPPORTING MENTAL HEALTH AND EMPLOYMENT (*Continued*)

existing skills, aptitudes and challenges; giving information about choices and options; tackling benefits issues; building basic work-related skills; identifying ongoing supports and practical needs.

- *Moving Forward* supports capability building in work preparation (support with applications, interviews, how to handle disclosure, information on rights); action planning; analysis of job roles and demands; financial information; identifying and accessing training or education; volunteering; making the right choices and planning for sustainable employment.
- *Keeping Going and Growing* concerns sustaining work and job retention by supporting individuals to establish appropriate ongoing mental health support in work; providing information/advice on rights and welfare entitlements; identifying ways of grading return to work and negotiating reasonable work adjustments; and employer engagement to facilitate retention.

The WORKS also assists occupational therapists in formulating their approach, since it enables their engagement with individuals' aspirations, and equips them with tools and information to collaboratively develop successful vocational pathways with individuals experiencing mental health issues (Cassinello and Bramley 2012).

BOX 21-2

THE USER SUPPORT AND EMPLOYMENT SERVICE (USES)

USES provides support to mental health service users in achieving and/or sustaining employment, specifically in the National Health Service (NHS) in Sheffield, England. It provides one-to-one, time-unlimited support to individuals; work experience opportunities; and workshops open to anyone wishing to explore employment issues around finding or keeping work.

Established in 2000, drawing on the User Employment model developed at South West London and St Georges' NHS Trust in England (Perkins et al. 1997), USES is predominantly staffed by people with lived experience of mental health difficulties. For example, the coordinator is an expert by experience as a service user, a former volunteer and now paid employee in the team. Suitable volunteering experiences are developed between the coordinator and potential volunteers based on their work aspirations, existing skills and the skills they wish to develop. Formal application and recruitment procedures within the organization are undertaken before volunteers could take up a post. Each volunteer then works with a mentor, a job description is developed and ongoing support to volunteers and mentors is provided by the coordinator. Through USES, service user volunteers report being able to rehearse new vocational directions, use and build on their prior experience (Fegan and Cook 2012).

An occupational therapist works as a vocational specialist in this team, offering an individually tailored approach to finding and achieving paid work with individuals, in which their interests and aspirations are paramount and strong working partnerships with individuals' mental healthcare coordinators and employment specialists are crucial, so as to collaboratively develop vocational plans that are flexible, sustainable and integrated with the other elements of the individual's mental healthcare provision. The roles of team colleagues with lived experience of mental health issues support the development of authentic, trustworthy relationships with individuals. Also supporting these roles, The WORKS offers a clearly articulated framework, whereby individuals and employment specialists can identify objectives and tasks, chart progress and development and navigate setbacks and challenges.

Occupational therapists are well placed to understand and work directly with occupational issues related to work and productivity. They can advocate that these issues are routinely attended to within mental health services. Vocational issues may traditionally have been seen as beyond the remit of mental health services, or that individuals' mental health issues needed to be resolved prior to attending to work or productivity. As a consequence, work and productivity have often not been routinely discussed by mental health workers with service users. By regularly asking questions about work and productivity from initial assessment through all phases of service contact and in discharge-planning, as occupational therapists:

- we avoid reinforcing the myth that equates working and productivity with wellness, and mental ill-health with worklessness, being unproductive or incapable of work

- we avoid leaving people with the sense that they are not capable of work, because of what they are experiencing and because we are not discussing their working lives or vocational options with them
- we support and encourage people's capabilities and drives to be active, occupied and productive, rather than narrowing our interest in people to their symptoms requiring intervention
- we work with individuals' vocational aspirations as a means of facilitating recovery
- we can instill hope and create opportunities for enhancing self-efficacy, self-determination and citizenship
- we create opportunities for real working alliances through acknowledging our common experience as people who want to do, achieve, and be seen as working, contributing and productive members of our communities
- we enable conversations with people about their concerns regarding working, and support their weighing up of options and development of strategies for dealing with issues of concern (such as job-seeking, disclosure, negotiating work adjustments, financial implications)
- we are aware that welfare policies and return to work imperatives, internationally, are placing greater emphasis on the workforce participation of people previously eligible for welfare payments; people with mental ill-health are likely to experience pressures for economic productivity in their daily lives, so that talking about work means these concerns are not silenced and supports can be offered.

There is a significant role for occupational therapists in: supporting people to pursue vocational goals, gain and sustain employment; and in providing leadership within mental health services on these issues.

PRACTICE AS A VOCATIONAL SPECIALIST

Occupational therapists may work specifically as vocational specialists within mental health services or may have a vocational leadership element within a broader occupational therapy role within a team, service or organization (Perkins et al. 2009). Vocational specialism involves a flexible, practical, capability-focused and often creative approach that has much in common with navigation (College of Occupational Therapists et al. 2007). It involves the development of trusting relationships, cooperation, collaboration and establishing a shared vision about possible vocational options and the variety of routes to reach them. It involves networking, curiosity, acquiring information, providing practical support, understanding how to navigate the service systems, the potential obstacles and who else may know the way. The navigator or guide must also have the courage to acknowledge when they need to ask others for directions, since the route will vary for each person.

Vocational specialist roles involve creating relationships with individuals, with other mental health workers and supporters, with other agencies and services, with employers and workplaces; and supporting mental health and wellbeing. With an approach comprising these elements, the vocational specialist may facilitate the development of mutual respect, instill hope and optimism, and lay the foundations for a productive working alliance to enable vocational success. These elements are briefly outlined.

Creating Relationships with Individuals

Trust, collaboration, reassurance, hope, flexibility and a capability focus are crucial to the development of an effective, trusting relationship and shared vision between the vocational specialist and the person with whom she or he is working (Johnson et al. 2009). Initially, individuals may need significant encouragement to believe they can have aspirations, reassurance about their ability to succeed, and support to contemplate change. It is important to take an approach that recognizes and validates each individual's beliefs, choices, pace, preferences and interests and prior experiences. Motivation, self-efficacy, confidence, responses to change and the complexity of individuals' situations are all variable. Often for individuals, considering employment is an anxiety-provoking prospect. Gaining an understanding of what work means to the person is therefore an important way to begin to understand individual

motivations. Discussion of 'the meaning of work to me' section in 'My Vocational Profile' can be a useful starting point (see Fig. 21-1). This discussion can be instrumental in identifying the person's perceptions of themselves and their potential role as worker.

The role of the vocational specialist also involves encouraging people to identify the obstacles and challenges involved in pursuing their vocational aspirations. This may require time, sensitivity and patience. However, the obstacles and challenges have to be fully understood to establish a shared understanding of them, so as to enable the person and the vocational specialist to think about how to tackle the challenges, to gauge and manage the pace of change and transitions involved. Here, enabling the person to identify strengths and supports is likely to be helpful in widening the possible strategies and solutions that might be used. See Fig. 21-2 'My Vocational Profile' for examples of potential obstacles or challenges as well as strengths and supports that may be useful in starting such conversations.

To further explore work-related issues with the person, two potentially useful work-specific interview tools that the Vocational Specialist might use are the Worker Role Interview (WRI) (Braveman et al. 2005; Lohss et al. 2012) and Work Environment Impact Scale (WEIS) (Moore-Corner et al. 1998; Williams et al. 2010). Informed by MOHO, they respectively explore return to work issues and the impact of the workplace on a person's participation in work (see Box 21-3). Other interview and self-report tools designed to allow a person to consider his or her role participation, usual time use and activity patterns, and activity-related interests and values may also be relevant and helpful (see Kielhofner 2008, for further examples).

Creating Relationships with Other Mental Health Workers and Supporters

Working in partnership with other mental health workers involved in a person's care and with the person's other supporters is an important task. Their attitudes towards the person's vocational aspirations may be motivating and supportive, or sometimes disempowering and thwart their efforts, depending on their views of an individual's capabilities and work prospects. Where workers have reservations and concerns about people's employment aspirations, this usually arises from their concern to keep people well and safe. This might be viewed negatively, but can also be really useful in supporting the person and the vocational specialist to remain focused on identifying the 'right' opportunities and supports at a pace that assures achievement and fosters recovery.

Collaboration with others ensures vocational plans include existing coping strategies, prevention and support plans, and ways of recognizing triggers and signs of relapse. This allows the development of achievable goals that everyone can support. Active involvement of other workers can sustain a sense of security and continuity, while the person navigates transitions and change. Working together can enhance the knowledge of other workers around vocational issues, as well as broadening their understanding of a particular individual's capabilities, strengths and aspirations. In addition, occupational therapists working as vocational specialists have mental health-related knowledge and vocational rehabilitation expertise that can create an added feeling of security for the person, while facilitating them in taking risks that are necessary in moving forward.

Creating Relationships with Other Agencies/Services

As a vocational specialist, effective collaboration with wide-ranging agencies and services is also often required. No one person or agency is likely to hold all the pieces in facilitating a person's pursuit of vocational aspirations. Welfare and return to work services are often complex in structure and organization, and change rapidly depending on the social, economic and political context. Therefore, good working alliances with employment agencies and providers (such as Jobcentre Plus in the UK) are crucial in enabling the vocational specialist to effectively support individuals in pursuing vocational options.

A good level of interagency cooperation can help the vocational specialist to recognize opportunities and identify their relevance to individuals. With functional knowledge of the practices and provisions of other services/agencies, the vocational specialist can inform individuals about their roles and facilitate their engagement, decision-making, and navigation

My vocational profile

(Tick as many as you like which apply to you in each section)

What work means to me

Money/financial security		Physical exercise		Mental stimulation	
Social contacts & networks		Gaining qualifications		Learning new things	
Contributing to others/society		Job satisfaction		Feeling useful/valued	
Structure to my time		Building my confidence		Self esteem	

Others:-

My current vocational status

Paid employment - in work Part/full time		Unemployed		Education/training Full time	
Paid employment - off work sick Job to return to yes/no		Unpaid work e.g. voluntary work - currently working		Education/training Part time	
Permitted work (paid)		Unpaid work e.g. voluntary work currently not working		Education/training Basic Skills	
Paid apprenticeship vocational training		Unpaid work e.g. voluntary work - future aspiration		Education/training Learning for leisure	
Sustaining current vocational status e.g. job or role retention		Other occupational choices e.g. leisure interests, family roles, caring responsibilities		Starting out: seeking information/ advice exploring options	
Paid employment – future aspiration		Unpaid apprenticeship vocational training		Other e.g. retired	

My current obstacles/challenges

My concerns about my benefits/ finances		Being in a new environment		My mental health issues	
I feel I lack knowledge about my options/choices		Meeting new people		Physical health issues	
I have some travelling issues & challenges		I need support with job searching		The impact of change on my current routine	
The reservations/concerns of family/ friends/carers/supporters/colleagues		I lack some work-related skills e.g. time keeping, computer skills		I have/had issues with a current/previous employer/ manager	
The negative attitudes of others towards mental health issues. My concerns about disclosing health issues and/or how to do this		Concerns about the effects of working on the services I receive, e.g. lack of out of hours services, I may be discharged if I return to work		The inflexibility of work options e.g. the hours, shift patterns, travelling required, levels of pay	
My fear of/the risk of failure		My drug/alcohol issues		My lack of confidence	
I lack some relevant skills (literacy, numeracy)		My childcare and/or other commitments		Others?	

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FIGURE 21-2 ■ My vocational profile. *(© Sally Bramley. Sheffield Health and Social Care NHS Foundation Trust.)*

Continued on following page

My Strengths

I am interested/keen		I am reliable		I am willing to learn and can be flexible	
I have supportive friends/family/ colleagues		I have past experience of work		I have information-finding skills	
I have support from CPN/SW/ Doctor/OT etc.		I have past experience of learning		I understand my own support needs	
I have some aspirations/goals		I have some necessary skills/ qualifications		I understand my benefits & financial situation	
I have some communication skills		I have a routine that fits my work aspirations		I have relevant level of literacy/ numeracy skills	

My vocational support networks

Job Centre Plus (for example Incapacity Benefit Personal Adviser)		OT/CPN/Social Worker/ Psychologist/Support Worker		Employer/line manager	
Disability Employment Advisor		Occupational Health		Family/friends/colleagues	
Educational support e.g. College Link Worker		Vocational worker		Support group	

My current Financial Situation

Job Seekers Allowance		Income Support		Paid salary/wage	
Disability Living Allowance (care component)		Disability Living Allowance		Private pension	
Incapacity benefit Employment Support Allowance (please specify)		Tax Credits		Any other type of benefit (Please state)	
Permitted Work		Housing Benefit		No benefits at present	
Carers allowance		Council Tax Benefits		Significant current financial concerns/debt	

Any other relevant information:-

My initial action plan:	**Who? Where? When?**
1.	
2.	
3.	

B

FIGURE 21-2, cont'd

of service systems and processes. For example, in the UK, the provision of accurate financial information and 'better off' calculations, through a direct link to personal advisers at Jobcentre Plus, is essential to individuals fully understanding their financial situations, and often also removing perceived barriers to employment associated with loss of welfare entitlements.

BOX 21-3
WORK-RELATED INTERVIEW TOOLS

WORKER ROLE INTERVIEW (WRI) (Braveman et al. 2005)

This interview explores psychosocial and environmental factors that influence return to work. Its semi-structured nature allows the vocational specialist to adapt questions to the person and their situation. It explores the person's past, present and future employment situation with questions in 17 areas listed below, which may be rated for the extent of their interference with the person's working.

Personal causation	1. Assessing own abilities and limitations
	2. Expectations of success in work
	3. Taking responsibility
Values	4. Commitment to work
	5. Work-related goals
Interests	6. Enjoyment of work
	7. Pursuing interests
Roles	8. Identifying with being a worker
	9. Appraising work expectations
	10. Influence of other roles
Habits	11. Work habits
	12. Daily routines
	13. Adapting routine to reduce difficulties
Environment	14. Perceptions of work setting
	15. Perceptions of family and peers
	16. Perceptions of employer/line manager
	17. Perceptions of colleagues

THE WORK ENVIRONMENT IMPACT SCALE (WEIS) (Moore-Corner et al. 1998)

Similar in structure to the WRI, the WEIS interview can support people in thinking and talking about their experience of a particular work environment with a vocational specialist. The WEIS is recommended for use with people who are employed and not presently working but anticipating return to a specific job or type of work. Like the WRI, it comprises 17 areas: time demands; task demands; appeal of the work tasks; work schedule; interaction with colleagues; group work membership; interaction with manager/supervisor; work role standards; work role style; interaction with others; rewards; sensory qualities; physical arrangement; social atmosphere; properties of objects; physical amenities and the meaning of work. The rating scale is the same as in the WRI.

The information gleaned can assist the vocational specialist in compiling a picture of the person's work situation, and support the person to identify and plan strategies for returning to work and negotiating work adjustments if needed.

Creating Relationships with Employers and Workplaces

It is not possible to support individuals in work or into work without developing relationships with employers and line managers (Sainsbury Centre for Mental Health 2009). This requires that the vocational specialist understands the world of work, the employer's priorities and responsibilities, as well as individual employee rights; it also requires awareness, tact and mutual respect.

The vocational specialist may play a significant and useful role in working with employers to inform their understanding of how to work with employees with mental ill-health. In addition, with prior agreement, they may work with both employees and employers to: negotiate return to work plans; suggest temporary or ongoing reasonable work adjustments, to facilitate job retention; and support an employee to discuss the potential impact of their health condition with their employer. In other circumstances, such as where a person is seeking work through an employment agency or other intermediary, the vocational specialist may have no direct contact with an employer. Nevertheless, a thorough understanding of the culture and functioning of workplaces and their demands on individuals is vital if the vocational specialist is to facilitate decision-making aimed at enabling the best fit between a person, employer and workplace.

Supporting Mental Health

Health management interventions are integral to vocational work with the majority of people experiencing mental health issues. Maintaining engagement through crises, episodes of acute mental ill-health, substance misuse, financial or housing instability and other individual life events, will necessitate collaborative working with the individual and other services and supporters. Managing these difficulties may require adjustment of vocational planning to take account of such circumstances. Where an individual's mental health fluctuates or deteriorates, the potential impact

of work-related transitions and vocational plans may need review with the individual and modification, while reinforcing established health-promoting strategies. In addition, sustained involvement in education or employment involves the development of strategies for self-managing mental health and participation (Fossey and Harvey 2010). For this purpose, a useful tool may be the 'Wellness Recovery Action Plan' (WRAP) (Cook et al. 2010).

As in other practice areas, reviewing plans regularly together is crucial to maintaining momentum, focus, direction and recognizing the distance travelled. The collaborative nature of vocational work and its focus on personal development offers an important opportunity to record progress. The meaningfulness and relevance of the record would be enhanced by recognizing achievements and identifying helpful strategies, increasing the person's sense of ownership. For instance, a personal development portfolio, log or diary, in paper or computer form, can enable the person to identify and chart their own skills acquisition and progress, as well as providing evidence for a CV or application at a later stage. Even more crucially, this can enable the person to hold a recovery perspective during periods of fluctuating health by offering a tangible reminder of what they can achieve. The vignettes in Boxes 21-1 and 21-2 illustrate how vocational specialists and mental health service users can actively collaborate to generate innovative approaches and strategies for supporting mental health, employment and other vocational aspirations.

SUMMARY

Employment is significant for economic and social inclusion. Productive occupations which are personally and socially valued can support recovery. There is evidence that people experiencing mental health issues can pursue their vocational goals with the right support. Mental health services should proactively attend to work and vocational issues. Occupational therapists can and should support employees to retain their employment; enable those without work to explore and pursue vocational goals; and provide leadership on these issues within mental health services and local communities.

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Section 6 PEOPLE AND SETTINGS

22 THE ACUTE SETTING

KATHERINE L. SIMS

CHAPTER CONTENTS

INTRODUCTION

In many places, people with mental health problems are supported at home in the community when their mental state deteriorates. However, there will always be some who are admitted to a unit in a hospital for a period of inpatient treatment. In this chapter, the word 'treatment' is used to reflect the hospital setting, where the focus is on acute symptoms and difficulties, addressed by a multidisciplinary team. As community services develop, occupational therapists are not always present within an acute setting, but there is a clear role for occupational therapy and the use of occupation both as an assessment and intervention medium. Focusing on an individual's strengths to support their return to occupational function is an important component of recovery from an acute episode.

This chapter starts with some essential information about the acute setting, followed by an analysis of how services are changing in response to the growth of community mental health services. The staff and others working in acute units are described, followed by brief explanations of the legislation, which may impact on their work. Specific considerations for occupational therapy are then discussed in terms of the occupational therapy process, indicating the importance of building a rapport, assessment and working with groups and individuals to prevent relapse and promote recovery and social inclusion. The occupational therapy role in the psychiatric intensive care unit (PICU) is briefly explored. Finally, two case examples are used to illustrate and summarize occupational therapy in the acute setting.

An Acute Episode

An acute episode of mental ill-health is characterized by symptoms that may affect a person's cognitive processes, beliefs, perceptions and behaviour. There may be a sudden onset of symptoms or a gradual deterioration leading to admission. Within any unit there will be a diverse population with many different diagnoses, including severe depression, bipolar affective disorder, psychosis, drug-induced psychosis, schizophrenia and personality disorders. It is important to remember that this is often a very distressing time for the service user and their family and friends. Any member of staff working in an acute setting will have a responsibility to support all involved and offer reassurance.

The Environment

An acute mental health unit will serve the local population and largely be reflective of the ethnicity and culture of the community. The unit will have gender-specific wards or areas within a ward. A modern purpose-built unit may have individual rooms and en suite faculties to maintain dignity and privacy. Some have an occupational therapy department with facilities such as group rooms, kitchen and computer access, art room and a gym. There may be designated areas on the ward for activity. Wards are staffed by qualified nurses who are supported by unqualified staff. The built environment is important and should be a therapeutic space that is clean and welcoming. As part of the social environment, all staff will have a responsibility to ensure that environmental standards are maintained and problems reported.

Maintaining Dignity and Privacy

When someone is admitted to an acute unit they may behave in a way that they do not do usually. They may be verbally abusive or aggressive, sexually disinhibited or emotionally labile, lacking control of their emotions. It is therefore important that both the environment and staff support an individual in maintaining their dignity and privacy and help them to keep safe. This may be as simple as knocking on a bedroom door before entering, supporting someone in being appropriately dressed and listening to someone's concerns (MIND 2004).

CHANGING NATURE OF ACUTE SERVICES

Prolonged inpatient admissions of months or years can be avoided for many people. As mental health services evolve and community services have developed and diversified (see Chs 1 and 22), acute settings have become more focused on minimising the duration of a person's stay.

More Acuity

The population of acute units has been changing, as have the interventions offered (Fitzpatrick et al. 2003). The emphasis is on admission as a last resort, when all other options are no longer considered appropriate, effective or safe. Admission to an acute unit may be legally enforced, for example in England under the Mental Health Act (2007), used when people are deemed to be a risk to themselves or others and will not agree to be admitted to hospital voluntarily. This means that those admitted to an acute unit will be very unwell. If they are admitted under the Mental Health Act, they are said to be 'under' or 'on' 'section', referring to the different sections of the Act (see below).

More Substance Misuse

Another change in the population profile is the increase in dual diagnosis. This is where a mental health service user also uses illicit drugs and/or alcohol. Due to their vulnerability, people with mental health problems can be at increased risk of using substances. This may be

a way of managing their symptoms, coping with social isolation, or due to being targeted by those who perceive and exploit their vulnerability. Occupational therapists in the acute setting will need to know about substance misuse and the impact on mental health and recovery. They will also need to have an awareness of the local substance misuse services and seek advice and training accordingly.

Shorter Admissions/Community Support

The emphasis in acute care is on the admission being for as short a time as possible, with early discharge and community support being implemented. The development of crisis teams and similar services has supported shorter admissions (Glover et al. 2006). This impacts on an occupational therapy service, as an admission is time-limited to an acute phase. Occupational therapists in an acute service have to be very responsive to the service needs and react accordingly. This means having a flexible working attitude as well as being able to work under pressure. There may be a requirement for working out of regular office hours, in the evenings and at weekends. This enhances the flexibility and speed of an occupational therapy service to respond to the constantly changing presentation of service users and develop as the service needs require. Assessments need to be completed quickly. However, the focus needs also to be on good-quality care, maintaining the person-centred philosophy of occupational therapy. A good knowledge of the local community and its resources is also required, to ensure appropriate provision of information and onward referral.

THE BROADER CONTEXT FOR ACUTE SERVICES

In England, 'New Ways of Working' recognized the shared responsibility of mental health services to prevent and reduce admission, requiring greater co-ordination of services and acknowledging shared or generic responsibilities (National Institute for Mental Health in England 2007). Admission to a unit, while sometimes necessary, can be a disempowering and frightening experience for people. Treatment in a home environment, if possible and appropriate, is preferred. Cost implications of acute inpatient care also impact on a service so alternatives to admission, within the community, are favoured (Department of Health 2002).

These community services are described in detail in Chapter 23 and it is important for occupational therapists in acute settings to know about them. Many people are supported by community mental health teams and may be referred to crisis and home treatment teams to prevent admission in acute phases. These teams may work in partnership with day services for enhanced support in the short term. People experiencing psychosis for the first time may receive services from an early intervention team. If admission is required, some mental health services operate a triage ward. Triage is an intensive process aiming to assess, stabilize and determine the best course of action for a person in an emergency or crisis situation. Triage wards are highly staffed, with very regular team reviews to clarify the need for admission and promote early discharge.

Promoting Discharge

Early discharge is encouraged once a person has recovered from an acute phase and is no longer a risk to themselves or others. Occupational therapy supports preparation for discharge in many ways, for example with functional assessments, home assessments, linking with community services and employment advice. Due to the limited time available for inpatient occupational therapy, work may be completed in the community after discharge, as part of an outreach service. This is not always possible but the advantage is that the person continues to work with a familiar member of staff and is supported through the vulnerable stage of transition.

Service User and Carer Involvement

Collaborative work with service users and their carers is valued by mental health services and has many forms, such as the formal Care Programme Approach (CPA) (CPA, described in Chapter 23). Other forms of collaborative work include risk assessment, service user evaluations and relapse prevention. Collaboration can often take place in meetings between the multidisciplinary team, service users and carers. While person-centred working is not new to the occupational therapy profession, it is important to ensure that the principle is embedded in all occupational therapy processes,

even when someone appears very unwell. Providing choice, considering needs and collaborative care planning are essential (Department of Health 2009).

Carers have specific needs and concerns that require consideration. The period leading up to admission may have been very stressful and distressing for a carer. Occupational therapy staff must be aware of this and local carers groups or support facilities, so they can signpost appropriately in preparation for discharge. People may not want their carers to be involved in their admission or discharge planning, requiring a sensitive approach from all staff. It is important to remember that it is still possible to listen to a carer's point of view and experience without breaching confidentiality. This can be done by listening but not providing any information, if permission from the service user has not been given. If a person gives permission for staff to contact their carer, then a systemic approach to planning should be undertaken, particularly at the stage of discharge. This approach considers those involved in an individual's life as part of a complete system, so that changes in one area will affect everyone in different ways, with many implications for future plans. Occupational therapists may also be involved in the education and support of carers and providing information, sometimes by facilitating support groups for carers.

Star Wards

Involving service users can have benefits beyond the individual. For example, the *Star Wards* initiative is a service user-led movement started by Marion Janner to support the development of best practice and care on inpatient mental health wards (Star Wards 2006). The aim is to improve the inpatient experience and outcomes. The information provided ranges from practical advice and suggestions through to publications and newsletters. Good practice and ideas are shared by staff and people on a website. There are many references to activities and occupation, and the website is a valuable resource and information tool for those working in acute care.

Care Pathways

In the UK, an acute service will have a care pathway, which outlines the care through admission, treatment and discharge. It will give an indication of what will happen, when and by whom. This will be multidisciplinary but each profession may have its own parallel care pathway. Current guidelines and evidence are used to write care pathways, to promote the most appropriate and effective interventions (see Ch. 9).

STAFFING

In an acute unit, the multidisciplinary team can consist of medical staff, nurses, occupational therapists, pharmacists, psychologists, social workers, arts therapists, support staff and community staff (Simpson et al. 2005). Good teamwork is essential, often indicated by effective communication in team meetings and informally. Some units have psychiatrists (medical consultants) that work across inpatients and the community in specific areas, treating the same people, regardless of whether they are an inpatient or not. However, in some units there is a functional split, where there are inpatient consultants and community consultants. There are advantages and disadvantages to both systems.

Multidisciplinary Team Working for Therapy Service Provision

Therapy services in acute settings are provided by a team which could include support staff, activity coordinators, other therapy staff and teachers, technicians and volunteers. Each team will vary in its skill mix and level of staffing, depending on the size of the unit, needs of the people and the funding provided.

Support staff assist occupational therapists in delivering occupational therapy. This may be by co-facilitating groups or by undertaking specific individual work under guidance. *Activity coordinators* provide activities for groups or individuals, often in the evenings or at weekends in the ward settings. Other therapy staff include arts therapists, such as *art psychotherapists, drama therapists, music therapists* and *dance and movement therapists*. They will contribute their own specific skills to the service and work alongside occupational therapists to support the therapeutic milieu. Other *teachers* and *technicians* may be present, particularly on a sessional basis providing a specific resource to the service: for example, yoga teachers, T'ai Chi instructors and sports technicians. Coordinating therapy services for an individual and

liaising about their progress with other members of the team is an important aspect of occupational therapy in this setting.

Support and Supervision

It is generally acknowledged that those working in acute care face particular stresses (Hummelvoll and Severinsson 2001).This is not only due to the fast pace of work and high turnover of people, but because the presentation of people can be very distressing. They may be presenting with unusual behaviour, responding to voices, present with self-harming behaviour or be suicidal. Some people will have distressing histories with sexual abuse or neglect. It is particularly important that staff or students who are new to the acute setting have opportunities to discuss their emotional response to their work. All staff should have access to informal support and formal supervision. This will be provided on an individual basis with a named supervisor but may also be a part of the team's processes. Some multidisciplinary teams have access to group supervision with an external supervisor. This enables the staff to discuss challenges and issues within their working practice and problem-solve together.

Volunteers, Peer Support Workers and Advocates

Volunteers are involved in providing activities, visits, support services or attending user groups. Volunteers who have experienced mental health problems themselves can provide specific insights into the user experience and offer support and hope to others. They can also provide training for staff. Others may use their own personal or direct experience to inform their role as an employed peer support worker. They work as part of the staff group and will facilitate groups or undertake individual work under the direction and supervision of qualified staff. They may be based on a ward or in an occupational therapy department. (Peer support is also discussed in Chapter 11.)

It is important within any service that service users and carers have access to a service which can advocate on their behalf or support them to make a complaint. Advocacy services include Patient Advice and Liaison Services (PALS), independent mental health advocates (IMHA) and independent mental health capacity advocates (IMHCA). Occupational therapists must be aware of how these services work so they can provide appropriate support and guidance, particularly as many individuals may have been admitted involuntarily.

LEGISLATION

The power to detain people for treatment for mental health problems is subject to legal constraints, to prevent human rights abuses. In the UK, relevant legislation is concerned with mental health, mental capacity, and safeguarding; and English laws are discussed here briefly.

The Mental Health Act 2007

The Mental Health Act 2007 is used to detain (or 'section') a person in a place of safety if they are considered to be a danger to themselves or others. This may be for an assessment period or for assessment and treatment, depending on which section of the Act is used to justify their detention (Rethink Mental Illness 2011). For example, section 4 allows for detention up to 72 hours for assessment, whereas section 3 allows for up to 6 months detention, for treatment. It is usual for a mental health unit to care for people under a section of the Mental Health Act, while others will be there on a voluntary or 'informal' basis. Those people 'on section' will have limitations placed on their movements, particularly with regard to leaving the unit, which has implications for participation in occupational therapy. They may be able to leave the unit if they have section 17 leave, which has to be signed for by their consultant psychiatrist. It is therefore essential that the occupational therapist is aware if someone is on a section and what the current restrictions are. Sections can be lifted or imposed at any time, so close liaison is required with ward staff.

Mental Capacity Act 2005

The Mental Capacity Act 2005 prevents decisions being taken on behalf of people without justification. Everyone is assumed to have mental capacity to consent unless it is established by the multidisciplinary team that he/she lacks capacity. In acute settings, lack of capacity is usually a temporary state during the acute phase of the illness. A person may lack

capacity to make some decisions but have capacity to make others. Any staff working within an acute unit may at times have to make decisions on behalf of a person when they are very unwell, but wherever possible the person must be supported to make their own decisions.

Under the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DOLS) were introduced to protect people in care homes and hospitals from being inappropriately deprived of their liberty. However, they do not apply if someone is detained under the Mental Health Act but would for informal or voluntary patients.

Safeguarding Vulnerable Groups Act 2006

To protect vulnerable people, legislation was introduced to enforce vetting of employees for previous criminal activity, and require staff to raise concerns they might have about the safety of others. Safeguarding seeks to ensure that no vulnerable adult or child is exploited or harmed by others. This includes physical, sexual, financial and emotional abuse. All staff whether qualified or unqualified have a duty of care to the vulnerable adults they work with. Mental health services should have a Safeguarding Lead and staff need to inform them if they have a safeguarding concern. This also includes any safeguarding concerns regarding children that may be in the family.

THE OCCUPATIONAL THERAPY PROCESS: ADMISSION AND ASSESSMENT

The process of providing occupational therapy follows a pattern (see Ch. 4) to ensure that the service provided is based on the best available information and adapted to meet individual needs and goals. In the acute setting, this process may be completed within a very short time period. Due to rapid changes in presentation of a person, any assessment process must be administered quickly. Deciding in advance which people have priority, because of their needs, will enable an occupational therapist to provide their interventions effectively. These priorities are usually defined in an effective occupational therapy care pathway.

Referral and Information Gathering

Occupational therapists often have a 'blanket' referral system in acute settings, which means that all the people admitted to the unit could have access to an occupational therapist. This has the advantage that the occupational therapist makes the decision as to whom is appropriate to receive services, rather than other team members. However, collaborative work with the multidisciplinary team is still required, to ensure that they understand the occupational therapy role.

All assessments follow a process of information gathering from records held by the unit and others such as care coordinators, nurses and carers. Information can also be obtained by an occupational therapist introducing themselves to the service user to build rapport. However, the person may be too unwell for the assessment process to be taken further at this stage. In this situation, the occupational therapist would monitor their progress on a regular basis, judging when it would be best to resume the assessment process.

Rapport Building

Rapport building could continue as part of this monitoring stage and could involve the occupational therapist simply making short daily interactions with the person so they become familiar with them. Sitting and chatting to a person may appear casual, but the occupational therapist will be observing and assessing their mental state, concentration, motivation, orientation and communications skills. All this will inform the occupational therapist when to move onto a more formal assessment process and introduce activity. Services users newly admitted to a ward may be frightened, disorientated, confused and withdrawn. It is vital for the occupational therapist to become a familiar and reassuring presence in order to build a collaborative therapeutic relationship with a person (Lim et al. 2007).

Risk Assessment

Due to the vulnerable presentation of people in an acute unit, the completion of a robust risk assessment is always a priority (see also Ch. 5). There will be a multidisciplinary team risk assessment that the occupational therapists must familiarize themselves with. The ward will have different levels of observations for each person. Some may be on close observation,

which means they are at risk, and are in sight of a staff member at all times. However, service user presentations change rapidly and someone who was on close observation due to risk one day might be significantly improved the next day and able to engage with the occupational therapist. Similarly, someone who is engaging well might deteriorate quickly and then be unable to leave the ward. Effective communication between team members is essential to maintain safe practice.

The occupational therapist must be aware of any forensic history, substance misuse or previous history of violence to safeguard their own personal safety and that of others. Staff may be required to wear personal alarms. Judging whether or not someone can leave the ward environment or go into the community is usually a multidisciplinary team decision. Certain activities that involve sharp implements or other potentially self-harming equipment, such as kitchen knives or scissors may need to be restricted. There will be local procedures regarding sharps and hazardous equipment, which should be followed, such as locking up procedures to ensure safety and minimize risk.

Positive risk management is often a part of discussions within the multidisciplinary team, with the carers and the person themselves. This is to ensure that while risk is minimized as much as possible, the person is supported to take responsibility for their own safety whenever possible (see also Ch. 11).

Occupational Therapy Assessment

The occupational therapist has a significant contribution to make within the overall multidisciplinary team assessment of a person. This includes having an occupational focus that identifies strengths, as well as areas needing development. Occupational therapists can contribute a unique perspective on a person's occupational functioning in domains, such as self-care, productivity and leisure. Most importantly, this will also include the person's own views on their strengths and areas needing development and support. Assessment will take place through both individual and group work and may also be focused on activities of daily living (ADL). The dual nature of an occupational therapist's pre-registration education will enable them to also consider a person's physical health needs and address these as appropriate.

Assessment is discussed in detail in Chapter 5. An example of a standardized occupational therapy assessment that may be used within an acute unit is the Model of Human Occupation Screening Tool (MOHOST). This is an observational tool that assesses motivation of occupation, pattern of occupation, communication and interaction skills, process skills, motor skills and the environment (Kielhofner 2002). The assessment process will enable collaborative planning of intervention goals and agreed outcomes. Assessments can be re-administered and used as an outcome measure.

Functional Assessments

Occupational therapists may often be required to assess a person's ability to do specific activities or tasks. This functional assessment may take place in the unit or the person's home environment, to inform decisions about their capacity for returning home, or the need for a care package or alternative placement. Their previous accommodation could be unsuitable, unavailable, unsafe or not meeting their needs. The occupational therapy assessment of function will be essential in contributing to the decision made. It could involve assessment of self-care and domestic functioning, mobility, safety and risk, as well as the home environment itself.

Physical Health Assessments

Because occupational therapy also involves working with those with physical health needs, professional knowledge and skills can be used to assess those needs in an acute mental health service. This reflects a holistic approach to care and ensures that physical health needs are addressed along with mental health needs. Enduring mental ill-health is associated with increased vulnerability to other health problems, including being physically frail due to age, neglect or substance misuse. Occupational therapists may need to assess for assistive equipment and order, fit and instruct in their use. It is therefore essential that mental health occupational therapists maintain their knowledge and skills in this area (see also Ch. 14).

Communication

Good communication is the key to building rapport and forming positive therapeutic relationships. Within an acute unit, people may be disorientated, confused

and frightened. Their admission may have been traumatic and they will find themselves in an unfamiliar environment. When service users are very unwell, they may not be able to retain information or comprehend what is being said to them. Equally, English may not be their first language or they may not speak English at all.

In this setting, occupational therapists must be creative and communicate through a different variety of media. This will include written information, information boards, leaflets, pictures, community meetings, individual verbal reminders and using interpreters (Parkinson 1999). They may have to repeat information many times and spend time orientating people to their surroundings and unit routines. Reassurance, support and maintaining hope are key within this process. It is important to remember that even though very unwell, people often have a memory of interactions with staff when they recover, even if they do not appear at the time to comprehend what is said to them. Staff and students should reflect on how it must feel to be very unwell in an unfamiliar setting and remember it is vital to treat someone with dignity and respect at all times (National Institute for Health and Clinical Excellence 2011).

THE OCCUPATIONAL THERAPY PROCESS: INTERVENTION

Occupational therapy in the acute setting often focuses on specific skills in individual and/or group sessions, aiming to prepare for discharge, prevent relapse and promote recovery and social inclusion.

Occupation

The main medium used for both assessment and intervention is occupation (College of Occupational Therapists 2006). The overall aim will be to enable a person to maintain skills, regain those lost and return to a level of occupational functioning for a safe discharge. They may also learn new skills to sustain their recovery. Because of the limited time available, the occupational therapist will need to establish strong working links with community services to refer the person on for continued work, if appropriate (see Ch. 23).

Occupational therapy sessions are individual, group or a combination of both, taking into consideration individual skills and interest. Motivation may be an issue, requiring the occupational therapist to spend time encouraging and supporting a person to engage in occupational therapy. Group sessions include those that develop skills and support function (see Chs 14, 15, 16, 17); with a protocol that explains the function and aims as well as the process and evidence. Social and recreational groups are often provided by support workers, activity coordinators and volunteers, taking place at evenings and weekends as well as during weekdays.

In an acute unit, groups have to be flexible to accommodate those who are acutely unwell. It is inappropriate to have very rigid boundaries, as any group will have a fluctuating population and attendance from day-to-day. This requires great flexibility, so that occupational therapists facilitating groups can adapt the group according to the needs of the participants in the room. People who are acutely unwell may have difficulties understanding and retaining information so repetition is important.

The consideration of individual cultural and religious needs should be evident in groups and individual work. Some people will be unable or unwilling to participate in a group. There will also be needs that can only be addressed through individual work. These can be identified through building rapport, assessment and identifying specific goals for intervention. Individual work might focus on confidence building, skills building, relapse prevention, seeking or returning to employment, structuring the day, reengagement with community activities, and identification of roles.

Relapse Prevention

For people with severe and enduring mental health problems, relapse prevention focuses on the reasons for the acute episode or 'triggers'. These may be environmental, physical, circumstantial or emotional. Relapse prevention involves exploring what led up to the admission and what behaviours were associated with this time. The aim is to put support in place to prevent another acute episode. This process is led by the person themselves, to produce a personal relapse prevention plan. This will state what to do in a crisis, with important contact details for help and support.

It is important to explore relapse prevention, to support people in their discharge and reduce or prevent future admissions. The acute setting can be a safe place to discuss what triggers led up to their current admission and what could be done differently next time, to support them. Triggers could be times or situations such as an anniversary of a bereavement, forgetting medication or becoming physically unwell. Behaviours could be poor sleep patterns, withdrawal from family and friends or a decrease in self-care. Information about these triggers and behaviours might emerge during occupational therapy and should be explored with the individual and shared with the multidisciplinary team. Avoiding relapse is an important component of recovery.

Recovery and Social Inclusion

Recovery does not necessarily mean a recovery from illness itself, which is a clinical recovery. In mental health services, it means recovery of a meaningful life, which will include occupation, which may be in the form of roles such as paid employment or parenting, or activities (NIMHE 2005). The focus is on instilling and sustaining hope, not on symptoms and limitations (see Chs 2, 6, 11, 23). Service users who are having an acute episode may be experiencing a sense of hopelessness and low self-esteem and confidence. Supporting them to rebuild their sense of worth is a key role for occupational therapy. The person-centred philosophy of occupational therapy enables recovery principles to be practised within an acute unit. This may involve enabling choices to be made within a group, recognizing skills and roles, involving individuals in goal-setting and enabling them to participate in activities that promote and develop their interests (Kelly et al. 2010).

Social inclusion is an important component of recovery. This is the process by which people are engaged with their community and services, including those that are mainstream services and available for everyone in the community (see Chs 2, 24, 29). This may include employment and education, as well as attending religious services, using the local gym or going to adult education classes. All occupational therapists in the acute setting should develop a working knowledge of what is available within the community and be able to discuss this information with people and carers.

EVALUATION

Evaluation is an essential part of any service delivery, as well as an opportunity to contribute to individual continuing professional development and the evidence base of the profession (see Chs 6, 7, 8). Evaluation can take many forms, including audit, research and service user evaluation. It is essential that occupational therapists take part in evaluation, to meet both professional and service requirements. For commissioning purposes, the need for occupational therapy within acute care will need to be evidenced.

PSYCHIATRIC INTENSIVE CARE UNIT

A psychiatric intensive care unit (PICU) is commonly found within an adult acute unit and is a locked ward with a higher level of security and staffing. The people may be on court orders, from detention centres or unable to be safely managed on an adult acute ward. PICUs are often gender-specific, i.e. either male or female.

Occupational Therapy Role Within a PICU

The occupational therapy role within a PICU will be similar to that in an acute unit, in that they will provide assessment and intervention using an occupational focus. The main difference is that the unit may be gender-specific, which needs to be considered for activity provision. The increased risk issues will inhibit what tools and equipment can be used, posing restrictions similar to those experienced by occupational therapists in forensic settings (see Ch. 27). The occupational therapist will often work within the ward environment and there will be significant limitations on people being able to leave, with some being confined to the ward. Provision of a programme of meaningful activity will be essential, requiring liaison with the ward and therapy teams.

CASE STUDIES

The following case studies illustrate how a significant amount of recovery can be achieved in a limited time and the importance of awareness of risk.

CASE STUDY 22-1

Susan

Susan was a 64-year-old woman who had been admitted following a manic episode. Susan had bipolar affective disorder and had been well for many years in the community. Initially, she presented with very manic behaviour, with a poor sleeping pattern and concentration. She was very restless, often pacing and dancing in the corridors. After a week with new medication, her symptoms abated and she had a better sleeping pattern and willingness to engage with staff.

The occupational therapist had started to build a rapport with Susan during her manic phase, engaging her briefly in conversation whenever she was on the ward. The occupational therapist gathered information about Susan during this period and spoke to her family and community staff. When she judged that Susan was more able to engage in conversation, the occupational therapist started the assessment process with her by discussing her situation.

Their discussion identified that deficits were mainly in concentration and process skills. Susan talked of her volunteer work and her family and friends. She told the occupational therapist of her love of cooking and her wish to return home as soon as possible. She was distressed about her admission after so many years being well and this had impacted on her self-esteem.

Susan started to join ward-based groups, gradually increasing the amount of time she was able to concentrate. She enjoyed groups that had an end-product, such as cooking and creative groups, and reported that they helped her build her confidence.

In individual work, the occupational therapist discussed Susan's daily structure and routine in the community and Susan identified that she would like to increase her volunteer work, as it provided her with a purposeful structure to her week. The occupational therapist provided information on the local volunteer organization and Susan contacted them prior to her discharge to arrange an appointment.

Susan's family had expressed concern that Susan was not eating properly before admission and not managing her home environment which had become neglected. On discussion with Susan, this was thought to be due to her mental state rather than a skills deficit. However Susan expressed concerns about coping at home following discharge. The occupational therapist completed a functional assessment and was able to report that she presented with no functional deficits in any areas. This reassured Susan and her family.

Susan was discharged home with support from the home treatment team following a 4-week admission.

Case study 22-1 demonstrates that despite limited time available for occupational therapy, a significant amount of recovery can be achieved. Regular review will indicate the effects of changes to medication and rapport building can start even if someone appears very unwell. Building on existing skills, such as Susan's interest in cooking, supports a person's confidence and self-esteem. Groups that have an end-product enable a sense of achievement with a product that can be shared. A functional assessment can indicate whether daily living skills are robust enough for a person to return home. This may be particularly important if a person lives alone or has little or no community support. Supporting a person at the time of discharge is more effective with a good working knowledge of community services.

CASE STUDY 22-2

Gavin

Gavin was a 30-year-old man admitted with severe depression and following a suicide attempt. He had been under the care of the crisis service prior to admission but the risk of suicide appeared too great to be managed safely in the community, as he lived alone, so he was admitted to hospital. He had recently had several life events which had led to his low mood and he was currently unemployed. He was assessed by the multidisciplinary team who agreed he was at a high risk of suicide, so was unable to leave the ward initially.

Continued on following page

CASE STUDY 22-2 (*Continued*)

The occupational therapist started to build a rapport with Gavin, talking to him in his room and supplying him with books and magazines. The activity coordinator encouraged Gavin to join recreational activities on the ward and he slowly spent more time out of his room. The occupational therapist started an initial assessment, building an understanding of his occupations and roles and assessing his occupational functioning. Deficits were mainly in communication, confidence and motivation.

Gavin started to attend the group programme, slowly building his confidence and engaging more with others. He used art as a means for self-expression, using it to explore his occupational goals with the occupational therapist. He also engaged with a psychologist. He identified work as a long-term goal but wanted to explore this when he was discharged, so the occupational therapist referred him to the local employment service. Gavin was keen to maintain his physical health and went to the gym in the unit. He also explored local social opportunities in the community, supported by the occupational therapist who then referred him to the community occupational therapist to continue this work.

Case study 22-2 demonstrates the importance of awareness of risk issues. Rapport building may be slow and assessment takes place over a period of time rather than in one session. It also demonstrates the importance of a combination of group and individual work to explore occupational goals with a person. Often, groups with an activity focus enable someone to express themselves or relax and talk to staff in a way they would not do in a more formal interview process. Chatting to someone can enable an occupational therapist to learn a lot about a person. The occupational therapist worked closely with the multidisciplinary team, especially the activity coordinator and psychologist. Long-term goals were identified but referred to the community occupational therapist to complete.

SUMMARY

This chapter has highlighted the importance of occupational therapy as part of the multidisciplinary team provision in an acute setting. The various challenges and the need for close multidisciplinary team working and communication have been identified. The occupational therapy process, including assessment and intervention through groups and individual work has been discussed. The unique contribution of occupation in the recovery process in the acute setting has been highlighted. The case examples have indicated the value of collaborative, person-centred work with everyone involved and the importance of an occupational focus in determining and achieving recovery goals.

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SERVICE USER COMMENTARY

I enjoyed reading this chapter to find out how occupational therapists do their job. In my experience, I have found occupational therapy to be very helpful, as on the whole, they were there to support me, not to tell me what to do. From my perspective, occupational therapy, along with the other related therapies, has provided a welcome respite from the medical model approach of doctors and nurses. The social model approach could be emphasized more. The chapter showed an assessment process, which had not been made clear to me when I was on the ward. Clear communication of what occupational therapists do, and why they do it, is important to me.

Patients, formal and informal, have to accept the need for assessment but it needs to be collaborative rather than oppressive. This is particularly relevant for the occupational therapists' role in discharge planning, where being assessed sometimes means passing or failing the test for going home. They should be aware of the stress felt by people as they were tested for their ability to make a meal in their own home. I always remember a woman describing to me that she had been cooking in her own kitchen for years but once she felt she was being tested, she fell to pieces. I am sure occupational therapists are aware of the impact of tests and adjust their scores accordingly but maybe this could be communicated better. Activities on and off the wards are important and offer a welcome distraction from the boredom of being confined to a ward or unit. I was not clear about the role of occupational therapists to provide activities away from the hospital. Many units have transport to provide physical activities, such as walking groups. The need for physical occupation such as this is acknowledged and valued by inpatients but do occupational therapists organize these activities or is it somebody else's job? I feel occupational therapists have a vital coordination role.

As an inpatient, it was not clear to me what meaningful activity would be on offer to me and how long I would have to wait to get it. These things are important when you are on a ward and you are bewildered by who is who and who does what. This is why occupational therapists should aim to coordinate a care plan, including a personalized 7-day-a-week activity plan with details of who, where and what to do. This is a focus for multidisciplinary working. The case studies could have provided a care plan including activities as an example.

Occupational therapy is described as person-centred, recovery-focused and flexible, which are all good qualities. There is reference to the importance of information giving, particularly in relation to discharge planning. How do they know the information is up-to-date? What support is there to help people like me follow it up?

Under mental health law, an occupational therapist can be asked, as statutory consultee, to give their opinion, which is recorded. Occupational therapists need to be aware of Human Rights legislation, including United Nations Conventions, such as the Convention on the Rights of People with Disabilities, which has been ratified by the UK and affects people on acute units.

Mary Nettle

23 COMMUNITY PRACTICE

SIMON HUGHES ■ HAZEL PARKER

CHAPTER CONTENTS

INTRODUCTION

This chapter introduces the community as a context for work with severe and enduring mental health problems, identifying how ill-health is defined and exploring the drivers that shape community mental health services. The approaches used by these services are explained as a basis for understanding teamwork. There is a section on medication, which is important for many people with severe and enduring mental health problems. In the UK, community mental health now encompasses many different service settings, raising an issue about how the required generic skills could overshadow the specific use of occupational therapy for recovery and support.

From a global perspective, challenges for people with mental health problems are primarily concerned with access to services and reduced life expectancy, often associated with stigma within and beyond health services.

The majority of people receive no treatment (WHO 2008). Life expectancy is reduced by up to 20 years for men and 15 years for women. Factors contributing to this include issues such as suicides and accidents producing higher rates of unnatural deaths. Smoking and use of other substances contribute to physical health problems which reduce life expectancy (Wahlbeck et al. 2011). The UN (2006) has promoted the Convention on the Rights of Persons with Disabilities, emphasizing the role of social policy, health promotion, illness prevention and care provision in tackling health inequalities.

Severe and Enduring Mental Health Problems

Diagnosis is often a requirement for access to mental health services. The two main frameworks that are used to define and identify mental health problems are the World Health Organization's International Classification of Diseases (ICD-10) and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-V). There are similarities between the two systems, which focus on symptoms to aid diagnostic reasoning and categorization. A survey by Mezzich (2002) of psychiatrists across 66 countries identified that the ICDH-10 system was preferred for clinical use, while the DSM-IV-TR was used more often in research.

For a wider audience, Rethink (2008) lists common features of definitions for people with severe and enduring mental ill-health as:

- They are diagnosed primarily with a mental health condition, typically schizophrenia or a severe affective (mood) disorder
- They experience substantial disability affecting their capacity to care for themselves independently, sustain relationships or commit to voluntary or paid employment
- They are currently displaying florid symptoms or experience mental health problems for prolonged periods of time
- They have experienced recurring crises, leading to frequent hospital admissions or interventions and/or receive significant and ongoing support from their informal carers
- They occasion significant risk to their own health or safety or to that of others.

These are common components between different diagnoses and definitions of severe and enduring mental ill-health, indicating the major impact on potentially all aspects of an individual's life at some point (Rethink 2008). The impact on their level of functioning means that people often require ongoing contact with services. Enabling them to overcome difficulties in coping with daily living occupations such as work or household chores is important, recognizing a person's potential for recovery and self-management.

Occupational therapy offers a valuable means for people to address these difficulties, working at levels of skills, tasks, activities and occupations (see Ch. 3). Occupation is used to address thinking, practical and organizational skills. Thinking skills include problem-solving, instilling hope, improving motivation, developing meaning and building confidence. Specific practical skills are wherever possible, negotiated collaboratively with the individual. Examples include budgeting, shopping, cooking, getting out and about, using public transport and using community facilities. Organizational skills such as balancing activities, structuring the day, establishing routines and making good use of time can also be promoted. These different areas of practice are supported by the drivers which shape community mental health services.

Drivers

Community mental health services are shaped by local, national and international policy-makers. In contrast to institutional settings, the World Health Organization (WHO 2007) considers community mental health services to be more accessible and effective. By reducing social exclusion caused by institutional care, there is less potential for neglect and violation of individual rights. In the UK, community care has generally been linked with greater satisfaction from service users and improved quality of life (Killaspy 2006). However, issues remain. It is not necessarily cheaper than hospital-based care. There are also concerns that new, smaller institutions have been created where the potential for harmful institutional practices remain. To guard against such practices, which favour the smooth working of the institution over individual rights, essential elements of good community care have been highlighted, including the provision of effective and accessible services that are highly individualized (van Weeghel et al. 2005).

Community care has not eliminated social exclusion, which is associated with inequality and the concentration of ill-health in poor and marginalized groups and communities (Godlee 2012). Policies to promote social inclusion have indicated the need to address the underlying social and economic causes (National Social Inclusion Programme 2008). However, challenges have arisen from reduced opportunities and resources for participation, caused by austerity measures.

These challenges, along with emerging evidence for effective interventions and approaches, constantly change the social, political and economic landscape. The occupational needs of individuals and communities can be championed by occupational therapists who are aware of this changing landscape and involved in shaping services. Regardless of the actual composition of services, priorities for delivering these services have to be agreed. Current priorities include ensuring that there is value for money, by focusing on the activities and interventions that are known to be effective. This has fostered processes for regulation and accountability at multiple levels, from individual professional accountability to an organizational and sector provider level (see Ch. 7).

Including service users in service evaluation gives voice to their expectations, stimulating current trends to include more personalized services with an emphasis on continued wellbeing and recovery. Accessible services require increasing use of digital media to communicate, assess, intervene and evaluate. Innovative practice involves developing entrepreneurship and understanding change management (see Ch. 8). The community setting offers many opportunities to demonstrate the importance and effectiveness of occupational therapy for people with severe and enduring mental health problems. The core principles can be aligned with specific supporting models and approaches such as recovery-oriented practice, a strength-based approach, the transtheoretical model of behavioural change and the stress vulnerability model.

SUPPORTING MODELS AND APPROACHES

Recovery-Orientated Practice

Recovery is a central theme in mental health and is covered more broadly elsewhere in this book. The focus for this chapter is on issues relevant to people with severe and enduring mental health problems.

In the UK, the shift to recovery-oriented practice was initially signalled in policy in 2001 (Department of Health 2001a), emphasizing that services would be as focused on recovery as they were previously on symptoms and illness:

> *The mental health system must support people in settings of their own choosing, enable access to community resources including housing, education, work, friendships – or whatever they think is critical to their own recovery.*
>
> ***(Department of Health 2001a, p. 24)***

Three tasks of recovery have been identified by Slade (2009): developing a positive identity, self-management and developing valued social roles. From an occupational perspective, this is congruent with developing meaning and purpose from occupation in real-world settings, while seeing oneself as more than just a diagnosis. In the long term, for an individual a stance of hope and optimism is necessary. People may not have this stance of hope at points of their journey through services. At these times, the hope of the occupational therapist may sustain them. The evidence suggests that for people with a diagnosis of schizophrenia, 20–25% of people experienced complete recovery and 40–45% achieved social recovery (Warner 1994). These rates were generally stable across the decades, regardless of developments in drug treatments. Complete recovery is considered to be the absence of symptoms and a return to the level of functioning prior to diagnosis.

However, there are significant differences in recovery rates between developed and developing countries (Dorrer 2006). Developing countries have reported superior outcomes although the exact reasons for this are not established. Different conditions may have different courses of recovery. Recovery from enduring depression for some individuals is a slower process over time than for broadly similar groups of people with a diagnosis of schizophrenia (Dorrer 2006).

The importance of medication as part of enabling recovery has been highlighted (Turton et al. 2010). The management of symptoms has been consistently ranked as an important priority for service users and carers, alongside the desire to see the development of new innovative drug treatments. In addition, there has

also been an emphasis on focusing on strengths, and the value of structure and routine through the use of meaningful activities.

Strengths-Based Approach

Statutory services have tended to be typically focused on providing care based on solving problems. A person is asked to identify their problem or multiple problems. Time is then spent with the person trying to improve such areas where they are experiencing deficits. To focus on deficits can act as a regular reminder of the problems or difficulties that are experienced. The strengths-based approach encourages a focus on a person's strengths: what is the person good at? What have they achieved in their lifetime? What does the person get most out of in their life? What do they want most in their life right now? The principles of the strengths approach appropriate to UK practice have been documented by Ryan and Morgan (2004), who view the service user as the director of the process. They place strong emphasis on the use of community and neighbourhood services as resources for integration, rather than focusing solely on mental health resources, making this approach compatible with recovery-oriented practice and promoting social inclusion.

Cycle of Change

An understanding of the cycle of change can support collaboration and the use of relevant approaches that engender positive change, such as the transtheoretical model of behavioural change (Prochaska and DiClemente 1986). This model describes stages of change, starting with the present and identifying appropriate approaches and interventions towards the maintenance of healthier behaviour. People may progress incrementally through the stages or move backwards (relapse) or forwards (recovery), including jumping between the six stages.

Pre-Contemplation

At this stage, the person is not ready to change. Their lack of readiness to change is validated. An evaluation of the individual's current behaviour is encouraged, while clarifying that any decision to change is theirs. An educational approach may be used to explore and personalize the risks and benefits of current behaviour.

Contemplation

The person is getting ready to change. Exploration of the pros and cons of behavioural change is encouraged and the recognition that ambivalence regarding change can delay action. The individual's current perspective continues to be validated, while reinforcing that the choice to change is theirs. The exploration of potential and positive outcomes from changes in behaviour is promoted.

Preparation

The person is ready to change. An incremental graded approach is used to define appropriate challenges. Potential obstacles are identified and a problem-solving approach used to explore possible solutions. Social support networks are involved where possible to support and encourage the planned behaviour change. Skill acquisition may be necessary at this stage to enable the individual to change previous behaviours.

Action

The person has started to make changes to their behaviour. Newly acquired skills may be consolidated into habits and routines. Consistency and persistence are encouraged and minor setbacks dealt with. Feelings of loss for previous lifestyle or friendship groups may be present; therefore, the long-term benefits and rewards for current behaviour are reinforced.

Maintenance

The person has continued with the planned behavioural change. Progression to greater self-efficacy is emphasized. Dealing with stressful situations and potential relapse is explored, to reinforce coping strategies and identify support mechanisms, including emergency or crisis contacts.

Relapse

The person may return to previous behaviours. This may occur at any point. The setback needs to be validated, while recognizing that change can still occur, with the potential for new learning from the experience. The triggers for relapse can be explored while reassessing the stage of readiness to progress again. Coping strategies and support networks can be revisited and strengthened where necessary.

The cycle of change is particularly relevant for community practice and its use can support the delivery of appropriate person-centred occupational therapy. Jointly agreed interventions can engender change and develop understanding of the individual's situation. This understanding can be used from the perspective of stress and vulnerability, which is now discussed.

Stress Vulnerability

The stress vulnerability model of schizophrenia described by Zubin and Spring (1977) sees individuals as having a predisposition or vulnerability to developing psychosis. Individual exposure to stress may trigger psychotic experiences. This simple model shows that more vulnerable people may need fewer stressors to develop a psychotic reaction. In contrast, less vulnerable people may need more stressors to develop psychosis. This model describes psychosis as being on a continuum, challenging stigma by suggesting that anyone could develop schizophrenia given enough stressors in relation to their own vulnerability.

Interventions may therefore be targeted at reducing stress or vulnerability. Working with the person on activities that they find relaxing can reduce personal levels of stress. Environmental stressors may be addressed directly, through changes to that environment or indirectly by removal to other less stressful environments. Vulnerability can be reduced by developing problem-solving skills, coping skills, social skills and support networks.

The stress vulnerability model incorporates biological, as well as psychological and social elements, by considering the effects of stress on physiology. As a biopsychosocial approach (Zubin and Spring 1977), it is relevant to all health professionals, enabling them to work together in teams. However, if the focus of this approach is on minimizing or avoiding stress it may lead to risk-averse practice, fostering low expectations of what individuals can achieve and undermining recovery-oriented practice and positive risk management (see also Ch. 11).

TEAM WORKING AND COORDINATED CARE

Team working is essential in providing a comprehensive and coordinated approach to the provision of mental health services. With the expansion of community care, policies such as the Care Programme Approach (CPA) (Department of Health 2008) have developed to ensure this provision is approached consistently for all.

The Care Programme Approach

The Care Programme Approach (CPA) (Department of Health 2008) was introduced in England in 1991 and reviewed in 2008 by the Department of Health. This approach continues to be central in organizing the delivery of care to those people who access secondary mental health services in the NHS. It is an integrated approach across health and social care services, promoting a coordinated approach within individual care packages. All services and resources are required to work together to provide the optimum level of care.

The aim of the CPA is to empower the person as the central concern, by considering all relevant aspects of their lives. It is for people with complex needs who require services from a number of agencies and/or professionals, because of the greater risk associated with their mental health problems. It is based on a whole systems approach, led by a care coordinator (Department of Health 2008). The CPA includes:

- comprehensive assessment of needs
- consideration and planning of all available resources to meet these needs
- regular assessment and review of risk issues and management plans.

It should also involve people who have a caring role, including them so that their needs can also be assessed and met where possible. This helps clarify expectations about roles and responsibilities, setting boundaries for individuals and agencies involved. Occupational therapists are included in the range of professionals that may be involved and are often care coordinators.

The Care Coordinator

The CPA requires that all individuals have a care coordinator, an identified professional who aims for a strong, sustainable and hope-inspiring professional relationship with the service user (Repper and Perkins 2003). To empower the person and emphasize their expertise on their own experiences, it is important that the care coordinator focuses on strengths and needs and is not distracted by the agendas and priorities of others involved. The agreed care plan should be specific to the individual.

For anyone with severe and enduring mental health problems it is important that regular reviews take place. Within the CPA, the care coordinator is responsible for ensuring that an individual's care plan is reviewed on a regular basis and that goals are specific, measurable, achievable, realistic and timely (SMART). Care plans are altered accordingly by the coordinator following agreement at each review. The care coordinator is not necessarily responsible for providing care but monitors that others are providing appropriate and timely care as agreed.

The role of the care coordinator is clearly defined by the CPA policy (Department of Health 2008) and is not profession specific. The process for identifying care coordinators for service users varies across teams, considering:

- the needs of the service user
- caseload sizes
- complexity of the case
- staff skills.

Care coordination should not take away from each individual profession's ability to provide more specific intervention plans, but raises issues about the tension between generic and profession-specific working.

Care coordination does require consideration of problems with symptoms, medication, housing, legal issues and risks. Discussing these issues could be negative if a good therapeutic relationship has not been formed. Occupational therapists are well equipped to establish a good therapeutic relationship, based on appreciating the person's strengths as part of an occupational journey to recovery (Kelly et al. 2010). However, often there are barriers to recovery due to lack of resources such as funding, opportunities, education and peer support. Overcoming these barriers requires creative thinking, to use occupational therapy specialist skills to support people effectively (see also Ch. 11).

Generic Versus Specialist Working

To provide specialist occupational therapy services, occupational therapists must spend the majority of their time using assessments and interventions that are occupationally focused (College of Occupational Therapists 2006). In contrast, generic work is defined as an activity that could be carried out by any profession or team member. Care coordination is often identified as generic work. However, as already identified, being a care coordinator does not necessarily mean providing services to a person, but coordinating their delivery. Profession-specific interventions can be provided alongside other elements of care. When working in teams and identifying appropriate care coordinators, people with greater occupational needs could be allocated to an occupational therapist for care coordination.

Another consideration is of the enhancements to a service user's care when there is an occupational therapist as care coordinator. For example, securing appropriate housing may be viewed as a generic task for care coordination. Often housing is something that needs addressing, as it is the key environment for recovery and enabling occupation in everyday life. From an occupational perspective, securing accommodation could be an occupation that the person needs to do. The occupational therapist as care coordinator can support and enable the person in this occupation. This is particularly important if the individual is to be empowered and able to recover the most fulfilling and best quality of life. Practically, the occupational therapist could work jointly on completing forms, enabling the person to feel part of the process and to take ownership of their achievement at each stage. Meeting a basic need such as accommodation can ultimately promote a sense of belonging.

Partnership Working

Partnership working has been defined in healthcare policy at every level of practice (see Ch. 8). Fundamental to this is the partnership between mental health workers and users of mental health services, as well as family and carers. Tait and Shah (2007) also highlight the benefits of non-statutory organizations being involved in partnership working. These organizations enhance statutory services through advocacy and campaigning roles. They focus on practical help with housing, welfare and financial advice. Social exclusion can be addressed with local services providing opportunities for work, training, leisure and social contact. Non-statutory services are sometimes more able to engage with people who distrust statutory services, being responsive to their needs but not

associated with compulsory detention and treatment (see Chs 22 and 27).

For effective partnership working, there needs to be a clear understanding of what different services provide, where there is an overlap of provision and what the unique aspects of a service are. Services need to be coordinated, with timely signposting so that people can make informed decisions to meet their needs and navigate their way around the multiple agencies.

Risk

Risk has implications for all areas of practice. The level of risk is constantly changing and often cannot be eliminated. Empowering people to make their own choices and decisions requires consideration of risks. With thorough assessment and good management risk can be minimized. When the media focus on violent incidents, especially in the community setting, they are quick to blame public services such as health and social care, which may have been involved (Anderson 2003). All practitioners must ensure decisions are defensible through gathering as much information as possible and making clear, reasoned, action plans. There are formal processes for clinical risk assessment and for people working alone. The community setting involves working in varied venues, requiring ongoing risk assessment, but there should always be positive risk management to balance avoidance with opportunities.

Clinical Risk Assessment

All members of multidisciplinary teams are responsible for contributing to the clinical risk assessment of a person. Clinical risk assessment takes place throughout the person's journey within mental health services (see Ch. 5). Workplaces will have local policies regarding risk and these must always be consulted for guidance when completing documents. In the UK, the Care Programme Approach (Department of Health 2008) ensures that detailed risk assessments are carried out regularly in a person's care.

Lone Working

Community working often means lone working. All employers and organizations should provide a lone working policy. While visiting people in their own homes a number of safety issues should be considered including:

- Does the person live alone or are there others in the house?
- How well is the person known to the service?
- Does any member of the household pose any known risks to others?
- Is the surrounding area safe or is there potential risk posed by others in the area?

If any of the above is a concern, then action must be taken accordingly and in-line with any relevant organizational policies. Considerations might include:

- A visit with two staff present
- Ensure a system is in place at base for notifying others of whereabouts and expected time of return
- Use mobile phones to inform others at base, of time of arrival and of leaving property
- Use other agencies, such as police, for support
- Identify an alternative safe place to see the person.

Additional considerations should also include:

- Are there animals in the household and is the owner able to keep them under control for the duration of the visit?
- Do people smoke within the household and are they able to abstain during the duration of the visit?

Sometimes if staff are concerned regarding visiting a particular household, then they will try to get in and out of the house as quickly as possible. This does not provide the person with the optimum level of service and places staff at risk, therefore, if there is such a concern, it is suggested that alternative arrangements are made.

Working in Varied Environments

Risk assessments must also be considered when arranging to meet at alternative venues. Other venues and considerations may include:

- Community mental health resource centres or the team office base: consideration must be given to using personal attack alarms and ensuring other staff are aware of any response required if alarm is sounded

- Alternative health and social care buildings such as GP surgeries: consideration must be given to any safety procedures including fire alarms, personal attack systems and how to notify resident staff when entering and leaving the building
- Community leisure facilities such as libraries or sports centres: consideration must be given particularly to confidentiality.

Positive Risk Management

Positive risk management can be an important part of a care plan. To avoid taking risks is to limit opportunities to learn and develop, as everybody takes risks within their lives (Ryan and Morgan 2004, p. 230). However, pressures on mental health services to minimize risk and negative publicity have an impact on willingness to take risks. This in turn can jeopardize recovery, as opportunities are missed. A collaborative and positive approach to managing risk in occupational therapy should empower individuals, promoting a sense of responsibility, while considering the impact of identified mental health problems. Taking reasonable risk is about empowering people to make their own decisions and choices with appropriate support (Department of Health 2007). For example, graded activity could be used to minimize risk, informed by the stress vulnerability model.

The challenges to positive risk management are not just about avoiding adverse events. There are other pressures to minimize or avoid risk, generated by an emphasis on treating symptoms, judging effectiveness of services by avoiding admission and staff assuming a role as the expert, overriding service users. Services as a whole must seek a balance: between measuring risks and being the experts, favouring practices that are evidence-based; and empowering the person as the expert of their own experiences and makers of their own choices (Bonney and Stickley 2008). There is limited evidence about positive risk management. It can pose ethical dilemmas within practice, as services have a responsibility to protect the public yet also to protect the service user. Professionals can find themselves acting in the interests of the organization over the individual (Stickley and Felton 2006).

Personalization

The personalization agenda values people being in control of the support they receive from social services, to live their lives with individualized support as and when it is needed (Department of Health 2007, 2010). Similar in approach to the Care Programme Approach and positive risk management, the person is central to the process of identifying their needs. The structure of statutory services and funding arrangements can be unhelpful barriers, limiting choice about resources for care and support (Carr 2010). One of the barriers in the UK is the division between health and social care services. By focusing on individualized support and packages of care, empowerment and positive risk management are promoted. People are supported to use their strengths and make informed choices to live independent and fulfilling lives.

The personalization approach calls for a major change in how social services manage care (Raven 2010), encouraging creative and individualized thinking. By enabling people to identify what is required rather than use what is available in terms of social support, planning care is more about directing the financial resources available to individuals. Through the personalization agenda in the UK, eligible people are able to make use of self-directed support, personal budgets and direct payments.

Key Terms in the Personalization Agenda

Self-directed support is the mechanism through which individuals are able to access personal budgets. A self-directed assessment will give consideration to an individual's circumstances, taking into account their whole situation including the needs of others providing support such as friends and families. Following assessment, an *indicative budget* is agreed, defining the amount of social care funding available to meet needs. A *support plan* can then be set-up based on the indicative budget and will be considered for approval by the local social care fundholders. Following approval, a *personal budget* is the amount of money that is allocated to and used by an individual to meet their support plan outcomes. A *direct payment* is one method of receiving a personal budget. The person receives the amount of money assessed as required into a personal bank account. They pay for the support that they require through a range of services, for example, private-sector care organizations, community groups, friends or family, in preference to statutory care provided by social services. Each individual should have support in devising their own support plan often through a

member of staff within statutory services, for example, a care coordinator.

Not all individuals wish to manage their personal budget independently. In these cases, a *notional budget* may be arranged, whereby the individual is still aware of the amount of money available to meet their needs. The person agrees the support plan with, for example, the care coordinator. The care is arranged by the care coordinator to be provided by one of the existing social care service providers, who will then receive payment directly from the council. Alternatively, a third-party organization can be requested to manage the budget and employ the care service that is required on behalf of the individual. All arrangements are regularly reviewed to ensure that social care outcomes are being met through the services employed to meet people's needs.

The ideas behind personalization echo the strengths model (Rapp 1998; Ryan and Morgan 2004) and the recovery approach (Anthony 1993), aimed at support and empowerment. The values of personalization have emerged from the independent living movement, which has promoted disabled people's rights. Social workers have engaged with these values to argue for personalization within social care. Nosowska (2010) suggests that occupational therapists also should draw on their values and use their core skills to promote personalization.

MEDICATION

Medication has a large part to play in the management of mental health problems. It could be argued that it does not fit within the remit of occupational therapists, who are primarily concerned with occupational performance issues. However, if occupational therapists are to provide comprehensive interventions, then medication has to be a consideration because of the large part it plays in people's lives. Two aspects of medication are considered within this section. The first is medication management as an activity. The second regards the effects of medication and implications for occupational performance.

Medications can be categorized into four major groups:

- *Antipsychotics*: used for the treatment of psychosis, e.g. to lessen hallucinations or delusions and reduce agitation
- *Antidepressants*: primarily used for the treatment of depression, although may also be licensed for some anxiety disorders
- *Mood stabilizers*: used primarily in bipolar disorder to control episodes of mania
- *Minor tranquillizers*: includes sleeping tablets and benzodiazepines. These are used for short-term sleeping problems and as sedatives for severe anxiety; also for short-term use only, due to addictive properties.

Medication Management

Medication is an important factor in a person's wellbeing, where severe and enduring mental health problems exist. Often, people will be expected to take medications for indefinite periods of time, complying with instructions and adhering to the recommended regimen for taking medication, known as *adherence*. Medication management requires that the team is able to communicate effectively with a person to gain a clear agreement to promote good adherence (Mitchell and Selmes 2007). There is a significant rate of non-adherence with medication for many mental health problems. The reasons for this can be varied and may be defined as follows:

- Cognitive difficulties: forgetfulness, confusion, memory, disorientation
- Belief: faith, insight, hope
- Knowledge: understanding of effects and side-effects, experience of undesirable side-effects, such as tiredness or increased appetite
- Barriers to accessing services: chaotic lifestyles, difficulties with community travel, financial costs for attending appointments/paying for prescriptions.

Medication management must, therefore, be considered as much an occupation as brushing teeth. Occupational therapists provide advice and education that is within their professional scope of practice (College of Occupational Therapists 2013). When there are problems, as with any other occupation, it is important that the therapist aims to identify the reasons for non-adherence with medication. If there are poor routines or forgetfulness then specific prompts and reminders could be suggested, such as setting mobile phone alerts or placing a note on the fridge door.

Some medications (e.g. clozapine and lithium) require regular attendance for blood tests and health checks. If a person does not keep an appointment, it is possible that some medications cannot be provided until the necessary health checks have been carried out. The occupational therapist could address issues, such as accessing public transport to attend for regular health checks.

Medication and Occupational Performance

While medications are used effectively by many people to reduce psychotic symptoms or improve mood, some may experience side-effects. These can include overtiredness, difficulty getting up or increased appetite. It is important that occupational therapists are aware of medications and their possible effects on people. This information can be used in the assessment of an individual's occupational performance. However, the occupational therapist should always be careful to liaise with medical and nursing colleagues, to ensure it is appropriate to use interventions such as altering routines, adding exercise into daily activities and menu planning to ensure a regular healthy diet.

There may be some community settings where it is essential to have a greater understanding of medication, for example, a crisis resolution team. Medication may be crucial at particular times, to achieve the best outcome. The occupational therapist should know when to engage other team members. This decision should be informed with knowledge of commonly used medications, including:

- Names of commonly used drugs
- Common side-effects of each drug
- Major contraindications
- Form of drug – oral tablet or injection
- Length of time for medication to take effect and expected outcome
- Details of any blood monitoring and other health checks required and frequency
- Action required if medications are not taken.

SERVICE SETTINGS

Community mental health services address diverse needs. In the UK, occupational therapists work in services such as crisis resolution and home treatment, early intervention in psychosis, community mental health teams, day services, assertive outreach services, personality disorder services, veterans' services and liaison psychiatry services. Each of these services is briefly outlined below. Occupational therapists are also increasingly being employed by non-statutory organizations, including charitable organizations, not-for-profit companies and for-profit businesses. These are emerging and developing areas that present challenges and opportunities for occupational therapists, requiring the development of entrepreneurial skills (see Chs 8, 12 and 29). Regardless of the service provider or setting, the political importance of promoting mental health in the community supports the role of occupational therapy (Department of Health 2011).

Crisis Resolution and Home Treatment Teams

In the UK, NHS crisis resolution teams are required to provide a 24-hour and 7-days-a-week service for anybody experiencing an acute mental health crisis. They were established to reduce demand for inpatient care (see Ch. 22) (Department of Health 2000). Policy guidance defined the structure of teams and best practice (Department of Health 2001b). These specialist multidisciplinary teams offer a service to:

- adults with a severe and enduring mental health diagnosis
- adults with a personality disorder
- adults with a co-existing mental health diagnosis and learning disability
- the above, who are experiencing an acute crisis and, without the existence of a crisis resolution service, may require hospital admission.

The teams aim to:

- provide comprehensive assessment of mental state and associated risk
- act as gatekeepers for hospital admissions
- provide a service to promote and facilitate early discharge from hospital
- provide a care plan for intensive home treatment where this is a suitable option
- continue with intensive home treatment until the individual is stabilized and referral to or transfer back to an alternative team can be made.

The teams are set up to provide high ratios of staff to service users to allow for up to 2–3 visits per day. The range of interventions carried out by the teams is varied and includes brief solution-focused interventions, practical problem-solving, medication management and support with daily activities.

Interventions within crisis resolution and home treatment services are brief, as once the crisis is resolved, it is likely that a discharge or transfer process will begin. Based on short-term goal-setting, interventions can include practical problem-solving, identifying and building on occupational strengths. People may be enabled to engage in self-care and leisure activities. It is important for occupational therapists within these teams to use a recovery approach, not allowing problems to become the prominent factor. Engaging in meaningful occupation can enable the person to rediscover their own strengths and coping strategies (NIMHE 2004).

Early Intervention in Psychosis

The rationale of early intervention is that intensive support at an early stage for people experiencing psychosis will reduce future need. Norman and Malla (2001) explored the duration of untreated psychosis and found that the earlier that treatment can be started, the greater chance that symptoms can be reduced. Specialized early-intervention teams have been developed internationally and evidence is still emerging of the effectiveness of the approach. Interventions focused on employment and family therapy have been found to be beneficial (Marshall and Rathbone 2011).

Early intervention services have two main objectives. The first is one of early detection, identifying and working with people with prodromal symptoms, which indicate there is a risk of developing psychosis. The second objective is to provide effective interventions for those who are newly experiencing psychotic phenomena, maintaining existing support mechanisms and social roles. This might involve promoting independence and recovery, emphasizing education and work-related outcomes. Many of the approaches and interventions are occupation-focused and supportive to the maintenance and development of life roles, requiring occupational therapy involvement.

Community Mental Health Teams

Where there is identified need following on from involvement with early intervention services, it is likely a person will be transferred to a community mental health team. These teams address complex needs, coordinating care from a multidisciplinary team. Within the UK, these teams may often be providing integrated NHS and social care services. They can include community psychiatric nurses, psychiatrists, social workers, occupational therapists, psychologists, pharmacists, arts therapists, cognitive behavioural therapists and support staff. They may also access additional resources, such as dietetics or physiotherapy as necessary. Some teams have been divided to provide specialist mental healthcare, according to diagnosis or need. For example, affective disorder teams alongside psychosis teams, or recovery and rehabilitation teams.

Based on collaborative working, the focus is on recovery and hope, while promoting good quality of life. Teams aim for the person to manage their life better. This can be achieved by enabling the person to identify a sense of purpose and meaning to their occupations, and form stronger relationships. Using a strengths-based approach (see above), a person is enabled to improve their chances of finding work, gaining education and maintaining suitable accommodation (Department of Health 2011). In this setting, occupational therapists aim to enable and empower individuals to become the makers and directors of their own existence (College of Occupational Therapists 2006).

Day Services

Mental health day services have traditionally fulfilled four main functions:

1. Short-term professional care
2. A place of safety or refuge during the day
3. A structured programme of daily or weekly groups for various purposes
4. A social context for peer support.

In the UK in the 1940s, it was recognized that people could receive mental health services without the inconvenience of hospital admission. Since then, day services have evolved and been subject to repeated scrutiny (Bryant 2011). The socially exclusive nature of some services has been observed, based on people

attending for prolonged periods of time, segregated from their own families and communities, and emphasis on social activities, apparently to fill time. Based on this observation, modernization of day services has taken place (National Social Inclusion Programme 2008). The first function above is now often fulfilled by community mental health, crisis resolution and home treatment teams. Places of safety are less easily identified but can include non-statutory provision, such as drop-in sessions at resource centres. For the third and fourth functions, people are encouraged to join community activities open to all and peer support has developed in different ways in different areas (Walker and Bryant 2013).

Assertive Outreach

Assertive outreach teams aim to engage people who struggle to access services, often because they have limited insight into the effects of their mental health problems. Alternatively, they may have had compulsory inpatient treatment against their will and struggle to trust mental health professionals (see Ch. 22). Assertive outreach teams also work with people who are unable to easily access services due to chaotic lifestyles. Most people have severe and enduring mental health problems, usually a psychotic disorder. They would be vulnerable or would present with high levels of risk if not engaged and appropriate interventions provided with an assertive approach.

Assertive outreach teams were first developed in America in the 1980s to reduce hospital readmission rates, following the closure of many of the old institutions (Stein and Santos 1998). This followed in the UK in the 1990s.

Key features of assertive outreach teams are:

- Staff to service user ratios of 1:12
- Multidisciplinary teams (sometimes small discrete teams within a wider community team)
- Team working approach (a caseload is shared among the team, although a care coordinator will be allocated to each service user)
- Emphasis is on engagement of service user through an individualized, recovery-focused approach that draws on individual strengths
- Intense support available including daily visits
- Time-unlimited services
- Interventions provided within the community and focused on non-mental-health resources
- Daily team meetings.

The role of occupational therapists in assertive outreach teams varies. Some will be employed into specific occupational therapy posts and some will be employed into generic posts as *assertive outreach workers*, with the same job description as other nursing or social work colleagues. This variance has led to professional debate regarding the generic or specialist roles that occupational therapists find themselves in (Pettican and Bryant 2007).

However, assertive outreach requires a flexible and creative approach to engaging and establishing therapeutic relations. Occupational therapists within assertive outreach teams can focus on occupation for effective work with service users, identifying what is important to a person and where their strengths lie. Focusing on everyday life can provide a welcome break from a focus on symptoms and medication. This everyday life focus can include: self-care and domestic tasks; social and recreational opportunities; and work and education. Practical problem-solving can build hope for the future, which is essential in a person's recovery (Slade 2009).

Housing

Housing problems and homelessness can be associated with severe and enduring mental health problems for many reasons, but often because of fluctuating support needs over a long period of time. The issue of housing is historically linked to deinstitutionalization with the closure of large hospitals and the shift of resources from inpatient to community settings. Nelson et al. (2012) highlight the issue that, for a proportion of people, deinstitutionalization has led to less secure accommodation with people more likely to be homeless or involved in the criminal justice system. The prevalence of psychosis is 4–15 times as high among the homeless population, increasing to being 50–100 times more likely in the street homeless population (Rees 2009). As the stability of housing increases, then rates of serious mental health problems decrease.

Supported housing offers different levels of support according to need; with an expectation that people will progress through services from levels of high support to levels of low support (O'Malley and Croucher 2003).

For people with severe and enduring mental health problems, this assumption may not reflect their ongoing needs and has led to instability in housing. Rees (2009) suggests that close working between housing, substance misuse and mental health services, with assertive approaches, achieves more positive outcomes.

The role of the occupational therapist involves working with the individual to identify the most suitable accommodation to meet their needs. There will also be work to develop skills to support their security of tenancy and progression to less supported environments (see also Chs 19 and 21).

Personality Disorder Services

Borderline personality disorder is characterized by instability in interpersonal relationships and impairment of social, psychological and occupational functioning (NICE 2009). This combination of difficulties raises challenges for community mental health services and so specialist services have been established in some areas. The prevalence of personality disorder has been estimated at 4.4% (Coid et al. 2006), with a predominance in urban areas and among men.

Key interventions are similar to other approaches to working with people with enduring mental health problems. Identifying long-term goals, including those relating to employment and occupation, should be carried out in collaboration with the individual. These goals should then be linked to realistic and achievable short-term objectives. Psychological approaches that support people to live with a diagnosis of borderline personality include dialectical behaviour therapy (DBT) and systems training for emotional predictability and problem-solving (STEPPS) (Federici and McMain 2009). Psychological approaches may inform occupational therapy for those in generic roles.

Military Personnel and Veteran Mental Health Services

Reactions to, and experiences of, traumatic events can lead to a range of mental health problems. Armed conflict is a reality across countries and regions around the world, adversely impacting on everyone in the area. The welfare and mental wellbeing of military personnel and veterans has renewed prominence due to the long involvement of the military in Iraq and Afghanistan. Occupational therapists have promoted their role in the treatment and management of Post Traumatic Stress Disorder (PTSD) (Baum and Michael 2008). They argue that, in addition to medication and talking, therapies that focus on functioning through social and other therapeutic activities are critical to recovery. In the UK, the NHS has dedicated web pages providing information on this issue (NHS Choices 2013).

Liaison Psychiatry

Liaison psychiatry teams provide the interface between mental health and physical health. The teams provide specialist mental health assessments to people in general hospitals. These may be people who are experiencing difficulty in adjusting to physical health problems or who have psychological comorbidities. They will also attend to people who have self-harmed and will carry out a comprehensive mental health and risk assessment. A person may then be transferred on to one of the other community mental health services.

Where there are felt to be occupational needs, occupational therapists are often accessed through other teams, either within the general hospital or via the other community mental health teams according to need. There are a growing number of occupational therapists within older people's liaison psychiatry teams.

CONCLUSION

The different community settings outlined offer many opportunities and challenges for working with people with severe and enduring mental health problems. Using supporting models and approaches can enhance practice and the experience of the person receiving services. Awareness of historical and current issues, as well as being alert to emergent themes, can aid appropriately responsive collaborative care.

Occupational therapists at times struggle to maintain professional identity: multidisciplinary teams may exert pressure for the therapist to work generically, while professional groups have an expectation that a specialist role is retained (Lloyd et al. 2004). The reality is that occupational therapists undertake a dual role and are competent mental health practitioners. Care coordination and recovery-oriented practice recognize and support the skilled use of occupation as a therapeutic medium. There is also the need to work

flexibly to best meet people's needs. It is suggested that occupational therapists prefer more of both generic and specialist roles (Lloyd et al. 2004). Responding to current demands and expectations requires a clear focus on how to make the most effective and efficient contribution, within diverse community mental health teams and services.

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24 OLDER PEOPLE

JENNIFER WENBORN

CHAPTER CONTENTS

INTRODUCTION

The number of older people is growing worldwide, including those surviving into very old age, due to advances in medicine and management of disease, lower rates of infant mortality and better public health awareness. The number of people with dementia is also rising, and is due to reach 1 million in the UK by 2021. The facts and figures in this chapter relate to the UK but, as the number of older people is growing worldwide, much of what is written here will be applicable to other countries; with the caveat that cultural differences need to be taken into account. Older people are often supported and cared for by family and friends, many of whom are older themselves. Hence, there is a huge financial and social cost of caring for older people, especially those with dementia.

Older people are the biggest users of health and social care services. Occupational therapists therefore

work with older people in many settings, including specialist older adults' mental health and dementia services, as well as emergency, medical and surgical wards in general hospitals and local authorities. Specialist mental health services are provided to older adults on inpatient wards and increasingly via a range of community-based services such as community mental health teams, home treatment teams and memory services. Occupational therapists increasingly provide services within care homes, often on an in-reach basis.

Services are provided within the context of ever-changing health and social care policy, albeit focused on a number of consistent themes. These include raising awareness of mental health issues and dementia; early diagnosis and timely access to services to support older people and their carers; the need for all staff in contact with older people to be aware of, and appropriately trained to meet, their needs; and specialist staff available in consultative, advisory and educational roles. There is an emphasis on enabling older people to remain as independent as possible for as long as possible within their own homes, with dignity and choice at the heart of service provision. There is also a key health promotion agenda focused on encouraging people to age healthily and actively, both mentally and physically (see also Ch. 2).

Older people can experience a combination of physical, psychological, sensory and cognitive challenges. Occupational therapists need to be able to differentiate between changes caused by 'normal' ageing and the impact of other physical or mental health conditions that are not an inevitable consequence of getting older. Many older people experience the impact of losses often experienced in old age, such as loneliness, loss of independence and roles and bereavement. However, depression and dementia are not inevitable features of the ageing process.

Each older person is unique but 'older people' are often depicted as a homogeneous group by the media using negative stereotypes. Older people can experience ageism and discrimination in terms of service provision with health and social care professionals making prejudicial assumptions about the validity of interventions.

Occupational therapists usually work as members of an interprofessional team, often linking with other statutory and voluntary agencies. Within older adults' mental health services, it is common for occupational therapists to cover a combination of generic mental health and specialist occupational therapy roles and activities. While this offers the opportunity to develop more generic skills in managing risks and crises, service demands may reduce the capacity to deliver occupation-focused interventions. A range of interventions are used by occupational therapists working with older people, both on a one-to-one and a group basis (see Ch. 16 on the therapeutic use of groups) and there is growing evidence to support the effectiveness of these and for occupational therapy specific programmes.

The first half of this chapter describes the importance of occupation in maintaining health and wellbeing in older age, highlighting health-promoting occupation-based interventions. The causes and impact of later life depression, and the potential occupational therapy role, are summarized. The causes, prevalence and diagnosis of dementia are outlined, along with a description of person-centred care and the range of evidence-based interventions that are commonly used by occupational therapists. The second section describes the occupational therapy assessment of older people and the most commonly used assessment tools. The Developmental Model (Perrin et al. 2008) that underpins the practice of occupational therapy in dementia is outlined. The role of community occupational therapy in dementia, and occupational therapy provision to care homes, is illustrated through examples of the profession's developing evidence base. Finally, practice issues such as mental capacity, assessing and managing risk and working with carers are discussed.

OCCUPATION FOR MENTAL HEALTH AND WELLBEING IN OLD AGE

The urge to engage in purposeful and meaningful activity is a basic human drive that is essential for physical and mental health and wellbeing, regardless of age. Our individual personality, life story, interests, values and beliefs influence our choice of activity, and what we do partly defines who we are. Participation in meaningful activity has a positive effect on the health, self-esteem, happiness and life satisfaction of older people (Gregory 1983; Bowling et al. 1997).It also reduces mortality (Glass et al. 1999) and is a key contributor to quality of life (Age Concern and Mental

Health Foundation 2006). Older people are encouraged to 'use it or lose it' (Gilhooly et al. 2003), as physical activities can postpone cognitive decline (van Gelder et al. 2004) and frequent cognitively stimulating activity can reduce the risk of dementia (Verghese et al. 2003).

The Well Elderly Study

Conducted in southern California, the 'Well Elderly Study' (Clark et al. 1997; Jackson et al. 1998) recruited 361 people aged 60 or over and living independently in the community. Participants were randomly assigned to either a preventative occupational therapy 'Lifestyle Redesign'® programme, a social activity group or a control group. Results showed significant benefit for people attending the occupational therapy group in terms of general health, physical and social functioning, mood and wellbeing. The social activity programme was no more effective in promoting health and wellbeing than receiving no intervention.

Lifestyle Redesign®

Lifestyle Redesign® is an occupation-based approach to healthy ageing. It aims to empower older people to examine and analyse their own occupations in order to enable participation in meaningful activity, thus maximizing independence and function, and potentially preventing or reducing a negative spiral of ill-health and disability. The programme is facilitated by occupational therapists and runs for 9 months. Participants attend a weekly, 2-hour group session and also have a monthly hour-long one-to-one meeting with a facilitator to focus on achieving their own individual goals. Sessions include didactic teaching alongside activity participation, with participants rating the role of each activity on their own health and wellbeing. The social activity intervention was a programme of the same duration run by non-professional staff providing activities to promote social interaction. The control group did not receive any intervention.

Lifestyle Matters

Inspired by Lifestyle Redesign®, a feasibility study was conducted (Mountain et al. 2008) in England to develop and evaluate a similar, occupation-based health promotion intervention tailored for the UK population. 'Lifestyle Matters' (Craig and Mountain 2007) was developed through consultation with older people. In total, 28 people, aged 60 or over and living in the community, were recruited. Two groups were established to receive the programme, which ran for 8 months, with weekly group sessions and monthly one-to-one meetings. One group was facilitated by two occupational therapists and the other by two occupational therapy support workers. Quantitative outcomes measured cognition, depression, functional dependency and quality of life and indicated an upward trend in quality of life. Qualitative analysis indicated that participants experienced benefits such as improved self-efficacy. The occupational therapists and support workers were equally effective as facilitators, although the occupational therapists also provided timely response to meet additional needs such as implementing assistive technology solutions. The efficacy and cost-effectiveness of Lifestyle Matters is currently being evaluated through a multisite randomized controlled trial funded by the UK's Medical Research Council's Lifelong Health and Wellbeing (LLHW) Cross-Council Programme.

Based on this evidence, occupational therapy interventions such as Lifestyle Matters are recommended within the NICE public health guidance, to 'promote mental wellbeing of older people in primary and residential care' (NICE 2008) along with physical activity and walking schemes. Occupational therapy input to train health and social care staff to effectively enable older people to participate in activities that help maintain or improve health and wellbeing is also recommended.

LATE LIFE DEPRESSION

Depression is a mood disorder, characterized by continued low mood and/or loss of interest and pleasure in nearly all activities for most of each day for the preceding 2 weeks; accompanied by one or more of the following symptoms: marked weight loss or gain, or increased/decreased appetite; disturbed sleep pattern; psychomotor agitation or retardation; feelings of fatigue or loss of energy; guilt or worthlessness; poor concentration or indecisiveness; recurrent thoughts of death or suicide or a suicide attempt or specific plan (DSM-IV criteria; American Psychiatric Association 1994). Its severity can range from experiencing low mood and depressive symptoms to a major depressive episode.

Prevalence

The percentage of people with depression is higher in the older age group than any other age group and it is the most common mental health disorder in older people (Age Concern and Mental Health Foundation 2006). The female to male ratio regarding depression is 70:30 and it is more common among people who are widowed or divorced (Baldwin 2002). Between 10–15% of older people living in the community have some degree of depressive symptoms, of which an estimated 2–4% have severe depression; and the prevalence rises to 26–44% for those receiving home-care (Banerjee et al. 1996; Baldwin 2002). The highest prevalence is found in care homes, with up to 40% of residents estimated to have depressive symptoms, although it is often not recognized and therefore not treated (Bagley et al. 2000).

Risk Factors

This higher percentage occurs in old age as people become more vulnerable to risk factors such as being widowed or divorced, experiencing physical ill-health or disability, lacking social support, being lonely and isolated, being retired or unemployed, and having a history of depression. Older people may also develop depression due to genetic susceptibility (which increases with age), neurobiological changes associated with ageing, or medication prescribed for other conditions. Major life events such as bereavement, separation, acute illness, moving to an institution, major financial crisis, negative interactions with family, loss of 'significant other' (including a pet) or caring for a family member (Baldwin 2002) can also trigger depression. Depression in older adults is associated with increased risk of death, disability and suicide.

Presentation

Depression is diagnosed using the same criteria as for younger adults. However, the presentation in older people often differs and is therefore not always recognized or treated. Older people are more likely to present with somatic symptoms such as loss of appetite or fatigue that may be falsely attributed to a co-existing medical condition, or just put down to 'old age'. Older people may minimize any feelings of sadness they have, being a generation not used to 'bothering' their doctor about how they feel. If left untreated, a person's behaviour can resemble that of someone with dementia. This is sometimes referred to as pseudodementia. It is vital to differentiate between depression and dementia in order to offer the appropriate management. The onset of depression can usually be pinpointed to a specific date, whereas the onset of dementia is much more insidious. Depression and dementia can also co-exist.

Alcohol Abuse in Older People

Approximately one in six older men and one in 15 older women drink alcohol at a potentially harmful level. Alcohol abuse can be precipitated by many of the same risk factors as for depression: bereavement, loss and loneliness; physical ill health, disability, pain and increasing dependence; and is more likely to go undetected among older people. Between 10–30% of older people who abuse alcohol become depressed and are then at greater risk of suicide.

Diagnosis

To understand what is affecting a person, so as to avoid any errors, a detailed history should be obtained from the person and family and should cover major adverse life events, previous coping strategies and personality traits, and drug and alcohol usage. Blood tests are taken to identify physical conditions that may resemble depression such as hypothyroidism, or any deficiencies that commonly occur in people who are depressed, such as folate levels, which may fall due to malnutrition caused by appetite loss. A screening assessment tool will also be used. Those commonly used with working age adults do not necessarily have validity and reliability for use with older people, so the most frequently used tools with this age group are:

- The Geriatric Depression Scale (GDS-15) (Yesavage et al. 1983). This is self-rated with 15 questions requiring a yes or no answer. Scores above 5 indicate depression
- Hospital Anxiety and Depression Scale (HADS) (Zigmond and Snaith 1983). This is self-rating on two subscales that measure anxiety and depressive symptoms over the preceding week. Scores above 8 indicate depression
- Cornell Scale for Depression in Dementia (Alexopoulos et al. 1988). This is specifically designed for use in dementia and completed

through an interview with the person themselves and/or a carer, depending on the severity of dementia. Scores above 8 indicate depression.

Intervention

The most commonly used medical intervention is a selective serotonin re-uptake inhibitor (SSRI). Although tricyclic antidepressants are equally effective, they also have more side-effects and are therefore less well tolerated (Mottram et al. 2006). Psychological therapies such as cognitive behavioural therapy have been shown to be equally effective in older and younger adults with depression (Cuijpers et al. 2009a) but are not always offered (Rodda et al. 2011). A combination of pharmacological and psychological therapies has been shown to be more effective than psychological therapy alone for older people (Cuijpers et al. 2009b). Physical exercise has been shown to be effective to improve depressive symptoms in older people (Mather et al. 2002) and people with dementia who exercise are less likely to be depressed (Regan et al. 2005).

Impact on Occupational Performance

Depression can affect people's motivation and ability to initiate or carry out activity. Someone who is depressed may lack concentration and confidence in their abilities, and find it difficult to make choices. Lack of appetite and changed sleep patterns can result in low energy, slowness and generalized aches and pains. People may become uninterested in, or neglect, their appearance. Feelings of anxiety can lead to agitation, wandering and behaviour that carers can find difficult to cope with. It is difficult to say categorically whether it is a lack of activity that leads to depression, or being depressed reduces participation. It is probably a combination of both. Where an older person experiences lowered mood precipitated by other risk factors, such as poor physical health or bereavement, this is likely to lead to reduced opportunities to participate in personally meaningful activities. The risk of depression can be reduced by taking regular exercise, planning for major life transitions such as retirement, seeking support when bereaved, maintaining activities and social involvement.

Occupational Therapy

Bearing in mind the link between participation in activities and maintaining mental wellbeing, occupational therapists have an important role in the detection and management of later life depression. The primary aim of occupational therapy intervention is to enable the older person to engage in valued daily occupations and roles. Occupational therapists use many of the interventions outlined previously, ideally with an occupational emphasis, and incorporating the following principles:

- Encouraging an individual to attempt activity
- Using familiar activities to increase self-confidence
- Using personally meaningful activities to increase motivation and self-confidence
- Limiting the number of choices to be made
- Enhancing self-confidence through self-care activities, such as hairdressing or manicures
- Providing reassurance and opportunities to wander safely to reduce agitation
- Encouraging people who are fatigued to do 'little and often'
- Setting short term, realistically achievable goals
- Using activities that quickly provide a successful, end result for positive reinforcement
- Providing opportunities for social interaction for those who have withdrawn or become isolated due to anxiety or bereavement.

DEMENTIA

Dementia is a clinical syndrome characterized by global cognitive impairment, which represents a decline from previous level of functioning, and is associated with impairment in functional abilities, and in many cases, behavioural and psychiatric disturbance.

(NICE and SCIE 2006, p. 43)

Causes

There are many causes of dementia with the most common in older people being Alzheimer's disease, which changes the chemistry and structure of the brain and accounts for approximately 60% of cases. Vascular dementia results from poor oxygen supply to the brain and, together with those who have vascular and Alzheimer's mixed, accounts for approximately 30% of cases. Dementia with Lewy bodies, caused by protein being deposited within nerve cells, shares features of Parkinson's disease, such as slowness of movement, and accounts for 4% of cases. Other, rarer

causes of dementia include frontotemporal dementia, HIV/AIDS, Huntington's disease, Creutzfeldt-Jakob disease, Korsakoff syndrome and Pick's disease. Early onset dementia refers to an onset before the age of 65 and late onset applies to an onset at 65 years or older. The presentation and progression of dementia varies from individual to individual, partly due to the underlying pathology, but also influenced by the person's own personality and their unique combination of practical and emotional support networks. What is common is its progressive nature.

Prevalence

The prevalence of dementia increases with age, doubling every 5 years from the age of 65 (Knapp et al. 2007). Hence 1 in 20 people aged 65 and over will have dementia, rising to one in five people aged 80 and over. The number of people with dementia is rising worldwide and is due to double every 20 years, to a total of 81.1 million by 2040 (Ferri et al. 2005). In the UK, approximately 800,000 people have dementia; two-thirds of whom live in the community, of which half live alone and are supported by approximately 670,000 family members (Department of Health 2012; Knapp et al. 2007).

Impact on Occupational Performance

A person with dementia can find it increasingly difficult to remember things, know where they are, recognise other people, keep track of time, organize themselves, understand what is being said to them, communicate with other people, make decisions, and learn new things. As a result, the person will experience increasing difficulty in carrying out everyday tasks. The need to engage in activity is intrinsic to all human beings and people with dementia are no exception, but they increasingly need the help of care-givers, be they family and friends (informal, unpaid) or health and social care staff (formal, paid), in order to do this (Kitwood 1997). As the person with dementia loses their skills, abilities and former roles, their carers often experience a feeling of increased burden and stress, which can impact on their own occupational opportunities and performance.

Neuropsychiatric or behavioural and psychological symptoms of dementia (BPSD), such as disturbed perception, thought content, or mood; or challenging behaviour, such as physical or verbal aggression, occur in approximately one-third of people with mild dementia, in two-thirds of those with more severe impairment. These problems are known to contribute to increased care-giver burden, institutionalization and decreased quality of life for the person themselves and their carers (Livingston et al. 2005).

Diagnosis

Currently in the UK, about half of people who have dementia never receive a formal diagnosis (Department of Health 2012) or it comes comparatively late, once crisis point has been reached. There is now an emphasis on early diagnosis, to enable people with dementia and their family to access support services and make informed choices to plan accordingly for the future. The establishment of dedicated Memory Services within community mental health services enables early diagnosis by specialist interprofessional teams, often including occupational therapists.

The diagnosis process includes obtaining a history, physical examination and investigations and use of a cognitive screening assessment. The Mini Mental State Examination (MMSE) (Folstein et al. 1975) is a well-known screening tool that has long been in frequent clinical and research use. It has the advantage of being quick and easy to administer but concerns about its validity with people with visual or language impairment, or those with low intellectual ability or poor literacy skills, or with non-English speakers have been raised. More recently, due to copyright issues and the potential cost of purchasing the necessary licence to continue using this tool, other options are being explored, such as the Addenbrooke's Cognitive Examination-III (ACE-III) (NeuRA 2012) and the Montreal Cognitive Assessment (MoCA) (Nasreddine et al. 2005). Impact on function and activities of daily living (ADL) will also be screened, possibly using an ADL scale, such as the Bristol Activities of Daily Living Scale (BADLS) (Bucks et al. 1996), which was developed specifically for use with community dwelling people with dementia and has been shown to be sensitive to change over time (Byrne et al. 2000). It is a carer rated scale comprising 20 personal care and instrumental daily living activities. An overall score of 0 indicates independence in all areas, while higher scores, up to a maximum of 60, indicate higher dependency.

Person-Centred Care

Kitwood (1997) first described the concept of person-centred care for people with dementia. Person-centred care is described as 'V + I + P + S', where V refers to *valuing* people with dementia, I refers to treating them as *individuals*, P refers to trying to understand their *personal perspective*, and S refers to supportive *social* psychology. VIPS also stands for 'very important persons', which – as a portrayal of the endpoint service user – is perhaps a simpler way of understanding the essence of person-centred care (Brooker 2007). Kitwood's Enriched Model of Dementia described the experience of living with dementia as a combination of five factors, represented by the mnemonic 'D = NI + H + B + P + SP'; where D = Dementia, NI = Neurological Impairment, H = Health and physical fitness, B = Biography/life history, P = Personality and SP = Social Psychology (Brooker 2007). Personality and biography cannot be changed – what has happened in the past cannot be altered – but greater knowledge about these factors informs assessment and planning. The nature of neurological impairment varies from individual to individual, depending on the type and rate of progression of the underlying disease, and there is ongoing debate about the degree to which this damage can be reversed. Carers therefore need to enhance wellbeing through promoting and maintaining physical health, and improving the social and psychological context within which the person lives.

Dementia Care Mapping (DCM) evaluates the quality of person-centred care. A 'mapper' observes six people simultaneously over a 6-hour period. The nature of activity being engaged in, and their perceived degree of wellbeing, is noted every 5 minutes. Wellbeing scores are produced for each individual, plus examples of positive ('uplifts') and negative ('putdowns') interactions between staff and service users. These data are used to inform and train staff to recognize and understand peoples' behaviour and thereby improve care planning and provision.

Interventions

A range of activity-based interventions have been demonstrated to be effective for people with dementia, and are recommended as good practice (NICE and SCIE 2006). For cognitive symptoms these include cognitive stimulation therapy, and for non-cognitive symptoms, or challenging behaviour, these include 'interventions tailored to the person's preferences, skills and abilities' (NICE/SCIE p. 28) – such as multi-sensory stimulation, the therapeutic use of music and/or dancing, animal-assisted therapy, and massage. For people with dementia who are also depressed and/or anxious recommendations include physical exercise and sensory stimulation therapies (such as reminiscence therapy, multi-sensory stimulation, and animal-assisted therapy). Occupational therapists use many of these interventions, which can be presented with a focus on occupational engagement. Two are briefly discussed here.

Cognitive Stimulation Therapy

Cognitive stimulation therapy (CST) incorporates principles of reality orientation, reminiscence, validation and person-centred care. The 7-week programme comprises fourteen 45-minute sessions, each related to a particular theme, such as sound, childhood or using money. The emphasis is on information processing, and props are used to provide multisensory stimulation. A multicentre, randomized controlled trial was conducted with 210 participants across 18 care homes and five day centres. The intervention group experienced significant improvement in cognition, and improved quality of life, but there was no difference between the groups for depression, anxiety, behaviour and communication (Spector et al. 2008).

Multisensory Stimulation

All people need sensory stimulation to interpret and interact with their environment and sensory impairment or deprivation eventually results in physical and/or social disengagement. Sensory impairment can occur as part of normal ageing or due to conditions such as dementia and alters our sensory experience. People in institutional care may experience sensory deprivation through a lack of environmental stimulation and sensory opportunities. A sensory approach aims to maintain interaction with the environment and other people by providing a range of experiences to stimulate all the senses – smell, movement, touch, vision, hearing and taste – even if verbal communication is no longer possible.

The use of specialist multisensory rooms or environments (MSE) originated in The Netherlands with the development of Snoezelen©, which literally translated, means 'to sniff and doze'. Beneficial effects

immediately after using such rooms have been noted (Livingston et al. 2005). Staff must be trained and users must be assessed in order to establish an agreed intervention plan. This ensures an appropriate level and type of stimulation is provided and avoids the dangers of sensory overload. However, a dedicated specialist room is not always necessary as many of the principles can be applied more generally. For example, using scented bath oils, background music and environmental props can turn a functional bath into a sensory experience. A range of sensory stimuli can be incorporated into the environment or used as an activity, such as rummage bags, sensory cushions and aprons, and these have been shown to effectively reduce challenging behaviour and depression in people with more advanced dementia (Verkaik et al. 2005). Interventions such as animal-assisted therapy (Morrison 2007) and using dolls and soft toys (James et al. 2006; Mackenzie et al. 2006) are additional elements that contribute to a sensory approach. Animal-assisted interventions are covered more fully in Ch. 20 in relation to green care.

Life Story Work

It is important to know the individual's life story (Kitwood 1997). Ideally, the person with dementia will be involved in relating their own life story but it is often left to carers to do this on their behalf at a later stage. Benefits include enabling staff to know and better understand the individual person and their behaviour, informing the care planning process, providing personalized care, ensuring continuity of care, and encouraging life review and reminiscence. It is potentially an activity that the individual, their family and staff can enjoy doing together, but it can also be an emotional activity that may need sensitive handling. Ensuring confidentiality is important as life story folders may contain personal information which the person or their relatives do not want to share with others.

Different formats of life story folders can be produced or purchased. It is a good idea to include a family tree, a list of significant dates, photographs and a frontispiece of current information about their home, family, likes and dislikes, emphasizing the more positive aspects. A memory box can also be created to contain objects of significance to represent the person's life. Increasingly, creative presentations are now possible utilizing technology such as digital picture frames. See www.lifestorynetwork.org.uk for more details about this. Also see Chapter 17, where storytelling is used as an example of creative activity and Chapter 20, which discusses personal narratives.

OCCUPATIONAL THERAPY AND OLDER PEOPLE

This section of the chapter describes occupational therapy assessment of older people and the most commonly used assessment tools. It outlines the Developmental Model (Perrin et al. 2008) as an underpinning of practice and illustrates the potential role of occupational therapy in community-based dementia care and in care homes, drawing on the profession's developing evidence base in these areas. It also discusses issues such as mental capacity, assessing and managing risk and working with carers.

Occupational Therapy Assessment of Older People

Assessment has to be timely – not whilst the person is psychologically unstable, but in sufficient time to allow for future planning. Assessment should be carried out at a realistic time of day, related to the person's normal routine. For example, carrying out personal care tasks in the morning if that is when the person usually washes and dresses. Performance can fluctuate at certain times of the day, possibly due to the condition itself, or caused by medication.

Peoples' homes are the most realistic venue for assessment and intervention. It provides a fuller picture and the occupational therapist may identify significant factors that have previously gone unnoticed by the individual, for example, potential fall hazards. Equipment can be installed, demonstrated and practised with *in situ*, and with the carer if needed. Most importantly, older people perform instrumental ADL significantly better in their own home (Park et al. 1994), including people with dementia (Tullis and Nicol 1999).

The aspects most commonly considered when assessing an older person include:

- *Communication*: What is the person's preferred form of address? What is their first language? What verbal and non-verbal methods of communication are used? Are there any speech or language impairments?

- *Sensory issues*: This includes smell, movement, touch, vision, hearing and taste. Does the client usually wear a hearing aid and/or glasses? Are these available for use at the time of assessment?
- *Orientation to time, place and person*: Does the person know the time of day, the day and date; where they are; who they and others are?
- *Cognition*: Areas to consider here include short- and long-term memory, concentration, visual-spatial awareness, sequencing and problem-solving abilities
- *Mood*: Does the person currently enjoy wellbeing, or not? Are they happy, relaxed, cheerful, realistic or sad, anxious, fearful?
- *Mobility*: Can the person mobilize indoors and outside? Can they use stairs? Do they need to use mobility aids?
- *Transfers*: Can the person transfer from their bed/chair/toilet/bath/shower? It is also important to note the height, type and layout of furniture
- *Personal care tasks*: Does the person have any problems with eating/drinking/washing/dressing/grooming/using the toilet?
- *Domestic activities*: Does the person have any problems with cooking/cleaning/shopping/laundry?
- *Occupation*: Does the person have any problems with self-care/work/leisure activities?
- *Daily routine*: Go through a daily/weekly timetable to highlight 'gaps' in service provision, occupational opportunities and social interaction
- *Physical environment*: Consider accommodation, access, layout, facilities, lighting, flooring, heating, and communication; both standard and in emergencies.
- *Potential hazards and safety issues*
- *Driving*
- *Equipment* already provided/needed, including assistive technology
- *Social environment*: Consider other household members (including pets) and any support/social networks that are available.

Obviously, consideration must be given to co-existing physical and/or sensory impairment(s) within the occupational therapy process but these are beyond the remit of this chapter. See Ch. 5 for a specific discussion about assessment and outcome measurement.

Occupational Therapy Assessment Tools

Many occupational therapists working with older people base their practice on the Model of Human Occupation (MOHO) (Kielhofner 2008) and use a range of MOHO-based assessments, including the:

- Model of Human Occupation Screening Tool (MOHOST) (Parkinson et al. 2006)
- Occupational Performance History Interview (OPHI-II) (Kielhofner et al. 2004)
- Volitional Questionnaire (VQ) (de las Heras et al. 1998)
- Assessment of Motor and Process Skills (AMPS) (Fisher 2003, 2006).

The AMPS is suitable for use with anyone, of any age, who experiences, or is at risk of experiencing, challenges with ADL task performance, and is sensitive to the smallest change in this. It has been shown as reliable and valid for use with older people with dementia living in the community (Robinson and Fisher 1996) but it is not suitable for people who are unable to participate in the initial interview, activity selection and contract setting that is required before the two task assessments take place. It may, therefore, not be suitable for someone with more severe dementia.

Other assessments commonly used with older people include:

- **The Canadian Occupational Performance Measure (COPM).** Based on the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Townsend and Polatajko 2007), the COPM (Law et al. 2005) uses a semi-structured interview to measure the individual's own perception of their occupational performance. It can be used with the individual and/or the carer, in which case the carer reports their own perspective and does not attempt to second guess the response of the person they care for.
- **Large Allen Cognitive Level Screen (LACLS)** The LACLS uses a simple task, leather lacing, as a screening test. Interpretation using the Allen Cognitive Scale of levels and modes of performance (Allen 1999) determines the level of cognitive disability which enables the provision of appropriate environmental support and intervention. It originates from the Cognitive Disability

Model (Allen et al. 1992). The Allen Cognitive Level Screen was assessed as being appropriate to use with people with dementia (Wilson et al. 1989) and a further study established the validity of an enlarged version (the LACLS) designed for use with older people with impaired visual or manual dexterity (Kehrberg et al. 1992).

- **Pool Activity Level (PAL)** The PAL instrument (Pool 2012) was developed as a practical resource for carers of people with dementia to identify and capitalize on the person's abilities in order to enable their engagement in meaningful occupation while also providing the necessary assistance to meet their needs. Pool, an occupational therapist, used underpinning theory from the Cognitive Disability Model (Allen et al. 1992). The instrument comprises:
  - A life history profile
  - A checklist
  - Activity profiles
  - An individual action plan for personal care activities.

The PAL Checklist covers nine everyday activities and the results indicate the level of cognitive ability that an individual has reached in terms of being able to engage in the activity, be that at the Planned, Exploratory, Sensory or Reflex level. The PAL activity profiles outline the likely abilities and limitations of a person at that level and provide guidance on how best to engage and enable an individual. The PAL Checklist has validity and reliability when used to assess older people with dementia (Wenborn et al. 2008). Widely used throughout the UK, it is recommended as an instrument to guide providers of daily living and leisure activities (NICE and SCIE 2006). Although designed for care-giver's use, it is usually occupational therapists that introduce it into services and oversee its implementation in practice.

OCCUPATIONAL THERAPY AND PEOPLE WITH DEMENTIA

Occupational therapists have a key role in enabling people with dementia to engage in personally meaningful occupations and advice and skills training from an occupational therapist to help maintain independence is recommended (NICE and SCIE 2006). In the UK, the latest (currently optional) module added to the Memory Services National Accreditation Programme (MSNAP) Standards (Royal College of Psychiatrists 2012) relates to the use of psychosocial interventions and includes a recommendation that 'People have access to personally tailored occupational therapy to assist them with their occupational and functional needs and to help maintain their health and wellbeing, independence and community living' (Standard 6.4.1). Standard 6.4.2 further recommends that 'The memory service has access to advice and support on assistive technology and telecare solutions'. The occupational therapy profession's philosophy fits well with the principles of person-centred care. More specifically, many occupational therapists use the Developmental Model to inform and guide their practice, as described by Perrin et al. (2008).

Developmental Model of Dementia

Underpinned by the work of Jean Piaget, who developed a theory of childhood cognitive development, and the Cognitive Disability Model (Allen et al. 1992), the Developmental, Model is based on the theory that the progressive cognitive changes experienced by a person with dementia mirror the cognitive development stages experienced by children in reverse order, as opposed to reverting to childhood as is often suggested. There are four stages (Perrin et al. 2008):

- Reflective (early stage)
- Symbolic (early to middle stage)
- Sensorimotor (middle to late stage)
- Reflex (late stage).

Cognitive changes experienced at each stage affect a person's ability to relate to the world and others, to think and to do. The main goal of occupational therapy intervention is to enable the person to engage with the world and others – regardless of their level of cognitive impairment – and so appropriate activities have to be selected and presented by occupational therapists in a way to enable optimal engagement.

Community Occupational Therapy in Dementia

The community occupational therapy in dementia (COTiD) programme for older people with mild to moderate dementia and their carers was developed and evaluated in the Netherlands (Graff et al. 2006). The intervention aims to improve the service user's ability

to carry out ADL, improve the carer's supervision and problem-solving skills so as to increase their own sense of competence and decrease their burden of care, and improve the quality of life for both parties. The COTiD programme comprises ten 1-hour sessions of home-based occupational therapy provided over 5 weeks, with the occupational therapist working in partnership with the person who has dementia and their family carer. A randomized controlled trial (RCT) was conducted with 135 people and their family caregivers. The primary outcomes were that the person with dementia's ability to perform ADL was enhanced, as was the carer's sense of competence. Secondary outcomes were enhanced quality of life, mood and general health status for both parties and carers' sense of control over their life. All scores improved significantly relative to baseline in the intervention group compared with the controls (Graff et al. 2006, 2007). The effect sizes of all primary outcomes were higher than those found in trials of medications or other psychosocial interventions, and were still present at 3 months (Graff et al. 2006). The intervention was also found to be cost-effective in reducing usage of health and social care services (Graff et al. 2008).

A subsequent study in Germany (Voigt-Radloff et al. 2011) found no difference between providing COTiD or a single occupational therapy consultation. This highlights the need to adapt complex interventions before implementation and evaluation in other nations. For example, COTiD appears to have potential for adoption in the UK but, bearing in mind the need for such cultural adaptation, a research programme is now underway to translate and adapt the COTiD intervention to maximize its suitability and usefulness within the UK setting before running a RCT, and subsequently an implementation study (see www.ucl.ac.uk/valid for more details).

OCCUPATIONAL THERAPY IN CARE HOMES

As the numbers of older people and people with dementia increase, so too does the population of people residing in care homes. Three-quarters of all care home residents have some degree of cognitive impairment (Macdonald et al. 2002), approximately 40% are depressed, and about a quarter have both dementia and depression (Mozley et al. 2000). Activity participation in care homes has been shown to improve residents' quality of life (Zimmerman et al. 2005), reduce levels of challenging behaviour and improve mood and function (Cohen-Mansfield 2005). The need to enable activity participation suggests a potential role for occupational therapy in care homes and two studies have sought to evaluate its effectiveness. The Care Home Activity Project (Mozley et al. 2007) tested the effectiveness of an occupational therapist working within a care home to increase participation in one-to-one and group activities, and to reduce the severity of depression. Wenborn et al. (2013) evaluated the effectiveness of an occupational therapist-led programme to train and coach care home staff to increase activity provision to improve quality of life for residents with dementia. Neither study produced quantitative evidence for the efficacy of the intervention, but both produced qualitative findings that suggested residents who did receive enhanced occupational opportunities had a positive experience. These studies illustrate the challenges in evaluating complex interventions, such as occupational therapy, in the real life setting of care homes, not least of these being the difficulties related to management and staff co-operation with the interventions. They also highlight the need to develop outcome measures that more effectively measure the focus of the intervention, such as level of engagement and activity, especially for those residents with more severe dementia.

Occupational therapists certainly have a role within care homes, not only to facilitate activity participation, but also to enable residents to live as independently as possible. This can be done through the provision of rehabilitation and re-enablement programmes and specialist equipment to enhance function and/or maintain safety and comfort. This may include hoists, specialist seating and splinting. These latter aspects become increasingly important as the person nears the end of their life, and can be provided not only within residential settings but also to people still living at home.

OCCUPATIONAL THERAPY PRACTICE

As well as the specific issues associated with working with older people with depression or older people with dementia, there are some general points for occupational therapists to consider when working with older people.

These concern mental capacity, assessing and managing risk, assistive technology and working with carers.

Mental Capacity

There will be instances when older people, particularly those with dementia, do not have the capacity to make and/or to communicate decisions regarding occupational therapy assessment and interventions. In the UK it is vital to be aware of the Mental Capacity Act (2005) and its implications for practice (see also Ch. 9). It has five statutory principles:

1. A person must be assumed to have capacity unless it is established that they do not.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him/her do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. A decision made, under this Act for, or on behalf of, a person who lacks capacity must be done their best interests.
5. Before a decision is made, regard must be given as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

The Act outlines how to establish that someone lacks capacity:

1. Does the person have an impairment of, or a disturbance in, the functioning of, the mind or brain (temporarily or permanently)?
2. Does the impairment or disturbance mean the person is unable to make this particular decision at this particular time? Can the individual:
   - understand the information relevant to the decision?
   - retain the information for long enough to reach a decision?
   - use or weigh the information to make a decision?
   - communicate a decision?

Occupational therapists must always ask for the person's consent before proceeding with an assessment or intervention and must re-check this on an ongoing basis. There may be occasions when a person makes a decision that the occupational therapist considers to be unwise, such as refusing the installation of equipment or provision of community services, or insisting on going home despite high levels of risk. There will be local procedures and guidance in place as to how to report, manage and document these decisions. There is further discussion about mental capacity in Ch 7 (in relation to professional accountability) and in Ch 10 (in relation to ethical practice.)

Assessing and Managing Risk

There are a number of potential risks facing older people. Depression or cognitive impairment can limit or decrease an individual's motivation or ability to undertake daily living skills, such as maintaining personal hygiene, meal preparation, using household appliances, shopping, medication compliance and managing finances. There is also the possibility of harming themselves or others through inadvertently flooding or setting fire to their home, or by driving dangerously. People who are disorientated in time or place can wander from their home and be at risk of accidents or hypothermia. People who are depressed are at risk of suicide. Older people may also experience physical health problems, which in turn impact on their safety; for example reduced mobility, falls and infection. A person's home environment may become unduly cluttered or require adaptation to enable safe access. Older people are also vulnerable to physical or financial abuse by others, including informal and formal carers. In this instance, occupational therapists need to follow the locally agreed Safeguarding Vulnerable Adults policy. Occupational therapists have an important role in the identification and management of risk. A validated assessment of unmet needs such as the Camberwell Assessment of Need for the Elderly (Orrell and Hancock 2004) can be used to identify and prioritize potential risks. Many organizations use their own locally developed tool.

Health and social care staff can aim to minimize the level of risk but never totally remove it. Risk may be managed through the provision of equipment, assistive technology, or support services. Re-design or adaptation of the environment, including the removal or adaptation of appliances, or to facilitate purposeful walking (as opposed to wandering) may also help.

As always, it is important to record all assessment and intervention, including any concerns about risk management recommendations made but declined by the individual. As discussed above, there is a difference

between someone making what the practitioner thinks is an unwise decision and them not having the capacity to make an informed decision. In the first instance, the occupational therapist must respect their decision and do what they can to minimize the potential risk. In the latter case, any decision that the occupational therapist makes on the individual's behalf must be in their best interest.

Assistive Technology

Assistive technology ranges from simple low-tech household devices to sophisticated sensors and computerized systems that are often connected to a call system or centre to alert a response, which is then referred to as 'telecare'. Assistive technology has been developed to support people with dementia and their carers to manage their daily activities and to enhance safety (van der Roest et al. 2012) and includes:

- Time-orientation devices, such as large-faced clocks and/or automated clock calendars
- Alarm and monitoring systems to alert carers, such as fall alarms, passive alarm systems, and bed and chair monitors
- Safety systems, such as automatic cooker switch-off, bath level/temperature monitor and control
- Adapted telephones, and audiovisual/computer systems to facilitate social contact and occupation.

Assistive technology equipment can maintain safety, monitor and maintain health, and enhance quality of life in several ways. It can remind people, provide them with something to do, point out or respond to danger, monitor activity, restrict access and egress, and keep people in touch with each other. For example, sensors that activate when a person with dementia gets up at night and alert the carer are cost-effective in terms of preventing or delaying care home admission. They also enhance quality of life for the person with dementia (who is thus enabled to remain in their own familiar environment for longer), and reduce the psychological and physical stress experienced by the carer. Chapter 9 highlights the ethical issues surrounding the use of assistive technology and telecare with older people.

Working with Carers

Often, a range of family and friends care for older people, and occupational therapists have a key role in supporting them. Informal carers should be offered a carer's assessment and appropriate support provided in response to identified needs. As discussed, caring for a family member is a potential risk factor for depression (Baldwin 2002). Occupational therapists have a key role in educating and training carers. This may include training in coping strategies to enable the cared for person to continue doing certain things themselves, rather than the carer doing them on their behalf. It may also include techniques for enabling activity participation, using equipment, and advising on benefits and direct payments. The COTiD intervention (described earlier) is a good example of an intervention that enables occupational therapists to engage in this educational/advisory/coaching role. Support can be provided to carers on a one-to-one or group basis. Occupational therapists also have a key role to provide training and advice to formal, paid carers on how best to enable older people to maximize function and maintain their engagement in daily activities and occupations, and how to use specialist equipment such as hoists. The role of carers is also explored in Chapter 11.

SUMMARY

This chapter has described and illustrated, using evidence-based examples, the breadth of occupational therapy practice with older people. The importance of differentiating between the impact of normal ageing and impairment due to underlying pathology, and between dementia and depression, is highlighted. Occupational therapists' person-centred philosophy is often extended to include the older person's family carer as well, bearing in mind the number of informal carers supporting older people and the increasing dependence that a person with dementia will inevitably have on such support. It is also important to recognize the potential risk of carers becoming depressed, hence the need to offer them support to meet their own needs as well as those of the person that they care for.

It is interesting to speculate on what the future holds for occupational therapy services for older people. The current policy focus on enabling independence, choice and control, accords well with the occupational therapy philosophy and therefore may be seen as presenting an opportunity. However, the need to develop yet more robust evidence to demonstrate the value of

occupational therapy intervention is a challenge that occupational therapists must embrace. See Chapter 9 on evidence-based practice.

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25 EMOTIONAL HEALTH AND WELLBEING OF CHILDREN AND YOUNG PEOPLE

SUSAN EVANS ■ JAGODA BANOVIC

CHAPTER CONTENTS

INTRODUCTION

The complexity of the contextual factors influencing children's and adolescent's emotional health and wellbeing presents occupational therapists working in Child and Adolescent Mental Health Services (CAMHS) with opportunities and challenges. As well as focusing on the child's mental health needs, occupational therapists' professional reasoning must also accommodate an appreciation of the child's natural developmental changes, the need for parental roles to develop alongside these, and the various social systems in which the child is living (including the culture and ethnicity of

the family, their school, their friendship circle and the wider community). Practitioners must also understand the different services and agencies that may be involved from public, private and third sectors, as well as government policy and other drivers. Additionally, they must be familiar with the law influencing how services are delivered. The different services and agencies that may be involved from public, private and third sectors, government policy and other drivers; and the law influencing how services are delivered. With these contextual factors paramount in CAMHS' work, this chapter adopts a UK orientation in its discussion of occupational therapists' work.

CAMHS comprises a range of agencies, services and individuals dedicated to the mental healthcare of children and young people aged between 0 and 18 years, and their families. It is usual for a child to be defined as a person under the age of 12 years and an adolescent as aged between 12 and 18 years. Adolescents are sometimes referred to as young people or abbreviated to *YPs*.

As with other fields of mental health practice, practitioners are striving to reduce stigma and promote positive mental health and timely access to services. Often the term 'mental health' has negative connotations. In their Scottish study, Secker et al. (1999) found that some young people found it difficult to consider the term 'mentally healthy' in a positive light at all, and focused instead on particular associations that the words 'mentally' and 'healthy' had for them. 'Healthy' was linked with physical health and 'mentally' was associated with mental *ill*-health. The stigma of mental illness remains a challenge when helping children, young people and their families to access support and engage with appropriate services. With this in mind, there has been a move towards calling such services 'Emotional Health and Wellbeing Services', as opposed to 'Child and Adolescent Mental Health Services'. However, since this is relatively new thinking, this chapter continues to use the term CAMHS in order to reflect the contextual literature and practice guidance that continues to shape practice in this field in the UK.

An Introduction to Children and Young Peoples' Mental Health

Integral to tackling stigma is the idea of positive mental health. This is true across mental health practice in general but it is, arguably, a particularly important feature of work with children and young people.

Rethink (2012) highlighted that everyone has 'mental health' and urged mental health service providers to consider the phenomenon of mental health in ordinary terms, such as: the way we feel about ourselves and the people around us; our ability to make and keep friends and relationships; our ability to learn from others; our capacity to develop psychologically and emotionally; our strength to overcome difficulties and challenges; our confidence and self-esteem; our ability to make decisions and having belief in ourselves. Occupational therapists endeavour to support these traits when considering children's and young peoples' needs. It is an approach which echoes the World Health Organization's (WHO 2010) perspective of mental health, which it defines as a state of wellbeing, in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. (See Ch. 2 for further discussion of wellbeing.)

Key Drivers of Service Development in the UK

Since the late 1990s, CAMHS have undergone major organizational changes in the UK. These have re-shaped services and re-emphasized the need for all professions to demonstrate their responsiveness to individuals' needs. Aiming to reduce stigma and develop interventions which promote positive emotional health and wellbeing for all, the changes have re-affirmed a focus on the following practice issues:

- The importance of involving parents
- Inter-agency working
- Easily accessible services and early intervention
- Reducing the stigma associated with mental health difficulties
- Responding to what service users want
- The prevention of ill-health
- Rigorous quality assurance and measurement of outcomes
- Delivering services that are personal, equitable, accountable and culturally sensitive
- Extra support for families from disadvantaged backgrounds
- Healthy environments in the public sector which promote physical activity
- Schools-based interventions

- Transitional support from adolescent to adult services
- Developing intensive community teams to prevent or shorten hospital admissions
- Greater recognition of the link between mental and physical health – including strengthening the provision of mental healthcare to people with physical illness and the quality of physical healthcare provided to people with mental health problems in general hospitals and primary care.

What follows is an overview of some of the main legislative and policy drivers in the UK that have brought about the organizational changes described above.

Every Child Matters (ECM) (DfES 2004)

This UK government initiative for England and Wales was based on the Every Child Matters (ECM) Greenpaper from 2003. It was produced partly in response to the death of Victoria Climbié, who was abused, tortured and murdered by her great aunt and partner in 2000, in the UK. ECM (DfES 2004) influenced school inspection criteria and built on existing plans to strengthen preventative services by focusing on four key themes:

1. Increasing focus on supporting families and carers
2. Early intervention
3. Integrated services, with clear lines of accountability
4. Ensuring people working with children are valued, rewarded and trained.

ECM (DfES 2004) promoted five outcomes most important to all children and young people (CYP), not just those using CAMHS: being healthy, staying safe, enjoying and achieving, making a positive contribution to the local community and wider society, in which they are living, and achieving economic wellbeing. This latter outcome relates to progression to further education, employment or training on leaving school, living in decent homes and sustainable communities, having access to transport and material goods, and living in households free from low income.

Healthy Minds: Promoting Emotional Health and Wellbeing in Schools (OFSTED 2005)

This report by the Office for Standards in Education, Children's Services and Skills emphasized the importance of mental health as part of education curricula. It called for mental health awareness training for education staff and advocated a whole-school approach to emotional health organized through the National Healthy School Standard (NHSS) programme, the Personal Social and Health Education (PSHE) curriculum, and the Social and Emotional Aspects of Learning (SEAL) curriculum resource.

Schools were seen as less stigmatizing locations for CAMHS provision and clearer procedures for CAMHS referral were put in place. Voluntary organizations – such as youth offending schemes and counselling services (see Useful resources) – were also used as venues where appropriate.

You're Welcome Quality Criteria (DH 2007) and You're Welcome: Quality Criteria for Young People Friendly Health Services (DH 2011b)

The 2007 document (updated in 2011) set out principles to help commissioners and service providers to improve the suitability of a wide range of NHS and non-NHS health services for young people. The quality criteria covered 10 topic areas: accessibility, publicity, confidentiality, consent, environment, staff training, skills, attitudes, values and joined-up working across agencies. It also established young people's involvement in the monitoring and evaluation of their 'patient experience'.

National CAMHS Review: Children and Young People in Mind (DH 2008a)

This independent review of CAMHS post-2004, focused on developing effective, integrated child- and family-centred services to improve mental health and psychological wellbeing. To do this, it promoted *universal* services (focusing on promotion, prevention and early intervention) and *specialist* services offering accessible and timely and evidenced-based support. *Universal*, *targeted* and *specialist* services are described in more depth later in the chapter. It required all CAMHS staff to have a clear understanding of their roles and appropriate skills and competencies.

The Children and Young Persons' Act (2008)

This provided for the wellbeing of children and young people and private fostering, with a particular focus on older young people in care and those making the transition from care. It is closely linked to other legislation such as the Protection of Children Act (1999), the

Safeguarding Vulnerable Groups Act (2006), and the Childcare Act (2006).

The Targeting Mental Health in Schools (TaMHS) Programme (DCSF 2008–2011)

This formed part of the UK government's wider programme of work to improve the psychological wellbeing and mental health of children, young people and their families. TaMHS aimed to help schools deliver timely interventions and approaches to help those with mental health problems and those at increased risk of developing them.

Healthy Lives, Brighter Futures: The Strategy for Children and Young People's Health (DH 2009a)

This guidance strategy built on the National Service Framework for Children, Young People and Maternity Services (DH 2004), Every Child Matters (DfES 2004), and the National Health Service Next Stage Review Government paper (DH 2008b) by promoting high-quality services and minimizing health inequalities.

Think Family Toolkit (DCSF 2009a)

This guidance reformed services for vulnerable children, young people and adults to enable early identification of families at risk of poor outcomes, and to strengthen families' self-help skills.

The Evidence Base to Guide Development of Tier 4 CAMHS. K. Kurtz Report (DH 2009b)

This report heralded a move away from an over-exclusive focus on inpatient care to 'wrap-around' provision across multiagency services including in-reach, out-reach, intensive and crisis community services, day provision, therapeutic fostering and other services. It identified certain groups at a high risk of developing mental health problems such as young offenders from criminal backgrounds, looked after children, children with learning and/or emotional and/or behavioural difficulties, children with a chronic physical illness and/or physical disability and/or sensory impairments, children who have been sexually, physically or emotionally abused, children whose parents have a mental health problem and/or a substance misuse problem, children who have experienced or witnessed sudden or extreme trauma, and children who are refugees. The report highlighted that good-quality services should be equitable, accessible, acceptable, appropriate, effective, ethical, and efficient. As healthcare practices have developed, the focus has been on the need for credible evidence of its effectiveness through the use of outcome measures.

Better Outcomes, New Delivery (BOND) (DfE 2012)

The UK government's mental health strategy (DH 2011a) stressed the importance of early intervention in emerging emotional and mental health problems for children and young people. As part of this strategy, the Department of Education funded a 2-year sector-led BOND programme aimed at building on the capacity of voluntary and community sector organizations to develop the standard and range of early interventions. They would also have a role in the purchasing and commissioning of services.

The Children, Young People and Families Specialist Section of The College of Occupational Therapy (COT: www.cot.co.uk) and its regional forums also influence service delivery in the UK by developing knowledge and skills, supporting continuing professional development and practitioner networking, and promoting research and evidence-based practice.

MODELS OF SERVICE DELIVERY

Arising from the UK government strategy document 'Together We Stand' (Social Services Inspectorate (SSI) 1995), a four-tiered framework was used to conceptualize CAMHS as a multi-levelled set of inter-related services. Each level aimed to address the different needs of children and young people. These needs ranged from stresses and worries, to more severe mental health problems such as eating disorders and psychosis. Since then, the CAMHS Review (DH 2008a) raised the need for greater integration with other services and this has led to the *universal*, *targeted* and *specialist* services referred to earlier. Although interpretation can vary locally, this classification aims to show which services are available to everyone and which are available only to some.

Universal Services work with *all* children and young people. They promote and support mental health and psychological wellbeing through the environment they create and the relationships they have with children and young people. They include early years providers and

settings such as childminders and nurseries, schools, colleges, youth services and primary healthcare services such as GPs, midwives and health visitors. Universal services equate to Tier 1 Service provision.

Targeted Services are engaged to work with children and young people who have specific needs; for example, learning disabilities, school attendance problems, family difficulties, physical illness or behaviour difficulties and those in care.

Specialist Services work with children and young people with complex, severe and/or persistent needs. This includes CAMHS at Tiers 3 and 4 of the conceptual framework (though there is overlap here, as some Tier 3 services could also be included in the 'targeted' category). It also includes services across education, social care and youth offending that work with children and young people with the highest levels of need; for example, in pupil referral units (PRUs), special schools, children's homes, intensive foster care and other residential or secure settings.

Tiered and Targeted Services

The CAMHS Review (DH 2008a) defined the tiers (illustrated in Fig. 25-1) as follows:

Tier 1

These services are provided by practitioners working in universal services (such as GPs, health visitors, teachers and youth workers), who are not necessarily mental health specialists. They offer general advice and treatment for less severe problems, promote mental health, aid early identification of difficulties and refer to more specialist services.

Tier 2

These services are provided by specialists working in community and primary care settings in a unidisciplinary way (such as primary mental health workers, psychologists and paediatric clinics). They offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery.

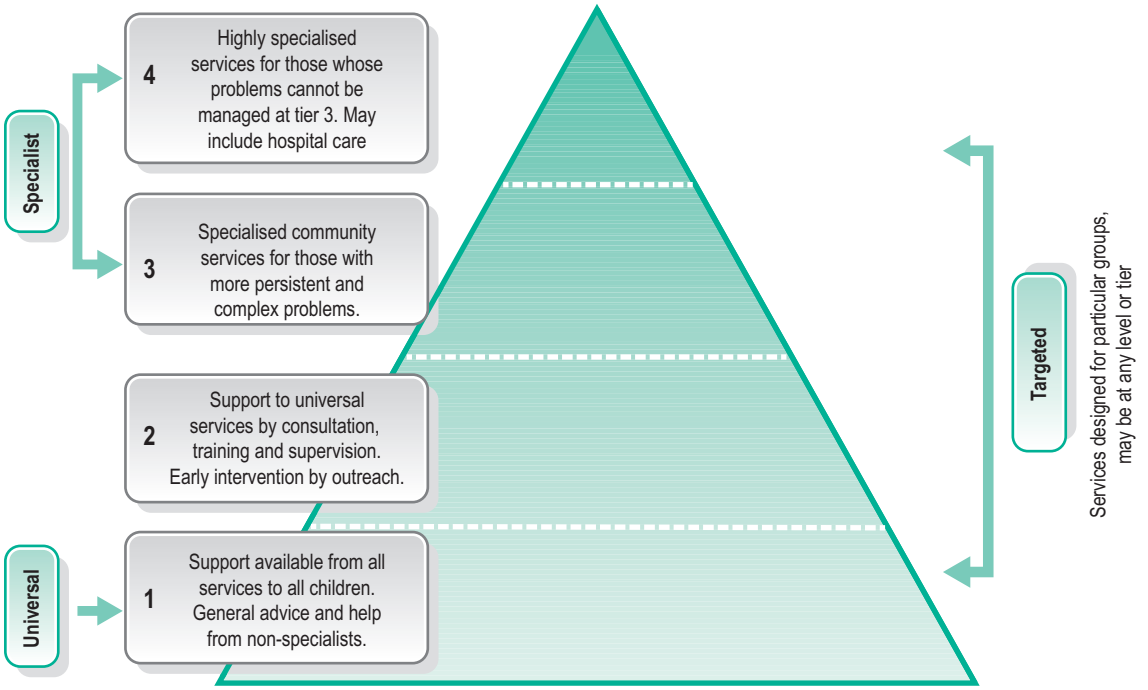

FIGURE 25-1 ■ CAMHS tiers and services. *Adapted from Nixon B 2006 Reflecting on the competencies/capabilities needed by the workforce in order to work effectively with children and young people around issues of mental health. A discussion document: CSIP, National CAMHS Workforce Programme, with permission from the author and Public Health England.*

Tier 3

These services are provided by a multidisciplinary team or service working in a community mental health clinic, child psychiatry outpatient service or community settings. They offer a specialized service for those with more severe, complex and persistent mental health problems.

Tier 4

These services are for children and young people with the most serious problems. They include day units and highly specialized outpatient teams and inpatient units, which usually serve more than one area.

Occupational therapists work across all tiers (as illustrated in the case studies later in the chapter) but are usually employed within specialist tiers 3 and 4.

CHILDREN'S AND YOUNG PEOPLE'S EMOTIONAL HEALTH AND WELLBEING

Risk and Resilience

In this section, we will consider the concepts of risk and resilience and how they contribute to mental wellbeing. Risk factors can be cultural, economic or related to medical conditions, which impact on opportunities and resources available to a child. These risk factors may affect the child's ability to become a meaningful member of the home, school or community. Risk factors can be internal (or intrapersonal) or external (involving family, school and community members). Resilience is the presence of protective factors, which can be seen as those qualities or situations that help minimize or modify potential negative outcomes (see also Ch. 2 for further discussion of resilience).

Occupational therapy assessments should always highlight the strengths and needs of service users. Awareness of risk and resilience factors for mental health difficulties in children (see Table 25-1) will also guide therapists' interventions and develop a 'wellness' approach by focusing on the development of 'life tools' such as friendship, assertiveness or problem-solving skills, or the ability to access physical activities to promote resilience.

It is recognized that the presence of risk factors increases the probability of a child developing a mental health problem. They are cumulative. If a child has one risk factor, their chance of developing a mental health problem is 1–2%. If there are three risk factors present, the probability is 8%, and if there are four or more, the risk increases to 20%.

COMMON PRESENTATIONS OF MENTAL HEALTH PROBLEMS IN CAMHS

When considering diagnoses, one needs to be mindful that child and adolescent presentations may be transient reactions to circumstances, or a reflection of their developmental stage. Many children and young people will be referred to CAMHS with a cluster of life problems, with no clear psychiatric diagnosis. In such cases, it is important to acknowledge that the person's presentation may be causing emotional distress but does not meet the criteria for classification as a mental health problem. Such problems, although distressing, tend to resolve themselves with minimal early intervention. A diagnosable mental health problem will be experienced over a longer period of time, cause considerable disruption to the family and require specialist interventions. Clinicians will consider an individual's situation carefully before giving a diagnosis, so as to avoid risking unnecessary stigmatizing. However, having a diagnosis can, in some cases (such as autism or ADHD) enable the child and family to access many helpful resources, services and finance to support them.

The International Classification of Disease (10th ed.) (ICD 10) (WHO 1992) and the Diagnostic and Statistical Manual of Mental Disorders (5th ed.) (DSM-5) (American Psychiatric Association 2013) are the most commonly used clinical tools used in diagnosing patients. The ICD 10 uses a multi-axial framework to classify disorders (WHO 2008). The six axes include: clinical psychiatric syndromes, specific disorders of psychological development, intellectual level, medical conditions, associated abnormal psychosocial situations and global assessment of psychosocial ability.

The Office of National Statistics (ONS) (2004) found that 10% of children and adolescents aged between 5 and 15 had a clinically diagnosable mental

TABLE 25-1
Risk and Resilience Factors

	Risk Factors	Resilience Factors
Child	Genetic influences Low IQ and learning difficulties Specific developmental delay Communication difficulties Difficult mental and emotional traits Physical illness, especially if chronic and/or neurological Poor academic performance Low self-esteem	Secure early relationships Being female Higher intelligence Mentally, physically and emotionally contented as an infant Positive attitude, problem-solving approach Good communication skills Planning skills, belief in control Humour Religious faith Capacity to reflect
Family	Overt parental conflict Family breakdown Inconsistent or unclear discipline Hostile and rejecting relationships Failure to adapt to child's changing developmental needs Abuse – physical, sexual and/or emotional Parental psychiatric illness Parental criminality, alcoholism and personality disorders Death and loss – including loss of friendships	At least one good parent–child relationship Affection Clear, firm and consistent discipline Support for education Supportive long-term relationship/absence of severe discord
Environment/ Community	Socioeconomic disadvantage Homelessness Disaster Discrimination Other significant life events	Wider supportive network Good housing High standard of living A high-morale school with positive policies for behaviour, attitude and anti-bullying A school with strong academic and non-academic opportunities Range of sport/leisure opportunities

Adapted from National CAMHS Review (DH 2008a).

health problem associated with distress and which impacted on personal functions such as family and social relationships, their capacity to cope with day-to-day stresses and life challenges, and their learning.

The data from this survey are shown below regarding the known major mental health problems in children and young people; though Young Minds (2012) believe this to be an underestimation. (Also see Figs. 25-2 and 25-3.)

A broad overview of several sources collated by Young Minds (2012), such as the UK National Census of April 2001, the Office of National Statistics' Child and Adolescent Mental Health Survey in 2004, offers what is, arguably, a more accurate picture of the incidence of common mental health problems among children and young people, as follows:

- One in 10 children aged between 5 and 16 years suffer from a diagnosable mental health problem. That is around three children in every classroom (Green et al. 2005)
- Between 1 in 12 and 1 in 15 children deliberately self-harm and around 25 000 are admitted to hospital every year due to the severity of their injuries (Fox and Hawton 2004)
- More than half of all adults with mental health problems were diagnosed in childhood but less than half were treated appropriately at the time (Kim-Cohen et al. 2003)
- Nearly 80,000 children and young people suffer from severe depression (ONS 2004)
- Over 8,000 children aged under 10 years old suffer from severe depression (ONS 2004)

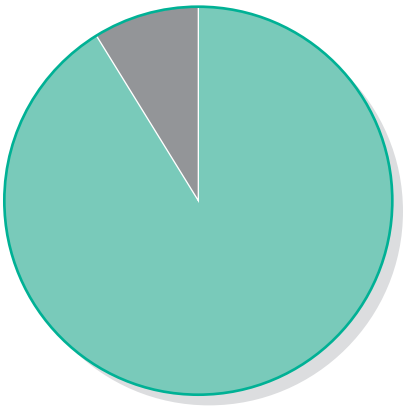

FIGURE 25-2 ■ Overview of mental health problems in children and adolescents. *Data from ONS (2004).*

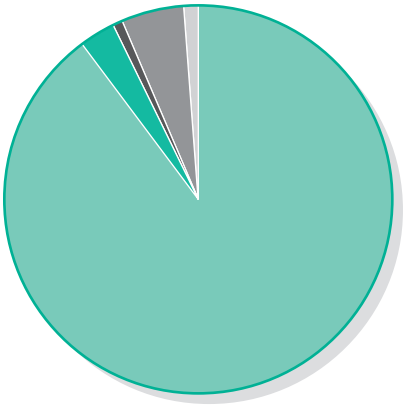

FIGURE 25-3 ■ Main mental health problems among children and adolescents. *Data from ONS (2004).*

- In total, 60% of children in care have a mental health problem. These are some of the most vulnerable people in our society (DCSF 2009b)
- In total, 95% of imprisoned young offenders have a mental health problem and many of these are struggling with more than one mental health problem (ONS 2004)
- The majority of presenting children and/or young people have more than one mental health problem at the same time. It is common for there to be more than five
- There is frequently an overlap between anxiety and depression and conduct and hyperactivity/attention-related disorders (Green et al. 2005; Parry-Langdon 2008)
- Services are endeavouring to address the concern that young people aged between 16 and 18 years often fall through the gaps in adolescent and adult service provision.

It is important to be aware of the signs and symptoms of mental health problems but, more importantly, to accurately assess how a mental health problem has impacted on the person's functional ability and the activities they value in life. As described in Table 25-1, accessing education is a key resilience factor in preventing poor mental health and social outcomes for a child or young person. Consequently, occupational therapists work closely with education services to ensure continuity of education and that this is provided at the right level to accommodate the social and emotional needs of the child or young person.

OCCUPATIONAL THERAPY IN CAMHS

Children develop a sense of self through their engagement in occupations. It is through their participation in daily activities, initially shaped by care-givers, which facilitates growth and maturity enabling them to develop and fulfil their potential. Occupational development is therefore progressive and dynamic. Haertl (2010) highlights factors such as will, personal motivation and social engagement as being instrumental to this process.

Mental health problems in children and young people impact on this developmental process. Occupational disruption hinders the acquisition of functional and psychological skills. The aim of occupational therapy is to minimize this disruption and facilitate the continuation of children's occupations in whichever setting they are. In short, it is the role of occupational therapy to facilitate and enhance childhood occupations, based on the following assumptions:

- Children are occupational and social beings
- The use of occupation is the foundation of occupational therapy and is equally important as a means and an end
- Personal, environmental, social, cultural and temporal factors influence occupational performance
- Occupational development occurs through a dynamic process involving innate drives and guided participation
- Engagement in occupation brings about change
- Occupational engagement influences health and wellbeing.

Occupational Therapy Assessments and Outcome Measures

Standardized assessments alongside clinical observations enable accurate assessment and provide base-line information for outcome measures. Some examples of standardized assessments used in CAMHS are given below and are referred to in the case studies provided later in the chapter.

The Child Occupational Self-Assessment (COSA)

This is a commonly used Model of Human Occupation (MOHO)-based initial assessment used to identify personal occupational goals and to assess outcomes (Keller et al. 2005).

Short Child Occupational Profile (SCOPE)

This is a MOHO-based occupation-focused assessment for children aged 0–21 years used to ascertain volition, habituation, skills and the environment which facilitates or restricts participation. Bowyer et al. (2008) confirmed that this test demonstrated validity in reflecting the construct of occupational participation for individuals. Minor adjustments were needed to improve standardization. This has been addressed through guidance for the training assessors who administer the test.

The Children's Assessment of Participation and Enjoyment (CAPE) and the Preferences for Activities of Children (PAC)

These two assessments are companion measures, based on self-reporting, of children's participation in recreation and leisure activities. They have proven internal consistency, test-retest reliability, content validity, and construct validity (King et al. 2004).

The Sensory Integration and Praxis Test (SIPT)

This test has statistical strength in test-retest and inter-rater reliability and in discriminative, criterion-related, content and predictive validity. The SIPT has 17 subtests, which assist in understanding a person's behaviour and learning needs by assessing certain aspects of sensory processing or perception related to language development, academic achievement and social behaviour. They also evaluate praxis, or the person's ability to cope with the tangible, physical two- and three-dimensional world (Ayres 2007).

Assessment of Motor and Process Skills (AMPS)

This is an observational assessment used to measure the quality of a person's activities of daily living (ADL) using specific tasks (Fisher 2001).

The Adolescent/Adult Sensory Profile

This measures a person's sensory processing abilities and profiles the effect of sensory processing on functional performance in their daily life. The sensory

profile is a 60-question self-report questionnaire (Brown and Dunn 2002).

The Assessment of Communication and Interaction Skills (ACIS)

This uses the domains of physicality, information exchange, and relations to describe different aspects of observed communication information during an activity or group (Forsyth et al. 1998).

The Canadian Occupational Performance Measure (COPM)

This measure detects change in a person's self-perception of occupational performance over time (Law et al. 2004).

In addition to these standardized measures, there is also a wide variety of non-standardized measures – such as observation of the duration, frequency, and severity of behaviours pre- and post-intervention, interviews with school staff, interviews with parents, goal attainment measures, and the achievement (or otherwise) of personally identified goals.

The following Case studies illustrate how some of these assessments might be used in the occupational therapy process and in interventions across the tiers. All names are pseudonyms.

CASE STUDIES

CASE STUDY 25-1

James

Referrer: Consultant psychiatrist, Tier 3 Child and Family Services Team

Reasons for referral to occupational therapy: Assessment of functional skills and support in re-engaging in activities of daily living.

Case summary: James, a 15-year-old boy, was admitted to an adolescent inpatient unit (Tier 4) under Section 3 of the Mental Health Act (1983). He had not attended school for the previous 6 months and had become withdrawn; spending most of his time in his bedroom, pacing or sitting or sleeping. Despite intensive support from the community-based Early Intervention in Psychosis team, home treatment was not sustainable. He was experiencing paranoid delusions, visual hallucinations and ideas of reference and was refusing medication.

Occupational Therapy Assessment: Due to the severity of his mental health problem during the first 2 weeks of his admission, occupational therapy focused on therapeutic engagement and gathering background information.

The Child Occupational Self-Assessment (COSA) was not considered due to James' inability to complete a verbally orientated assessment. Instead, the Short Child Occupational Profile (SCOPE) was used. Information was collated based on the occupational therapists' observations of James' engagement in a range of activities plus additional information from his parents, school and nursing staff. Observations were gathered about James baking, playing a board game, playing sport with his peers, eating a meal, washing and dressing. This highlighted certain strengths, such as James' motivation to interact with people on a one-to-one basis, his skills in basketball and cooking and his interest in listening to music.

James' needs included general reality orientation (which globally affected his process skills) and awareness of daily routines. He required verbal encouragement to initiate, sustain and complete most activities, especially self-care and support in simple decision-making. Medication was causing a hand tremor (affecting fine motor skills) and negatively impacting on his energy levels and sleep pattern with the result that his optimum functional period during the day was after lunch. He was very sensitive to busy, noisy, environments and group situations, which exacerbated his psychotic symptoms. A Sensory Profile (Brown and Dunn 2002) was then completed to assist in addressing sensory sensitivities and identifying distress management strategies.

Occupational Therapy Intervention Plan: Initial aims focused on James' reality orientation (increasing his awareness of himself and the impact of his actions on the environment), through multisensory tasks,

CASE STUDY 25-1 (*Continued*)

increasing his social confidence by developing distress management skills, and modifying his environment by creating safe corners in his bedroom with beanbags and dimmed lighting. Sensory-based therapeutic activities using heavy muscle work, such as digging, sweeping, drumming, clay work and bread-making were used due to their neuro-physiological calming effect and the way they fostered a connection between the 'self' and the environment. Using activity analysis, the complexity of activities was graded according to the number of steps involved, the mode of instruction, the duration of the task, the degree of decision-making required or the equipment used.

Once James' psychotic symptoms were stabilized through medication, the occupational therapy goals were reviewed using the SCOPE and COSA. This identified two further goals:

1. *To help James re-establish friendships, by linking with the school basketball team*. This involved the use of role play and story boarding to adopt a problem-solving approach regarding how James might make an initial contact and decide what to say about his admission and his mental health problems.
2. *To facilitate James' confident return to school and his management of the school routine*. This included working with James' parents and the Early Intervention Team to identify early signs of relapse, recognize situations that could exacerbate James' psychotic symptoms, and to develop management strategies and support networks. With James' consent, this information was shared with the education services.

Outcome: James' final formal review and a repeat of the SCOPE reflected global improvements, including improved confidence. James had begun to attend basketball practice sessions, was attending school part-time, had a positive structured routine at home, and was able to engage in brief conversations if they were initiated by others.

CASE STUDY 25-2

Lydia

Referrer: Tier 2 Mental Health Practitioner

Reasons for referral to occupational therapy: To clarify diagnosis as part of the multidisciplinary assessment and to support Lydia in returning to school by helping her manage her anxiety.

Case summary: Lydia, an 11-year-old girl, was referred to the Child and Family Service (Tier 3) due to increasing parental concerns about possible depression and anxious behaviours. Since starting secondary school 6 months previously, she had become verbally aggressive to teachers and peers, was running out of lessons and had difficulty forming and maintaining friendships. In the past 2 months, she had refused to attend school. The initial family assessment indicated longstanding difficulties in relationships and behaviours, indicating a possible undiagnosed autistic spectrum disorder. (See Ch. 26 for more detailed coverage of autism.)

Occupational Therapy Assessment: Assessment comprised the Child Occupational Self-Assessment (COSA), the Short Child Occupational Profile (SCOPE), the Adolescent/Adult Sensory Profile, the Sensory Integration and Praxis Test (SIPT), formal clinical observations for sensory integration and praxis and the Assessment of Communication and Interaction Skills (ACIS).

The assessment highlighted several strengths. Lydia was motivated to do educational work and was extremely talented musically, playing a range of instruments, which she enjoyed. She enjoyed learning, particularly acquiring factual information. She responded well to structure and routine. She was able to engage in individual tasks or working in a pair. She had supportive parents and supportive school staff, who were keen for advice on how best to support Lydia.

Continued on following page

CASE STUDY 25-2 (*Continued*)

In terms of Lydia's needs, she had poor self-esteem and found it hard to manage transitions from one activity to another. At such times, Lydia would become truculent and refuse to end the activity or would walk out of the room, refusing to return. It was hypothesized that her aggressive and/or rude outbursts were due to sensory processing difficulties (see Ch. 26). She found it challenging to manage sensory triggers, such as noise levels in corridors, the proximity of fellow pupils when having to line-up for registration, the smell of cooking food from the canteen and having to sit at the front of class to receive close teacher supervision (which also made her feel trapped because she was unable to see an exit). Lydia also struggled with social skills such as knowing how to ask peers if she could join a game, turn-taking or talking about topics other than her music lessons and instruments. The assessments contributed to confirming the diagnosis of autistic spectrum disorder.

Occupational Therapy Intervention Plan: This comprised a range of approaches. A psycho-educational approach with Lydia's parents, teachers and her referring mental health practitioner aimed at increasing their understanding of Lydia's particular sensory processing difficulties. A school visit was done to assess the environment and to recommend environmental changes and strategies. These included having quiet corners within classrooms and other parts of the school to which Lydia could retreat, having a pre-agreed exit strategy from classes, seating her near a door, coming into school earlier to avoid the busy, noisier times, leaving lessons early to be able to move around the school when it was quieter, and using study corals in the library to focus Lydia's attention when she felt overloaded.

Lydia was supported to become more aware of her triggers and changing alertness/arousal levels, and to develop strategies to achieve the 'just right level' of alertness that would enable her to function in a more effective and satisfying way. Lydia was also encouraged, using role play and stories, to feel more confident about letting her parents and teachers know when she felt distressed. CAMHS supervision was also provided for the mental health practitioner and an identified teaching assistant, who planned to provide focused 'friendship skill sessions' within the school for Lydia with another peer with similar difficulties.

Outcome: As a result of everyone connected with Lydia having a greater understanding of her needs and her newly acquired management strategies, Lydia was able to integrate successfully back into her school, with additional educational support. Her outbursts decreased and her marks improved. Her parents reported that they now looked forward to family events because they understood Lydia's triggers and how to support her in managing her difficulties.

CASE STUDY 25-3

Callie

Referrer: Consultant psychiatrist, Tier 3 Child and Family Service's Team

Reasons for referral to occupational therapy: To make a general functional assessment and to support Callie in managing her free time and in expressing herself.

Case summary: Callie, aged 13, was referred to an adolescent inpatient service due to significant weight loss, low mood and difficulty sharing thoughts and emotions. She lived with both her parents and younger brother Joe, aged 9. Meals at home were difficult, taking up to 2 hours. The trigger for Callie's deterioration was an incident when she had choked on food at a family party but had then been obliged to finish the rest of the meal. Callie stated she did not want to grow up, had great difficulty relaxing and had an exceptionally active routine, demanding constant parental input. She had no friends. She was academically very bright but was refusing to attend school. Swimming had been a calming influence but, due to extreme weight loss, it was medically advised that she should not engage in this at present.

CASE STUDY 25-3 (*Continued*)

Occupational Therapy Assessment: The occupational therapy assessments included the COSA, SCOPE, ACIS and the Adult/Adolescent Sensory Profile. Together, these identified strengths in her creativity and sporting achievements and abilities, and in her sibling relationship with Joe, who she enjoyed playing with. Needs identified included help with Callie's sensory modulation difficulties, support for the parents' boundary-setting in relation to Callie and issues around the life/leisure imbalance for the family as a whole, now that family life seemed to revolve around Callie.

Occupational Therapy Intervention Plan: The aims were for Callie to develop more effective self-calming strategies through sensory integration using vestibular and proprioceptive-based interventions, for the family to be able to engage in individual and family-based leisure interests, and for the family members to be able to safely express and manage their own and each other's anger.

Occupational therapy was part of a therapeutic milieu, including clinical psychology, nursing care, educational assessment and intervention, family therapy and medical and psychiatric reviews. Due to difficulty in engaging the family in formal family therapy, occupational therapy addressed family issues through less formal family work. This was co-facilitated with her key nurse and focused on the issue of family life seemingly revolving around Callie and on exploring each family member's anger triggers and management styles, as this appeared to be a taboo subject for Callie's parents.

In terms of family life, artwork was used as a medium for exploring how each person would like to use their free time and how this could happen. On a large sheet of paper, all drew or wrote on post-its 'what would make a fantastic weekend' for them. Callie's father valued going for a walk alone to buy a newspaper and Callie's mother wanted to see friends and go to Quaker meetings. Both these activities had stopped over the past year because of the family's focus on Callie's needs. Joe wanted to go to the cinema, play football, and go to an adventure park as a family. Callie wanted to spend all day swimming. Weekly goals were agreed to help structure the family's weekend activities, including identifying more sedentary activities or 'chill times' that could be done together or individually – such as painting, baking, watching DVDs, craft activities or computer games. Goals were reviewed on a large piece of paper, graffiti style, to encourage engagement. Rewards for achieving goals were also planned, for example 'family movie nights' building up to a family trip to an adventure park.

In terms of anger triggers, each family member completed a non-standardized questionnaire in which they ticked relevant statements about their own trigger situations – such as 'when people talk about me behind my back', 'when I get work wrong', 'when other people get hurt', 'when others won't play with me', 'when I'm treated unfairly', 'when I'm losing at football', or 'when people don't give me a chance' – and talked about their feelings around these. Different management styles currently being used were discussed, including Callie's father 'just walking away', her mother 'having long rants', Callie hitting out or threatening suicide or going to her room and cutting her legs, and Joe sulking and slamming doors. Methods of helping Callie to calm down were explored, including Callie being trusted to go to her room to use sensory strategies (which she practised) or to go for a walk with the dog for 10 minutes on an agreed route. At this point, Callie's parents agreed to meet with the team's social worker (having refused this earlier) to build on their parenting skills and boundary-setting.

Outcome: Callie became less demanding as she became more insightful into the impact of her behaviour on her family and more motivated to eat to ensure she could engage in physical activities and return to swimming. She gradually became more able to enjoy solitary and sedentary activities, although her preference for physical activities was acknowledged. Family life became more balanced and her parents became more confident in maintaining boundaries when the children's behaviour was more challenging and oppositional. The community CAMHS team then continued family and individual therapy to help Callie develop her social skills.

CASE STUDY 25-4

Charlotte

Referrer: Family therapist

Reason for referral: To help build Charlotte's confidence and self-esteem.

Case summary: Charlotte, a 9-year-old girl, had been attending family therapy for several sessions with her new adoptive parents. She was having difficulty settling in to her new home and bonding with them and had become withdrawn at home and at her new school. She was isolated from her peers and was finding it difficult to concentrate on class work.

Occupational Therapy Assessment: The occupational therapist began by completing an initial interview with Charlotte's parents using the SCOPE parent interview. The SCOPE was then completed with Charlotte. These assessments identified that Charlotte found it difficult to express her emotions to her adoptive parents and her peers, that there was a lack of routine at home, and that Charlotte struggled with doing things as part of a family and understanding her role. However, there were notable strengths too. Charlotte enjoyed sports and creative activities, enjoyed being with her adoptive parents and wanted to feel part of a family. On this basis, she was motivated to work with the occupational therapist to improve things at home and school.

Occupational Therapy Intervention Plan: The occupational therapist met with Charlotte's parents to discuss the importance of routine and of having clear roles and expectations. Together with Charlotte, they formulated a household routine, initially focusing on times for breakfast, dinner and bedtime and later, also looking at tasks relating to these. Charlotte was also encouraged to choose an activity that she would like to do with her adoptive parents; a new activity that they could learn together.

Outcome: As Charlotte's confidence increased and her ability to express her emotions improved through the family activities, they learned that they were able to rely on each other and work as a team. Charlotte's increased confidence at home was generalized to the school environment. This led to her wanting to become more involved in school activities. Charlotte was referred to the Nurture Group run by occupational therapists at the child and family clinic, to continue to improve her confidence and self-esteem. This group used creative activities to facilitate communication and self-expression (see Ch. 17 for further exploration of the use of creative activities).

Ultimately, the routine at home led to a better balance of family life and enabled Charlotte's parents to assist her in developing appropriate occupational goals.

CASE STUDY 25-5

Omar

Referrer: General practitioner

Reason for referral: To assist Omar in managing his anxiety and to enable him to continue attending school.

Case summary: Omar, a 15-year-old boy living at home with his father, had become increasingly anxious and fearful of leaving the house alone. This followed an incident of cyber-bullying at Omar's school, which involved derogatory mobile phone texting and posting insulting comments on a social networking site. Omar's sleep was poor and he experienced his heart racing, with shortness of breath. He also felt sick and had difficulty concentrating. His anxiety led to poor school attendance, which was affecting his grades and likely future exam success.

Occupational Therapy Assessment: The occupational therapist interviewed Omar to review the duration and intensity of the anxious symptoms and to explore his concerns. Omar was also given a mood diary to help him to record his symptoms over a period of 1 week. The assessment highlighted a number of strengths. Omar wanted to go to university and was motivated to return to school to continue his studies. He had maintained contact with school friends and was attending church each Sunday with his family, where he sang in the choir. However, Omar was becoming increasingly anxious on leaving the house alone.

Occupational Therapy Intervention Plan: The occupational therapist adopted a psycho-educational

CASE STUDY 25-5 (*Continued*)

approach to equip Omar with a range of relaxation and diaphragmatic breathing exercises to help him remain calm. He was also encouraged to develop and write down coping statements to use when he felt anxious.

Using a structured problem-solving approach to identify and explore Omar's fears, these were broken down and recorded in Omar's mood diary, along with a course of action to address each one. Using a behavioural approach, the occupational therapist employed a graded exposure plan to help Omar leave the house alone and to attend school. Omar's family were also engaged in these plans where appropriate. Weekly goals for Omar were jointly set, initially with support but with a gradually increasing level of independence.

Outcome: As Omar mastered the relaxation techniques and began to use them independently, he reported a reduction in the intensity of symptoms. He reported that this, together with the behaviour planning, was giving him a greater sense of control, which enabled him to return to school more confidently.

CONCLUSION

Occupational therapists working in CAMHS are presented with complex cases which require a depth of knowledge of child development, familiarity with a range of mental health problems, and well-developed skills in working with both the child and their family or carers. The importance of assessing the child/young person's needs in the context of their family and broader social relationships (including school) cannot be overstated. This will ensure that the occupational therapy intervention is targeted to bring about change needed to promote emotional health and wellbeing.

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USEFUL RESOURCES

www.chimat.org.uk/champ/camhs.

The mental health and psychological wellbeing section of this site will update practitioners on policy issues and good practice guidance.

www.youngminds.org.uk.

This is a general mental health site, with information sections for all different types of mental health problems; where to seek advice, videos and podcasts.

www.psychosissucks.ca.

This site offers information to help early identification of psychosis and access to help.

www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-RR049.

This site offers explanations of social and emotional aspects of learning (SEAL) in school curricula.

www.ceop.police.uk/.

This website for children and young people – Child Exploitation Online Protection – is run by the police and provides advice and training resources for professionals and young people.

www.childnet.int.org.

This website helps keep children safe online.

www.u-think.org.uk.

This is a children and young people's website from Rethink – a UK mental health charity. It has games, and advice and links related to all sorts of emotional and mental health issues.

www.b-eat.co.uk.

This is an eating disorders website for children and young people – part of EDAUK – with stories, strategies, online support and information.

www.nshn.co.uk.

This site is from the National Self Harm Network. It has links to the National Society for the Prevention of Cruelty to Children and Saneline.

www.thinkuknow.co.uk.

This is a safety website for children and young people; part of www.CEOP.police.uk, run by the police. It offers advice, training and resources for professionals and young people.

www.griefencounter.org.

This is a bereavement website with an advice section for children and young people, schools and parents.

www.rd4u.org.uk.

This is the children's section of CRUSE bereavement counselling and support services.

www.talktofrank.com.

This is a government-sponsored drugs and alcohol website for young people.

http://www.equip.nhs.uk/.

This site provides access to information on health conditions to help people manage their health better using high-quality videos, social media tools, games and applications to show the information in an interesting, informative and imaginative way.

www.ocdaction.org.uk.

This site provides support and information for people affected by obsessive compulsive disorder.

http://www.wikicamhs.co.uk/home/induction/CD1.

This site provides an introductory Child and Adolescent Mental Health Work Book and CD.

www.catch-22.org.uk/.

This site is from a social enterprise targeting the most vulnerable young people. It aims to help prevent involvement in crime and/or substance misuse, encourage engagement in education, develop work and independent living skills in preparation for leaving care or custody, and parenting skills.

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SERVICE USER COMMENTARY

Reading this chapter led me to reflect on the role of occupation in my own experience of mental illness and recovery during adolescence. It also led me to consider the applicability of diagnostic criteria to this age group and the different ways in which mental health conditions can present.

Can diagnostic criteria be readily applied to individuals who are still developing? With the apparent emphasis on such criteria in decision-making and care-planning, may this lead to some individuals not receiving the appropriate support? Guidelines are helpful, but the individual's perspective on their situation and what has changed, carries a wealth of information in this age group. When I first approached my GP with anorexia, my behaviours, beliefs and views about myself were all affected. However, I hadn't lost sufficient weight to meet the full diagnostic criteria. Intervention at this point may have helped to limit the embeddedness of certain unhelpful behaviours, beliefs and rituals.

Similarly, I wonder if a focus on observable change in behaviours and attitudes is more relevant than looking for specific signs and symptoms when identifying mental health conditions in this age group. While reduced activity needs to be explored, so do areas of over-activity – rather than disengaging and failing at school, my perfectionistic traits meant that I was achieving well academically. Instead of reduced physical activity, I was trapped in a cycle of compulsive exercising. In fact, the times when I was most high-achieving and most active were when my condition was at its worst.

The focus on the impact of mental illness on occupational participation rather than purely assessing symptoms resonates with my experience. My symptoms were important, but of greatest importance was the impact of my condition on my life. While my perfectionism and obsessive-compulsive traits meant that I was writing and re-writing schoolwork, impaired concentration impacted my ability to study. Obsessive exercising and reduced calorie intake meant that I lacked the time and energy to play music. My days became absorbed by food shopping, cooking and checking items. As a result, socializing became impossible and little time was left for what I enjoyed. I was extremely active, but engaging in occupations that were harmful to me.

While occupation paved the route into my illness, it has also been both a means and an end to my recovery. However, re-engaging in occupations that I enjoyed was challenging. My ever-changing role among my school friends and family was hard for both myself and others around me to adjust to. This was a particular issue when considering the developmental stage of my peer group and natural reactions from family members. While I was trying to adapt my behaviours, it felt like others had become used to my 'new' ways and were trying to pre-empt my distress by supporting my safety behaviours. We had adjusted to my illness, but we now had to adjust to my recovery, and it felt like we were unprepared for this.

Reflecting on it now, change seems to be a salient message for this age group. Change in terms of how an individual is feeling and what they're doing; in terms of their occupational balance and range of activities, and in terms of recovery and the process of change for both the individual, their family and their friends.

Sarah Marley

26 LEARNING DISABILITIES

JANE GOODMAN ■ WENDY WRIGHT

CHAPTER CONTENTS

INTRODUCTION

This chapter provides an overview of current practice in the area of learning disability in the UK. It sets this practice in its historical context, outlines key aspects of service philosophy and explores the changing role of the occupational therapist. It also examines the occupational therapy process, using illustrative case studies, and the reader is directed to additional resources to explore certain issues in more depth.

An Overview of Learning Disability Practice in the UK

People with learning disabilities and those with mental health difficulties were confined in the same institutions in the past. There is, therefore, a shared history of societal stigma, discrimination and segregation. This has led to confusion about the differences between the two service user groups and about how to provide appropriate support (Thomas and Woods 2003).

In recent years distinctions between the two groups have become much clearer. In contrast to mental health problems (which usually develop after childhood, may be temporary, and change over time), learning disabilities are characterized by significant impairment in intellectual and social functioning with an onset before adulthood and with lifelong impact (Debenham 2010). Pressure from service user groups, combined with government guidelines has led to the development of

more individualized services (DH 2001a). However, reviews of the implementation of the Valuing People White Paper (DH 2009a) highlighted the need for further work to ensure that all people have individual care plans and can access relevant support services regarding their general health, housing, employment, finance and education. The needs of carers and older people are addressed also.

In addition to broad changes in health and social care provision – such as integrated service provision, generic working and social enterprises (Her Majesty's Government 2007; Darzi 2008) – learning disability practice has been influenced by cases of service failures, such as in Cornwall Health Trust (Commission for Healthcare Audit and Inspection 2006) and in Bristol, at Winterbourne View (Care Quality Commission 2011). These cases raised issues about the welfare of service users, including safeguarding from abuse, response to medical needs, and the training and supervision of staff. It is therefore essential that practitioners keep abreast of practice developments and maintain high-quality services that address the full range of service users' diverse needs.

Furthermore, there is an increased prevalence of mental health problems among people with learning disabilities (About Learning Disabilities 2011). This requires an understanding of different approaches to mental health problems, particularly in terms of the impact that an individual's learning disability will have on their communication, behaviour and daily occupations.

Defining Terms

The term *learning disabilities* is in common use in the UK (replacing the term mental handicap) in policy documents (Emerson and Heslop 2010). However, there is no universally accepted term and *learning difficulties* is often favoured by service user groups. This should not be confused with specific learning difficulties experienced by children with medical, emotional or behavioural needs who do not have intellectual impairment (Warnock 1978; Holland 2011).

The Department of Health defines learning disability as 'the presence of:

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- a reduced ability to cope independently (impaired social functioning);
- which started before adulthood, with a lasting effect on development'.

(DH 2001a, p. 14).

This definition encompasses a wide range of needs and abilities. Individuals with mild learning disabilities may lead independent lives, while those with moderate or profound disabilities will need extra support with communication, mobility and/or personal care, and may be regarded as vulnerable adults. The mini case studies presented in Case study 26-1 give an indication of the range of learning disabilities.

CASE STUDY 26-1

Mini Case Studies Illustrating the Range of Learning Disabilities

JOHN

John (46 years) has mild learning disabilities and lives in a housing association flat. He performs his own domestic and daily living tasks and a support worker helps him with budgeting and home management strategies. John works part-time as a waiter. He has a good social life and visits friends regularly. He values his independence highly.

MARY

Mary (32 years) has moderate learning disabilities and lives alone in a privately rented flat. She is independent in personal care but has daily support to manage domestic activities, budgeting and travel. She works part-time in sheltered employment and attends a cookery course at college. Mary enjoys her independence and has the right level of support for her needs.

FREDA

Freda (23 years) has profound and multiple disabilities, including developmental delay and cerebral palsy. Freda recently moved into a residential home, receives 24-hour care and is dependent on carers for all personal care, mobility and daily activities. With support from the occupational therapist and carers, she participates in social outings, swimming and sensory and creative activities. She attends a local authority day centre 3 days per week.

In practice, the terms 'learning difficulty' and 'learning disability' are often used interchangeably (Emerson and Heslop 2010) and other terms such as *intellectual disability* or *developmental disability* may also be used. People with learning disabilities represent about 2% of the UK population, although differences in definition and data collection mean this is an approximation (Allgar et al. 2008).

The terms *autistic* or *autism* are also found in this field to describe people with '… a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them' (National Autistic Society 2011a). The term *autistic spectrum disorder* recognizes that autism may affect people in different ways. Some people with autism are able to live relatively independent lives but others may have accompanying learning disabilities (National Autistic Society 2011a). People with either of these diagnoses generally come under the umbrella of learning disability services while those with a diagnosis of *Asperger* (or *Asperger's*) *syndrome* (National Autistic Society 2011b) do not.

Historically, definitions of learning disability have been based on individual factors such as educational ability, IQ, social functioning or adaptability, and the prevailing sociological, psychological, medical, anthropological theories of the time (Gates et al. 2007). Gates et al. (2007) argued that '… no single criterion is likely to provide a definitive answer' (p. 4) to the challenge of defining learning disability and it is now recognized that a combination of factors (combined with the time of onset) should inform diagnosis (Holland 2011) and needs assessment.

The terms 'mental impairment' and 'severe mental impairment' are used within the Mental Health Act (DH 1983), the benefits system, and the Criminal Justice system. These have a specific legal meaning and should not be confused with the needs of the general learning disabilities population (Northfield 2004).

In addition to their learning disability, some people also experience mental health problems, physical and sensory disabilities, and a higher incidence of health problems such as heart conditions, diabetes and epilepsy. Despite the commitment to ensure equality of provision in Valuing People (DH 2001a) there remains a shortfall in relevant services for people with a learning disability, combined with poor access and lower uptake (Ouellette-Kuntz 2005; Krahn et al. 2006). Consequently, Allgar et al. (2008) noted that health outcomes are poorer compared with the general population and recommended the early identification of such problems in primary care and the development of preventative strategies including health checks.

Causes of Learning Disabilities

For a significant proportion of the population (about 50% of those with a mild learning disability and 25% of those with a moderate to profound disability), there is no known single cause of learning disability (Holland 2011). However, recognized causes include genetic conditions (such as tuberous sclerosis and Hurler syndrome) and chromosomal abnormalities such as Down (or Down's) syndrome (Watson 2007). Additional contributory factors include birth trauma, premature birth, early childhood/maternal infections and environmental factors such as the effects of drugs, alcohol, or the effects of poor socioeconomic conditions such as malnutrition or social deprivation. Watson (2007) suggested that an understanding of the stage at which the learning disability occurred and potential causative factors is essential in working holistically with service users.

Increased access to genetic testing, pre-natal care and medical advances mean that more advice and support (such as genetic counselling) are now available for parents. While this helps in identifying potential risk factors when planning interventions (Watson 2007), these developments inevitably raise moral and ethical dilemmas for those making decisions (Holloway 2007).

Whatever the cause of an individual's learning disability, it is important to distinguish between the impact this has and the influence of additional health issues. Identified needs can then be appropriately addressed rather than automatically attributing them all to the individual's learning disability.

CARING FOR PEOPLE WITH LEARNING DISABILITIES

A Historical Perspective

Historically, the segregation and stigmatization of people with learning disabilities arose from a societal view that they were, at various times, a possible threat to the gene pool, uneducable and/or unemployable

or 'medical cases' requiring treatment (Grant and Ramcharan 2005). These views still have an influence to some extent today, in terms of negative societal attitudes and poor access to services.

Institutional Care

From the end of the 19th century and for much of the 20th century, custodial care was a key feature of services for people with learning disabilities. It was a politically and socially determined phenomenon that paid scant attention to the views of service users (Carpenter 2002; Atherton 2007; and see Ch. 1 for the history of institutional care). In response to recommendations in the 1913 Mental Deficiency Act, residents were drawn from '… Victorian Asylums, hospitals and poor houses, as well as from the streets, workplaces and family homes' (Fitzpatrick 2011, p. 486). Self-sufficiency in institutions emphasized education, work, leisure and medical treatment (Carpenter 2002; Atherton 2007). The strong work ethic found many residents working in the kitchen, laundry, industrial workshops and gardens to serve the institution's residents and staff. Children were often admitted to custodial care to protect them and the community from the presumed impact of their mental deficiency, such as irregular school attendance (Carpenter 2002).

While early legislation provided for community resettlement, in practice, institutional care was lifelong for many people. This shift in ideology can be attributed to a number of causes, notably 'the eugenics movement and the development of a standardised instrument to measure intelligence' (Goodman et al. 2009, p. 24), fuelling the view that people with a low IQ had a permanent disability. Legislation in the early 20th century outlined how people (who were considered 'mental defectives') should be detained in institutional care. The result was a significant increase in admissions to long-stay hospitals, which was to last until the Mental Health Act of 1959, when compulsory detention was removed in favour of informal admissions. Research studies in the 1950s criticized the notion that IQ was the only measure of a person's ability and discovered that rehabilitative activities and training improved the potential for learning (Goodman et al. 2009). However, it was not until much later in the 20th century that community care was developed. Case study 26-2 provides an illustration of institutional living.

CASE STUDY 26-2

A Case Study of Institutional Living

Harold (75 years) lived in a hospital for people with learning disabilities, for most of his adult life. On admission, at 17, he was described as being of low intelligence and vulnerable to abuse, and the hospital was to provide care and protection. Harold worked in the carpentry workshop, making and repairing furniture. While Harold had a network of friends among the staff and residents, opportunities for independence and personal space were limited. Meals, clothing and social activities were institutionally provided.

QUESTIONS TO CONSIDER:

- Why were many people with learning disabilities committed into institutions for much of the 20th century?
- What is the likely impact of institutional living on the individual's health, work and relationships?
- What things might people have valued about living in the institution?
- What are the ongoing influences of the institution on peoples' lives once they left it?

From the early 20th century, 'occupational therapists' are mentioned in the literature about institutions, although initially such 'therapists' were untrained staff. Changes in philosophy (from self-sufficiency to therapy) and loss of land in the 1950s, saw a gradual increase in the provision of educational and creative activities such as rug-making, basketry, woodwork, gardening and stool seating, alongside traditional industrial and workshop activities (Carpenter 2002):

> *With the loss of the fields and farming, the main day-time activity of the inpatients was in Industrial Therapy and Occupational Therapy. An occupational therapist … was the first person employed and came to manage the Industrial Therapy as well as the Occupational Therapy department.*
>
> ***(Carpenter 2002, p. 119).***

For many people, occupational therapy provided structure to their week. It was often regarded as

work and was highly valued as the day-time occupation away from the ward. The therapeutic activities were graded to increase skill levels and were chosen for their physical, social and cognitive benefits. However, there was limited scope for individuals to engage in activities focused on increasing their independence.

Resettlement and Community Care

Since the latter part of the 20th century there has been a move away from institutional care towards community living. While the underlying philosophies associated with this shift have made a significant difference to peoples' lives, the long-term impact of institutional life left many people ill-prepared for community living.

Although key policies in the 1950s had mentioned community care options and the 1971 White Paper advocated a reduction in hospital beds and increased provision in the community (DHSS 1971), it was not until the 1980s and 1990s that resettlement programmes became fully developed (DH 1990). Multiprofessional resettlement teams coordinated the resettlement process with occupational therapists playing a key role in assessing individuals and assisting the development of skills for living in a range of accommodation types, such as small supported group homes, core and cluster services, and smaller institutions. Approaches to resettlement varied; encompassing help given to people within the institution *before* moving to the community, and providing support once a move had been made (Values into Action 1994). Case study 26-3 provides an example of resettlement.

Community Learning Disability Teams

Alongside the closure of hospital services Community Learning Disabilities Teams (CLDTs) provided a coordinated and planned local service for people with learning disabilities (Goodman et al. 2009), including those who were already living in the community and later those who were resettled. These teams were jointly coordinated between health and social care services and were multidisciplinary, comprising social workers, community nurses, occupational therapists and other professions. CLDTs remain the main point of access to health and social care services up to the present.

CASE STUDY 26-3

An Example of Resettlement

Lucy (52 years) was resettled into the community in 1995. She lives in a small group home with six other residents. At first, she found it difficult to settle. Lucy missed the freedom and space of the hospital and contact with friends. She felt isolated, confined by the small space and scared to go out. However, in her new home, she likes having her own room and more involvement in decisions about her food, clothes and activities.

Now, she has a good circle of local friends and enjoys her own roles within the home. She is learning cookery at college and travels independently to do shopping or visit her family.

QUESTIONS TO CONSIDER:

- What are the benefits and disadvantages of living in a small group home for service users, staff and the community?
- How could some of the disadvantages be overcome?

Today, the role of the occupational therapist is central in the CLDT in providing specialized interventions, advice and education, and in contributing to generic team roles such as care co-ordination and person-centred planning (Lilywhite and Haines 2010). CLDTs work in close harmony with housing provision, day services, generic health services and social care providers.

Changes in Philosophy

Only in the latter part of the 20th century have people, through their own efforts and through changes in the philosophical approach to service provision, become more valued as self-determining individuals and considered as 'people first'; capable of making a valid contribution to society. In the UK, legislation such as Valuing People (DH 2001a) and parliamentary attempts to change attitudes through bills such as the Disabled Persons (Independent living) Bill (UK Parliament 2006) have highlighted the needs and rights of people with learning disabilities to lead more self-determining and fulfilling lives in the community (Goodman et al. 2009).

Nirje and Wolfensberger's ideology of 'normalization' has been influential in this respect (Nirje 1969; Wolfensberger 1972). It advocates for the right of people with learning disabilities to experience 'normal' patterns and developmental stages in life and to make valued contributions to society. The more recent developments in this field have been termed social role valorization to emphasize the importance of recognizing what is socially valued in society. These ideals are reflected in the influential work of O'Brien (1987) who established five principles on which contemporary learning disability services should be based: community presence, respect, community participation, competence and choice.

Generally, there has been a shift away from a *medicalized* view of people with learning disabilities – which focussed on aspects of individuals' health and behaviour that could be changed for the benefit of the wider community, often without the individual's consent (Goodman et al. 2009) – towards a *social model*, which considers the extent to which society enables or prevents an individual from leading a full life. This emphasizes practitioners' role as *enablers*, maximizing individual's engagement with life opportunities.

The Contemporary Practice Context

The key influential legislation in the early part of the 21st century has been the Valuing People White Paper (DH 2001a) and Valuing People Now (DH 2009a). The principles espoused in these documents represent a concerted effort to design services that are based on individuals' needs and also to provide funding and implementation guidance, aiming to do this in partnership with service users and their support networks at all levels of service.

Collaborating in service provision in meaningful and positive ways requires a change in attitude and a move towards shared power and control. This includes providing accessible information, advocacy (and supporting self-advocacy) and appropriate levels of support (Parry and Jones 2009). The work of People First, an international self-advocacy organization, is committed to achieving this (see Case study 26-4 and Useful resources at the end of the chapter).

CASE STUDY 26-4

A Case Study of a People First Group

Anthony (37 years) is an active member of a People First group. He attends meetings to discuss how to help individuals become more involved in decisions about their care. Anthony often gives talks about his life experiences in the community. He also belongs to a men-only, self-help group, which organizes trips and leisure activities. Anthony met his girlfriend through the 'Stars in the Sky' dating service at their local centre.

QUESTIONS TO CONSIDER:

- What issues are associated with supporting people with learning disabilities in their relationships?
- How might you set about enabling people to be fully involved in service development?

The Valuing People White Paper (DH 2001a) addressed four key areas: choice, independence, inclusion and rights. These permeate all aspects of a person's life, including housing, employment, health, relationships, day services and education. It urged implementation through partnership boards and tools, such as person-centred planning and Health Action Plans to enable individuals to enjoy greater self-determination in their lives (DH 2001a, b). In addition to these changes, more attention is now paid to involving service users in recruitment, service user forums for planning and evaluation of services, staff training and development, and advocacy support for the individual.

Person-Centred Planning

Person-centred planning is 'a way for people with learning disabilities to plan for what they want now and in the future, with the people in their lives who they like and trust' (Kirklees Council 2008). This process makes use of planning tools such as MAP (Making Action Plans) and PATH (Planning Alternative Tomorrows with Hope) (O'Brien et al. 2010), to help the person engage fully with their plan, emphasizing their strengths and abilities and enlisting support from family and friends.

Health Action Plans aim to enable an individual to get the support they need to lead a healthy life. They can be developed by the individual or with a health facilitator such as their carer, healthcare worker or GP. The plan is personal to the individual and contains information about their mental and physical health needs, medication and health contacts. With the individual's consent, it can be shown to others in order to provide appropriate help or advice. Plans may be in pictorial, digital or electronic formats to suit the individual (DH 2007a).

Valuing People Now (DH 2009a) reported good practice and significant change for many people but also highlighted that there was still work to be done to ensure that everyone had appropriately planned access to services. The Care Planning Approach (CPA) ensures that the service user is always at the centre of their care, while the Triangle of Care approach is aimed at improving partnership working between service users, staff and carers (National Mental Health Development Unit et al. 2009), to ensure equal involvement in planning care and working towards recovery (Mental Health Foundation 2012).

Although, in a minority of cases, institutional care (albeit in smaller-scale 'institutions') still exists for some people, it is very different to the resettlement provision in the 1980s and 1990s, with a growing emphasis on personalized, supported accommodation. There has also been better integration across health and social care and an increasing role for third-sector organizations in the provision of housing and day services over the past 10 years. Recent innovations include the transformation of some services into social enterprises, with the aim of increasing productivity, quality of care and job satisfaction (DH 2012).

Changes in the funding of service provision are also a feature of the current practice context. For example, by using Direct Payments (DH 1997) local authorities have more flexibility in providing individuals with funding to purchase individualized packages of care (such as day care placement or a support worker), although local differences and slow take-up have been noted (Ryan 1999; Samuel 2011).

OCCUPATIONAL THERAPY AND LEARNING DISABILITY

Occupational therapists 'have wide roles supporting engagement in occupation and promoting independence and community participation' (Lilywhite and Haines 2010, p. 1), as well as advocating on service users' behalf to ensure they are central in the care-planning process. As with other professions, the occupational therapist's role is rapidly changing. Generic or extended roles, such as that of care manager, key worker or trainer are often balanced with the specialist role addressing the impact of the person's learning disability on their daily occupations.

Although there is an increasing demand for assessment rather than direct intervention (Lilywhite and Haines 2010), occupational therapists continue to use their specialist skills in negotiating with the individual to prioritize needs, targeting assessment and intervention in these areas, and working as part of the wider inter-agency and multidisciplinary team to do this. In many cases, this includes implementing interventions through others by training and advising carers or other professionals, enabling them to support the person in their day-to-day environment.

Interventions may focus on providing opportunities to engage in new occupations or to develop skills in using public transport, home management, or using community resources; the overall emphasis being to increase independence. Enabling service users and their carers to implement strategies for managing sensory processing and physical challenges within daily life is a major role also.

A feature of occupational therapy is often long-term intervention across a person's lifespan, including a key role in supporting people with complex needs and at times of transition in their lives (Lilywhite and Haines 2010). In this regard, therapists are often challenged to use the whole breadth of knowledge and skills related to both physical and mental health. Occupational deprivation and the limited opportunities to engage in socially accepted roles, relationships and communities strongly influence occupational therapy interventions in this field.

Referral

People can refer themselves or be referred by another person (such as a carer, professional or family member) as part of an individualized person-centred plan.

Most referrals are made to the CLDT and the occupational therapist will determine which aspects of the referral require their assessment and/or intervention. Access to inpatient or generic (mental health, primary care or older adults) services may be gained by direct referral through the individual's GP or following a CLDT referral.

Referrals are screened to establish suitability, level of priority, funding agreements, the need for CLDT coordination, and whether an inpatient bed is required.

Consent

The issue of consent to intervention can be complex. It may involve consideration of reduced mental capacity and additional communication difficulties. An understanding of the implications of The Mental Capacity Act (DH 2005) is essential, particularly within inpatient settings, where individuals may refuse admission or interventions. Deprivation of Liberties assessments may be put into place if the person is assessed as not having the capacity to make decisions about their treatment (Ministry of Justice 2008).

Establishing how best to communicate with the person may be a necessary precursor to discussions about consent. Visual aids and objects of reference may be used to ensure that the person understands the type and purpose of interventions being suggested. For those without capacity to consent to interventions in inpatient services a 'Best Interests' meeting may be convened to make a decision on their behalf (DH 2005). Case study 26-5 gives an example of a complex consent issue.

The Department of Health (2001c) advises people with learning disabilities to consider key questions (What do you want to do? How will it benefit you? What will it feel like? What might go wrong?), before giving consent, and to seek clarification if they do not understand. In practice, someone else may need to advocate for the person to answer these questions.

CASE STUDY 26-5

An Example of a Complex Consent Issue

Carol (23 years) has Down syndrome and does not speak. She lives in a residential home. She keeps crying and holding her face. She probably needs to go to the dentist, but she always gets distressed when she needs to go.

QUESTIONS TO CONSIDER:

- How could you check that she is crying because her tooth hurts?
- What could you do to help her to understand what the dentist will do?
- How will you know if she agrees to go?
- What are the implications if she does not go?
- Who should make the decision?

Risk Assessment and Risk Management

Risk assessments may be specific to the occupational therapy interventions or be generic across the interprofessional team. An example of an occupational therapy risk assessment for an ADL kitchen is shown in Table 26-1. Specific risk assessment procedures may be applied within inpatient services and in relation to treatment under the Mental Health or Mental Capacity Acts (DH 1983, 2005, 2007c).

Assessment

To establish a baseline of functioning and to prioritize occupational therapy interventions, information is gathered from the service user through formal interview(s) and informal conversation. Accessing previous records and discussion with family, friends and carers are also important sources of information.

Within inpatient settings, after an initial period of observation and information gathering, a formulation meeting may be organized (including carers, relatives and professionals), to ensure that the information is accurate, comprehensive and conducive to needs-led care planning (AWP 2012). The process should take into account communication needs and offer people with learning disabilities an equal opportunity to access and understand information about their care.

Following initial information gathering, other formal, standardized or observational assessments will be made. Observing the individual engaging in ordinary occupations in a familiar environment (without the need to communicate complex assessment instructions) can provide useful information. Although these informal, observational assessments have been criticized in the past for lack of objectivity or standardization, it remains one of the most common assessment methods

TABLE 26-1

Considerations and Strategies for Using a Therapy Kitchen

Potential Risk	Service User Considerations	Risk Reduction Strategies	Benefits of the Activity Outweigh the Risks? Y/N	Level of Support Needed?
Mobility	Physical disability affecting walking or standing? Any mobility aids?	Is a walking stick or perching stool, etc. needed?		Level 1 Independent if staff are within sight Level 2 Independent if staff are in the kitchen to support and advise Level 3 Staff support, guidance, practical assistance is needed Level 4 High level of staff support to ensure task completed safely
Sensory	Hearing/sight problems? Taste/touch/smell problems?	Ensure glasses/hearing aid are worn if needed, room is well lit, reduce noise levels, etc.		
Physical health	Any physical health problems/ special dietary requirements? (diabetes, coeliac disease, cultural needs, etc.)	Ensure suitable options available, support use, etc.		
Fine motor skills	Any difficulties with grip/ dexterity/tremor, etc?	Provide special equipment if needed		
Mental health	Any evidence of delusions, hallucinations, confusion, suicidal intent or ideation? Do they self-harm?	Identify risk management strategies and responsibilities		
Challenging behaviour	Any history of using weapons? Do they move quickly from baseline to crisis? Any known triggers?	Identify risk management strategies and responsibilities		
Other risks	Any other potential risks?			

used (Goodman and Locke 2009), partially due to the difficulties in establishing and comparing norm-referenced data for this service user group (Hong et al. 2000; Fisher 2001). Communication difficulties, sensory impairments and/or a limited emotional vocabulary to describe feelings and experiences may also limit the scope of more formal assessment methods.

Accurate, structured recording of the information is essential. An interest or observation checklist may be used, or a hospital passport (a document providing essential health information to inform professionals prior to interventions being undertaken) (Easy Health 2012). It is important that all documentation is in a format that is accessible to the individual and may include pictures, clear language and digital formats.

Formal or standardized procedures are also used to provide objective and validated outcome measurements, as long as they take into account the specific communication and learning needs of the individual (Goodman and Locke 2009). Generally, it is most important to choose assessment tools that are relevant to the individual and their context, are reliable, and measure what they set out to measure (Carnaby 2004).

Formal Assessment

The full range of standardized assessments available to occupational therapists may be used when assessing the needs of people with learning disabilities, such as the Canadian Occupational Performance Measure (COPM) (Law et al. 2005), the Model of Human Occupation Screening Tool (MOHOST) (Parkinson et al. 2006), and the Assessment of Motor and Process Skills (AMPS) (Fisher 2006). Additionally, a number of sensory processing assessments and mental health assessments are available.

The choice of assessment tool may be informed by the responsiveness of the service user, the adaptability of the tool, and the accuracy of information provided. In making

adaptations to standardized assessments (to increase their accessibility for people with learning disabilities), care should be taken to ensure that it does not adversely affect the scoring of the assessment or impact on the results.

The AMPS assessment tool is widely used, particularly with service users who are able to actively engage in the interview process and select and perform familiar tasks. Where an individual's learning disability limits their communication, or independent living skills, or increases their need for support from others, the occupational therapist may discreetly observe their performance of familiar daily living tasks (such as, by joining them for a meal or assisting with dressing). These observations can be scored and entered as data to formulate an AMPS assessment in the usual way.

The Canadian Occupational Performance Measure (COPM) is described by its designers as being adaptable to meet the particular communication needs of the service user (Law et al. 2005). This could include modifying interview techniques, altering the language used or (instead of using numerical scoring) using emoticons.

Planning

Intervention planning involves activity analysis, grading and adjusting levels of support as in other fields of occupational therapy. However, risk assessment should also include positive risk management plans to ensure that opportunities exist for the person to learn through experience (Lilywhite and Haines 2010).

At this stage, occupational therapists are concerned with exploring 'the options available to meet client goals, their own tools and processes for implementation, and most importantly how they can work in collaboration with the client' (Goodman and Locke 2009, p. 54). A key consideration may be the training and ongoing support of carers or support workers who implement plans on a daily basis in familiar environments.

Choice of relevant outcome measures should also be made at this stage, to ensure that all are clear about how progress will be measured and what, it is anticipated, will have changed as a result of interventions.

Intervention

Lilywhite and Haines (2010) identified several broad intervention areas in learning disability practice including: working with challenging behaviour; addressing sensory processing needs; work and employment; skills development; addressing profound, multiple and complex needs; and parenting. Occupational therapists often become involved with people at times of transition such as from school to work, after bereavement, when leaving home, or when becoming a parent. At these times of change the experiences of people with learning disabilities are often different to those in the general population. Many individuals will have experienced institutional care, where making these transitions was less of an issue. Now, as the majority of people with learning disabilities live at home, moving away from family may pose additional economic and social pressures arising from societal stigma and low expectations, the lack of suitable resources, and limited opportunities to take up independent roles (Hurst 2009a). Occupational therapists enable the service user and their carers to identify specific occupations, roles and skills that can be developed or need to be supported in the new environment. Environmental adaptation or preparation will be a key role, as will be implementing strategies for emotional support.

Occupational therapists have traditionally had a significant role in relation to work and employment for people with learning disabilities and continue to do so, as advocated in Valuing Employment Now (DH 2009b); though there are regional variations and some uncertainty about how occupational therapy should link with specialist employment services. Nevertheless, occupational therapists are well-equipped 'to identify people's abilities and support needs in order to enable accurate job matching, job adaptation and grading of activities within the work environment' (Lilywhite and Haines 2010, p. 26). This role, therefore, includes enabling people to gain work skills and adapting working environments.

Within mental health services, specific interventions may include individual or group activities focussing on self-esteem and self-confidence, restoring work–life balance, relaxation and anxiety management, anger management, sensory integration and support in developing a recovery/wellness plan.

Choosing meaningful occupations as therapeutic media may include the provision of opportunities for new or alternative life experiences that enable the person to make informed choices about their life. Choosing socially acceptable occupations that enhance dignity, are age-appropriate and which promote independence and self-esteem, is essential if people are to engage with therapy (Hurst et al. 2009).

Evaluation/Outcome Measures

There is now an increased emphasis on evaluation against agreed criteria, to ensure that both individual and service goals are achieved, and that professionals' time is used effectively. Local requirements for generic outcome measures are variable however, and there is some evidence to suggest the use of goal-setting/review and individualized outcome measures, such as the Support Planning Outcome Tool (SPOT), are becoming preferred methods within this field (Young and Chesson 2006; Turning Point 2009). Occupational therapists can respond by ensuring that profession-specific measures are used to demonstrate the impact of their interventions on meeting service users' needs.

Discharge

This stage may require that information is passed on to relevant people in the service user's daily life and is recorded in personal plans. Referral to other services may also be needed and work with carers may enable service users to make transitions to different services. Information gathered at this stage may also be used to support funding applications and packages of care.

SPECIALIST AREAS OF INTERVENTION

The rest of this chapter considers occupational therapists' roles in four specialist areas: mental health and learning disabilities; challenging behaviour; working with sensory processing needs; and older people with learning disabilities. This is followed by consideration of several emergent areas of practice. Other areas of intervention mentioned earlier in this chapter can be followed up using the further reading recommendations at the end of the chapter.

It should be noted that where the primary problem is not the learning disability itself, occupational therapists may work jointly with therapists in mainstream services to ensure that accessible intervention plans are created. This includes acute inpatient admissions to physical or psychiatric services. To aid this process, many general hospitals now have a learning disability liaison nurse, who will ensure that services are tailored to individual need and that information is provided in an accessible format.

Mental Health and Learning Disabilities: 'Dual Diagnosis'

In mental health services, 'dual diagnosis' usually refers to the co-existence of a mental health problem and substance misuse (DH 2006). In learning disability services, the term is more often used to describe the co-existence of a mental health problem and learning disability (Bernal and Hollins 1995). An example of dual diagnosis is presented in Case study 26-6.

There is much debate as to the exact causes of the increased incidence of mental health problems among people with learning disabilities (Watson 2007). Social exclusion and stigma (including increased vulnerability to attacks and abuse) may be factors. Also, some learning disability syndromes (such as velocardiofacial syndrome, Williams syndrome, fragile X syndrome, Down syndrome and Autistic Spectrum Disorder) carry an increased risk of developing concurrent mental health problems (Watson 2007).

Additionally, people with learning disabilities may be unable to adequately communicate their feelings, leading to misdiagnosis or further difficulties. They may already exhibit challenging behaviour, and further

CASE STUDY 26-6

An Example of Dual Diagnosis

Laura (33 years) has mild learning disabilities and is autistic. She lives in her own flat and, until recently, worked as a cleaner in an office. She was sacked for frequent lateness, and was arrested for shoplifting and assaulting a police officer.

Her family referred her to the CLDT, as they were worried about the changes in her behaviour. During a home visit, lots of empty cider bottles were noticed in her bin and her hands were trembling when she made drinks.

QUESTIONS TO CONSIDER:

- What might explain the changes in Laura's behaviour?
- What questions might you ask her to explore your suspicions?
- What should the police consider when arresting a person who may have learning disabilities?

negative changes in behaviour may be overlooked or misunderstood as a result.

People with learning disabilities may experience mental health problems in 'episodes' which can vary in severity and length of time, or their problem may be enduring. Often the symptoms and underlying causes can be treated with medication or other interventions, such as psychological help, as in the general population. However, where it is inappropriate for the individual to access generic mental health services, they may be admitted to a mental health unit for people who have learning disabilities. The staff here (which includes occupational therapists) will have training in, and experience of working with, both mental health difficulties and learning disability and will offer support and assessment on a 24-hour basis through a multidisciplinary team, while maintaining links with the CLDT.

Where the person does not have a Health Action Plan (DH 2007a), they will be supported to develop this during their admission. The inpatient occupational therapist will carry out assessments and interventions using individual and/or group activities focussed (typically) on independent living skills, personal activities of daily living, social skills and anxiety management. Advice to family and carers on how the individual may be supported to manage their own mental health is also important.

Inpatient services may also provide longer-term admissions for rehabilitation or to provide a 'step down' service for people who have moved back to the locality from more secure, out-of-area placements. This provides a high level of support, while the individual establishes links with the local community team. Services for people with a learning disability and additional mental health problems follow recovery principles (Mental Health Foundation 2012), as in mainstream mental health services.

Challenging Behaviour

Often, challenging behaviours are a means of communicating distress, illness, frustration or other emotions that the individual may not have the vocabulary to express verbally. Providing accessible information, and giving adequate time and support for the individual to process it and to learn more adaptive ways of communication may be beneficial, in addition to advising carers on strategies to support the individual (DH 2007b).

A significant change in presentation, including self-injury or an increase in violence and aggression, may be indicative of an individual's changing needs (see Case study 26-7). This could include a physical or mental health problem, communication difficulties, social needs (including placement, work–life balance or relationship issues), or difficulty in processing sensory information. In these situations, individualized assessments and intervention plans are essential. Occupational therapists may carry out a sensory processing assessment to identify what the person is communicating through their behaviour or what function it serves, and to help them identify more adaptive ways of expressing or meeting this need.

Interventions include sensory processing/integration techniques or identifying meaningful activities to provide roles and structure for the individual. Therapists will help the individual and those supporting them to identify triggers, indicators of arousal and strategies to manage difficult situations. Observation of everyday activities and assessment of individual or group sessions will contribute to the multidisciplinary assessment and the development of a support package for the individual aimed at reducing the intensity and frequency of the challenging behaviours.

If an individual exhibits a consistent level and type of challenging behaviour over a number of years, an individualized placement may be appropriate in a

CASE STUDY 26-7

An Example of a Person's Challenging Behaviours

James (34 years) lives with his elderly parents. He has profound learning disabilities and distinctive patterns of obsessive behaviour. He recently lost his day centre placement due to increased aggressive, destructive and self-injurious behaviours. He has been referred to the CLDT for a full assessment of his needs.

QUESTIONS TO CONSIDER:

- What might have led to a change in James' behaviour?
- How would you go about assessing him?
- Who would you speak to, to find out more?
- What interventions might you offer?

setting where the accommodation, skill mix, experience and staffing levels are designed to meet their needs. Occupational therapists can advise on the appropriate type and balance of daytime activities, and on environmental and support needs for the individual.

Sensory Processing Needs

An increasingly high number of referrals for occupational therapy are for people who have sensory processing difficulties, which impact on their behaviour and their ability to engage fully with everyday occupations. This includes people presenting with challenging behaviours, Autistic Spectrum Disorder and those with profound and multiple disabilities.

Managing the complex and often conflicting amounts of sensory information around us (our sensory diet) is an essential aspect of day-to-day living. Ordinarily, when we experience too much or too little information for our comfort, we adjust our behaviour or position in order to feel comfortable again. For example, if we feel bored, we may fidget, stretch or yawn; if we are in pain, we will do something to ease or stop it; if we feel restless, we may go for a walk or do something active. Sensory processing needs should be seen in this context.

The senses are usually considered to be touch, hearing, sight, taste and smell but assessments may also explore vestibular and proprioceptive systems, as well as the impact of sensory processing difficulties on an individual's day-to-day life and behaviour.

Some people with learning disabilities find it hard to fully process and make sense of sensory information. They may find some sensations or activities unpleasant (for example, environmental noises such as television or talking, certain smells such as perfume or cooking, or light touch such as showering, or bright lights or different colours). In these situations, people may exhibit strong reactions to these triggers such as withdrawal or aggression (otherwise known as sensory defensive or hyperreactive behaviours). By contrast, some sensations may not be registered at all, prompting extreme behaviours to try to gain extra sensory input (such as self-injurious or destructive behaviours), known as sensory seeking or hyporeactive behaviours (Townsend 2009). Lack of sensory experiences in early life may be a particular issue for people with profound and multiple disabilities, resulting in limited opportunities to engage in daily occupations and the sensory input that this provides.

Occupational therapists combine their knowledge of sensory processing and occupational performance to complete a full sensory processing assessment, which indicates whether an individual has difficulty in processing sensory information from their surroundings and how this impacts on their skills and behaviours. It enables therapists to obtain a baseline of function from which goals can be identified. Interventions can then focus on adapting environments to provide an appropriate level of stimulation or arousal and include a range of activities matched to the individual's sensory needs. The aim is to enable the individual to feel 'just right' in less extreme and more socially acceptable ways. Interventions could include everyday tasks that involve pushing, pulling or lifting; movement activities; graded exposure to different textures, sensations, smells and so on. Lilywhite and Haines (2010) describe, for example, how they modify the environment in order that someone on the autistic spectrum can be, 'in that lovely calm and alert state so they can actively engage rather than being highly aroused or under aroused' (p. 23).

Bundy et al. (2002) describe three elements of sensory integrative work: direct and indirect intervention and consultation. Occupational therapists provide direct interventions through controlled amounts of sensory challenge; often using ordinary occupations – such as hair brushing, washing up, or eating – to provide opportunities for sensory input and social interaction (Townsend 2009). Through indirect interventions a third person (carer or parent) is trained to implement specific activities with an individual. Consultation is used to provide education, information and strategies for understanding the service user differently. (See Case study 26-8.)

Repeating the assessment at intervals will provide a measure of progress and interventions and goals can be modified accordingly.

Older People

Due to advances in healthcare, many people with learning disabilities now have a longer life expectancy (Holland 2000). However, inactive lifestyles and health inequalities mean that life expectancy is still lower than the general population and atypical patterns of ageing are experienced by some (such as increased likelihood of people with Down syndrome developing Alzheimer's disease) (Thompson 2007).

CASE STUDY 26-8

An Example of a Sensory Integration Approach

Yvonne (22 years) has moderate learning disabilities and autism. She lives at home. She likes things to be 'where they belong' and becomes distressed in noisy or busy environments (e.g. shopping trips, or when her sisters play loud games). When distressed, she is aggressive towards herself and the people around her. This has become much worse recently.

A sensory processing assessment indicated that Yvonne is tactile defensive and proprioceptive seeking. To help her family to understand her need to feel safe and in control, various strategies were implemented, including:

- Calling out when approaching Yvonne to let her know that you are coming; knocking on the door; checking that it is OK to go in, etc.
- Planning shopping trips during quieter times or using smaller shops
- Introducing gardening to give Yvonne proprioceptive feedback (digging, pushing the wheelbarrow and cutting the grass).

Introducing these activities and approaches helped Yvonne to become calmer and less aggressive.

QUESTION TO CONSIDER:

- What else could be considered to support Yvonne and her parents?

Consequently, in addition to their learning disability, individuals may also need support to cope with changes in their physical or mental wellbeing as they get older. The impact of these changes on their daily routines, home life and support networks can be significant. Communication difficulties or other behaviours may mask the ageing process and therefore impede diagnosis. Occupational therapists and others who know the person well, will play a role in observing changes in behaviour, personality or emotions that may be indicators of deterioration in physical or mental health (Hurst 2009a). Providing additional support for hospital admissions, moving home, coping with bereavements, life-limiting illness and diminishing networks of support, are all areas that may impact differently on people with learning disabilities compared with the general population.

While accessing generic services is encouraged, some people will require integrated or specialist services that continue to address their learning disabilities. The National Service Framework for Older People (DH 2001d) clarifies the need to balance issues attributable to their learning disability and those due to ageing; ensuring that, where relevant, person-centred plans are linked to services for older people.

Occupational therapy assessment and intervention focusses on identifying the impact of changes on the person's daily life, including the individual's ability to remain (with support, perhaps) in their customary environment. Alternatively, it may indicate ways of supporting transitions to new environments. Bereavement, loss and end-of-life support can be significant areas of concern, particularly as people with learning disabilities have, historically, often been denied opportunities to be involved positively in these aspects of life.

EMERGING AREAS OF PRACTICE

In addition to the practice areas highlighted in this chapter so far, occupational therapists are also working in new developing areas of learning disability practice, such as health promotion, working with parents who have learning disabilities, palliative care and forensic services.

Hurst (2009b) noted that health promotion has a growing impact due to governmental focus on health and wellness and an emphasis on improving health and access to health resources for people with learning disabilities. Occupational therapists may be directly involved in promoting healthier lifestyles through assessment of a person's understanding and skills, with regard to their health needs and enabling them to learn or relearn occupations that will improve their health. Indirectly, they may support the person to develop Health Action Plans or advocate on their behalf to access resources.

Lilywhite and Haines (2010) found that some occupational therapists are supporting parents who have learning disabilities. They emphasize their role in working with the parent but at the same time, work closely with children's services to ensure that child protection systems are in place and that they address, 'the needs of

both vulnerable groups for the best outcome for both sides' (p. 25). The role may involve assessment of specific or generic parenting skills and advocating on their behalf to enable appropriate support to be put in place.

Newer areas of work include contributing to improving access to, and the experience of, palliative care services for people with learning disabilities (Thompson 2007) and working in forensic services with adults with learning disabilities who have been convicted of an offence, or are alleged offenders.

SUMMARY

This chapter has considered the historical and contemporary contexts for working with people with learning disabilities. The role of occupational therapists is interwoven throughout, exploring how specialist and generic issues can be addressed. While in the past, within institutional settings, the role focused on provision of occupation and day services, the current emphasis is on enabling individuals to engage in occupations that promote their independence and contribution to society. This is done in partnership with the service user and their support networks, and often involves directing others to implement interventions within familiar environments. Working as part of wider inter-agency teams is a key feature enabling access to more generic services.

Specific areas of intervention have been outlined and illustrated with case examples. The occupational therapy role continues to develop as service priorities change and the reader is encouraged to use further resources for more detailed information on specific aspects of intervention, services and philosophies.

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USEFUL RESOURCES

The following organizations have useful websites to find out more about the needs of people with learning disabilities:

British Institute of Learning Disabilities. Available at: http://www.bild.org.uk (accessed 01.05.12.).

Foundation for People with Learning Disabilities. Available at: http://www.learningdisabilities.org.uk/ (accessed 01.05.12.).

MENCAP. Available at: http://www.mencap.org.uk (accessed 01.05.12.).

People First. Available at: http://peoplefirstltd.com/ (accessed 12.10.12.).

SERVICE USER COMMENTARY

My name is Eric and I have a learning disability. I live alone in a flat and I have support coming in three times a week. I am quite able, so I've never had to live in the institutions. If I had been there, I think I would have liked the occupational therapy because it is good to have things to do.

I did not find out I even had a learning disability until I was in my 30s. Once they found out I had a learning disability, I got some support, which has helped me. I know there are lots of different words for 'learning disability'; I don't really mind which one people use.

I have lived in different places with different types of support. I lived in a shared house for a while. I had to share a bathroom, which I did not like. I don't like people who make a lot of noise. It suits me to live on my own. I like having things to do. I would really like a job.

I worked with an occupational therapist for about 2 years. She started to see me after I lost my job because I got quite low. I let the housework and washing go. To start with, we just played games and stuff while we got to know one another. After a while, we started working on the housework. She helped me work out how to use the washing machine (it was broken) and then we got a routine for doing the washing and then the ironing. We worked together and she helped motivate me. We also did cooking together; I learnt meals like steak and chips and pork chops. We worked out how I was going to have a better diet.

Since I finished with my OT, I still have some low days but I have yoghurt most days and fruit twice a week. I have bought a new washing machine, mini oven and hoover. I have hot meals now and do my shopping and cleaning unsupported.

I miss my OT now but I think she helped me get on top of things. The things that are written in this chapter are right. I have done standardized assessments and informal ones and I think they are both okay. What I have found helpful is when I am listened to and given control about what happens. I wouldn't like other people deciding things for me.

My advice to occupational therapists is to try to help people with learning disabilities by taking the time to understand them and making sure they understand you.

Eric Seall

27 FORENSIC AND PRISON SERVICES

SHARON McNEILL ■ KATRINA BANNIGAN

CHAPTER CONTENTS

INTRODUCTION

This chapter describes occupational therapy in forensic and prison services, considering risk assessment and team working. Offence-specific interventions will be explored. The chapter ends with a consideration of the challenges occupational therapists face in delivering occupational therapy within forensic and prison services.

Criminal justice systems vary across the world; the system in England and Wales is used as an example because it is the system the authors are familiar with. Anyone working with people with mental health problems in other criminal justice systems across the world will need to take account of the legalities and procedures within the system they are working. For example in the USA, the different states that constitute the USA all have different mental health laws; South Africa has the Mental Health Care Act 2002 and in Japan, there is the Act on Mental Health and Welfare for the Mentally Disabled.

What are Forensic and Prison Services?

Forensic mental health services have evolved over a period of 200 years to accommodate people who had committed an offence but were deemed insane and so not responsible for their actions (Duncan 2008). As a result of cases such as James Hadfield and Daniel McNaughton, legislation was passed to allow the incarceration of mentally disordered offenders and services developed to ensure that the places of incarceration were both therapeutic and secure (Duncan 2008).

The term *forensic* is defined as 'relating to or denoting the application of scientific methods and techniques to the investigation of crime or relating to courts of law' (Soanes 2008). This should not be confused with forensic science, which is about establishment of scientific evidence for courts. Within health and social care, the term forensic is used to refer to working with individuals who are involved with a court of law or criminal justice system, or who are at risk of becoming so, and also have a mental health condition that precludes incarceration in a mainstream prison. It is not safe for these individuals to be admitted to an open ward, so they need to be treated in secure environments. The level of security they require depends on the danger they present to themselves and others (Rutherford and Duggan 2007). A key difference between mainstream mental health services and forensic mental health services is that the offending behaviour which brought the person into the criminal justice system is addressed, as well as their mental health problem(s). For example a man charged with serious assault might have problems with antisocial behaviour, such as violence and aggression, arising from impaired mental health associated with a diagnosis of schizophrenia. His care plan would include medication to ameliorate symptoms of psychosis, such as hallucinations or delusions. It would also include interventions to address his antisocial behaviours, requiring him to engage with social skills development or anger management.

Why are Forensic and Prison Services Needed?

In the UK, the Reed report (Department of Health and Home Office 1992) was a catalyst for reforming of the criminal justice system so that mentally disordered offenders were diverted away from mainstream prisons in order to improve their care and rehabilitation. A sizeable proportion of men and women in prison experience two or more mental health disorders (Ministry of Justice 2009) and prisons are not effective in treating the causes of offending behaviour. The risk to the community posed by many individuals with mental health problems or learning disabilities is outweighed by the risk to them of exploitation by other prisoners. More recently, a 'care not custody' campaign in the UK has led to a national liaison and diversion service for vulnerable offenders to be developed and evaluated.

There are a variety of offences that bring an individual into contact with the criminal justice system: aggression and violence; theft; arson; stalking; harassment; murder; attempted murder; manslaughter or sexual offences, which can include offences towards children, adults or sexual exposure. The services that an individual might receive, and the settings they may eventually be admitted to, depend upon the nature of the offence; for example serious offences would mean that an individual would be admitted to a high-security environment. In some cases, individuals may not have been arrested or charged with an offence, but there is a serious risk of offending, and local services such as mental health teams, police or social services, may have information which suggests the likelihood of offending is significant enough for an individual to require input from a forensic team; this may be community-based.

Labelling and Stigma

Occupational therapy is the term used in this chapter rather than *forensic* occupational therapy, which has been used in previous editions of this text. Forensic settings can make occupational therapy practice more challenging because of the stringent security procedures and legal requirements. However, beyond this, the focus of occupational therapy is no different to other mental health settings. There is a need to avoid additional stigmatization of people in forensic and prison services, who experience the double stigma of being labelled as both mentally ill and a criminal (Thornicroft 2006). The stigma and discrimination faced by many are commonly described as being worse than the direct experience of mental health problems. Media coverage of high-profile cases may make it hard for the general public to understand that many people who have been in contact with forensic and prison services no longer present a danger to themselves or others (Thornicroft 2006). The consequences are that some women entering the prison system will choose not to disclose mental health problems through fear of being stigmatized or being perceived as different (NACRO 2009). It is important that occupational therapists not only avoid

exacerbating the stigma, and the attendant discrimination, but work actively to reduce both.

THE SETTINGS FOR FORENSIC MENTAL SERVICES

Occupational therapists work in a range of forensic settings (Duncan et al. 2003; Craik et al. 2010), including prisons, secure units and with specialities such as personality disorder services (see Ch. 23) or learning disabilities (see Ch. 26). In England and Wales, there are a number of different secure services for the mentally disordered offender; including low secure units, regional secure units, special hospitals, dangerous and severe personality disorder (DSPD) units and prisons. The nature of their services and security vary depending upon who they serve and the levels of risk the individuals pose both to themselves and to others. As the levels of security and risk vary, so does the work the occupational therapist can do within the setting. Tensions can exist between providing the right levels of security for safety and creating an environment conducive to care and treatment. Occupational therapists working in this field need to familiarize themselves with the language of the criminal justice system, for example criminogenic lifestyle; index offence; offending behaviour; public protection; resettlement and security; as well as developing a detailed understanding of the legal framework they will have to practice in. The legal context shapes intervention planning, so that any activity planned does not contravene any legal restrictions. For example, a person may not be allowed, due to a legal restriction from the ministry for justice, to go to certain places such as parks or shopping centres.

Referral to Forensic and Prison Services

Referral criteria for forensic and prison services include details of the mental disorder (usually identified prior to referral by prison teams or diversion teams) and offending history or risk of offending. Referring agencies include:

- Other secure services such as high-, medium- and low-security services including psychiatric intensive care units (PICU)
- Community learning disability teams, community mental health teams, crisis teams
- The criminal justice system including the courts, the probation service, the prison service, Crown Prosecution Service and solicitors
- Multi Agency Public Protection Arrangements
- Social Services departments
- Child and adolescent services
- Youth offending teams.

Many services have assessment teams which include psychiatrists, nurses, occupational therapists, psychologists and social workers. Prior to a referral being accepted, assessment is conducted by the team. Often it can be difficult to clearly identify a person's true presentation and a period of further assessment will be required. Assessment involves information gathering from the individual and their family/support networks as well as from those who are currently providing care and/or support. An effective team approach to assessment will use the team member's specialist professional skills and knowledge, to map out the individual's life and identify what has led to the offences. A formulation will enable the team to identify possible outcomes of treatment pathways. Then a decision will be made about whether to accept the referral. This process may vary in different teams and settings.

Low-Secure Units

Low-secure units can be found within mental health hospital settings or within communities. The individuals who reside within these units may have progressed from medium-secure services and be working towards community reintegration, or they may have come directly from the community or prison services. The low-secure unit will tend to admit individuals who pose a lesser risk to others. The nature of the offences committed does not tend to include serious crimes such as murder. The low-secure unit will still operate security and have locked doors, with levels of restrictions on items allowed such as lighters, sharp items such as razors, and movement between wards/units will still be restricted. Many low-secure units, e.g. PICU, will operate the same environmental levels of security as medium-secure units. However, in low-secure services there may be more movement in and out of the unit, with people having greater community

access. This will be escorted or unescorted, depending on a person's level of risk.

Regional Secure Hospitals (Medium-Secure)

The function of a medium-secure unit is to provide a step down in levels of security from a high-secure setting and provide further access to assessment, treatment and interventions for people who are able to move towards rehabilitation and community integration. In some instances, they will move directly from low-secure services to medium-secure provision, when there is an increase in risk behaviours that cannot be managed within the provision of the low secure service. In other instances, they may be directly admitted to medium-secure provision from prison or from court. The majority of referrals will come from prisons and other secure services. Where referrals come from the prison, a psychiatrist within the prison will have already completed an assessment and a team from the secure service will then complete further assessments to determine the suitability of the secure environment. The medium-secure or regional secure unit operates a high level of relational security (see Box 27-1), where people are observed closely, their movement around the units is restricted by a number of locked doors and access to therapy areas may have to be escorted. To begin with unescorted leave will not be granted in a medium-secure unit.

Daily security checks are carried out by the unit staff. These include:

- Perimeter checks, making sure all windows and doors are not tampered with
- Cutlery counts each meal time, as well as counting kitchen items, including pots and pans
- Entrance and exit checks, making sure that all the doors lock correctly
- Kitchen safety including counting the sharp knives and scissors (usually kept in a locked safe)
- The nurse in charge will count any monies held on the unit in the safe
- Newspapers and magazines will be checked and any content deemed inappropriate will be removed

BOX 27-1

SUMMARY OF LEVEL AND FORMS OF SECURITY

PHYSICAL

Physical security varies according to the level of security but comprises:

- External or perimeter security, e.g. fences or walls
- Entry security, e.g. locked door or airport style security
- Internal security, e.g. locked doors, secure window fittings and personal attack alarms
- Safe design of wards and off-ward activity areas.

PROCEDURAL

Procedural security refers to the various control processes that are regular features of life in secure environments and have been developed to minimize risk of harm to all individuals within the environment. Essentially, there are three components which contribute to procedural security, i.e. control of communications, control of items and control of people.

RELATIONAL

Relational security refers to the importance of the therapeutic relationship for maintaining safety:

- Developing positive therapeutic relationships
- Management of violence and aggression
- Individual responses to therapeutic interventions
- Security intelligence.

'See, Think, Act' is a guide for staff working within secure units to understand relational security and the role that they have to play in ensuring a safe and effective environment (DH 2010). It describes relational security as the knowledge and understanding staff have of a person and the environment and how the knowledge and understanding is translated into appropriate response and care (DH 2010). The guide offers a person-centred model, identifying relevant factors:

- Team – boundaries and therapy
- Other patients – patient mix and patient dynamics
- Inside world – personal world and physical environment
- Outside world – outward connections and visitors.

The aim is for all staff to observe what is going on in the environment, the importance of thinking about what the behaviour observed really means and the importance of acting before something goes wrong.

Based on Duncan (2008).

- Random checks may be carried out to check for any contraband items in bedrooms
- Daily communal areas checks including the courtyards, lounges and any quiet areas.

Other methods are used subtly within the environment to aid safety and security; for example furniture within communal areas may look like regular furniture but be weighted so that it cannot be lifted easily, moved or thrown. Similarly, in the bedrooms, the furniture is fixed to the floor. In many modern units, the fixed furniture has been carefully designed to provide safety and security, while looking homely and comfortable. Many units are designed to have minimal blind spots to make observation easier; in some units, this is achieved using CCTV (closed circuit television). To maintain privacy and dignity, the use of CCTV is usually only in corridors or communal areas and not in bedrooms.

Many medium-secure settings will have designated occupational therapy centres, where the occupational therapist can use activity as a therapeutic tool to enable occupational engagement, promoting choice, developing skills, increasing motivation and working with the individual to realize their potential. Activities may include art and craft, music, computers, wood work, animal care, gardening, adult education, social groups and sports/gym. Security and risk will feature highly in the occupational therapist's intervention planning: items such as knifes, scissors, needles and tools are all required to be counted before and after a person enters or leaves an area.

Special Hospitals (High-Security Hospitals)

Special hospitals, as part of a continuum of mental health provision, provide a therapeutic environment within a maximum-security setting for those people who are deemed dangerous and of sufficient risk to themselves and others to require the high-security setting (Walsh and Ayres 2003). While special hospitals may look like a prison from the outside, inside treatment takes place within a therapeutic environment, focusing on increasing social interaction to avoid withdrawal as well as skills development, through the use of art, education, vocation and social activities. In the UK, they are part of the National Health Service. Some special hospitals, such as Rampton in England, provide discrete services including:

- Specialist high-secure women's services
- High-secure learning disability services for the whole of England
- A Dangerous and Severe Personality Disorder (DSPD) unit
- National high-secure deaf service, which provides comprehensive multidisciplinary team assessment, treatment and rehabilitation for up to 10 deaf people, irrespective of their diagnosis or treatment pathway.

The average stay is 6.5 years before progressing to a medium-secure unit.

Dangerous and Severe Personality Disorder (DSPD) Units

These units were established to treat violent and sexual offenders that otherwise would be deemed untreatable and to promote public protection (Ministry of Justice and Department of Health 2008). The term DSPD is an administrative rather than medical label, which is applied to people who:

1. Are more likely than not to commit an offence that might be expected to lead to serious physical or psychological harm from which the victim would find it difficult or impossible to recover.
2. Have a severe disorder of personality and a link can be demonstrated between the disorder and the risk of reoffending (Ministry of Justice and Department of Health 2008).

DSPD units are designed to deliver mental health services for people who are or have previously been considered dangerous as a result of severe personality disorder (Home Office 1999). The main objectives of the programme are:

- Improved public protection
- Provision of new treatment services improving mental health outcomes and reducing risk
- Understanding what works in treatment and management of those who meet DSPD criteria.

The main philosophy of the DSPD programme is that public protection will be best met by addressing the mental health needs of a previously neglected group.

Prison Services

There are a vast number of prisons in England and Wales. Each prison is usually divided into two types of provision for men and women separately; remand and sentence serving. Those on remand are housed within the remand section of the prison, usually a separate block or wing and they are able to have frequent visitors and wear their own clothes, however if convicted, they are then moved to a part of the prison that reflects the nature of their crime (Rogowski 2002), i.e. Category A prisoners are those whose crimes are serious and they require high levels of security, such as terrorists. Other categories go down towards category D, which are open prisons, where the inmate will have some level of day release, for example to a work placement.

Healthcare in prison is often delivered within a certain part of the prison and, similar to a health centre, it is run by healthcare professionals, either employed by the government as part of the penal system healthcare provision or by health services. In the UK, there have been a number of developments in the provision of healthcare services within prisons over the last decade; the aim is to have on offer a service to inmates that is equal to that they would receive as members of the wider community (Hills 2003).

Within the prison setting, mental health issues are common; 10% of men and 30% of women have had previous psychiatric admission before they entered prison. Women prisoners account for 54% of self-harm incidents. Male prisoners, with experience of psychosis, are more than twice as likely to spend 23 or more hours a day in their cell than those without mental health problems (Prison Reform Trust 2010). The proportion of people in prison who have learning disabilities or learning difficulties that interfere with their ability to cope with the criminal justice system has been estimated at 20–30% (Ministry of Justice 2009). The effects of being incarcerated or detained within prisons is well recognized; the fact that the environment and regimes are designed so that a person's ability to make choices is taken from them is intentional. Hills (2003) stated that the restricted and institutionalized nature of prison life is intended but it impacts on occupational choice and balance, contributing to mental health problems. Healthcare teams based in prisons have to be skilled in recognizing the impact of the environment, taking into account the social environment for prisoners may involve bullying, harassment and even exploitative relationships (Garboden 2011).

The professionals within the prison service work closely with other secure services so if, for example, an inmate is displaying signs of an emerging mental ill health, they will refer them to the regional secure unit for further assessment and similarly, where an inmate may potentially be within the learning disabilities range, they can refer to the learning disability forensic service for further assessment. Where individuals have mental health problems at the time of their arrest, or of sentencing, the courts will refer them directly to mental health or learning disability forensic services for assessment before they are prosecuted. If the services find that the individual does not have a learning disability or does not require the regional secure unit provision, they may be returned to prison and in some cases, if an individual has been through a learning disability forensic service and completed various treatment pathways and reoffends, the courts will automatically opt for a prison sentence, though the service will still remain closely involved.

WORKING IN SECURE SETTINGS

Whatever area of forensic and prison services occupational therapists work within, they will face the same challenges of balancing risk management with creating a therapeutic environment. Occupational therapists have to follow strict protocols for risk and safety for themselves and others; movement between areas is restricted and community presence is unlikely. It is important that occupational therapists maintain a person-centred approach with individuals but within the constraints of the environment.

Working in secure settings requires the occupational therapist to consider risk in every intervention and interaction as some people pose a greater risk than others; for example those who are acutely unwell or those who have been newly admitted and where little is known about their history and risk factors. Responsibility for safety lies with the occupational therapist who should consult relevant records prior to meeting a person, to be aware of known risks. They must communicate with the unit or ward staff before any session, to be sure it is safe to meet with

the person. Adequate steps to ensure personal safety should be taken, for example, having a member of staff present or conducting a session in a place where others are present. Most units will operate an alarm system, which requires the occupational therapist to carry an alarm on entering the environment. When the alarm is activated, a response team attends to the alarm call.

Risk Assessment

As a team member, occupational therapists participate in risk assessment. Basic principles include exploring risk factors in relation to the individual and others. Current and past history will be considered, to inform a risk management plan. The documents for risk assessment and management will vary from setting to setting. Services may use specific risk assessment tools such as the HCR-20 (historical, clinical, risk management) or use a tool developed by the service – although it is suggested that tools based on intuition and clinical experience alone are not sufficiently reliable in assessing risk (Ho et al. 2009). Risk assessment has become an integral part of the management of the mentally disordered offender (Ho et al. 2009) and should be seen as dynamic and ever-changing.

Risk assessment principles should be adhered to throughout the occupational therapy process. Cordingley and Ryan (2009) suggest that there is no specific model for occupational therapy risk assessment. For example, while facilitating a group, the occupational therapist needs to consider the mix of group members, by questioning whether certain individuals will provoke others, and considering if some individuals are likely to be vulnerable if mixed with others. Cordingley and Ryan (2009) suggest that risk can be mapped for occupational therapists by using the concepts of the Person, Environment, Occupation and Performance Model.

O'Connell and Farnworth (2007) highlighted that, for occupational therapists, no clear rationale has been offered as to why a separate risk assessment would be needed from the risk assessment completed by the team. However, many occupational therapists choose to have a separate assessment that is cross-referenced to the team risk assessment. Additional details relate to the specific risks involved in activities such as cooking or in places such as an occupational therapy workshop. Inventories are often used for items such as scissors, needles and knives. There may also be restrictions on the types of glue used or the availability of sticking tape. Assessment by the team should consider potential risks to the individual and to others, including those associated with a physical impairment or limitation, which may increase the likelihood of accidental self-injury. However, it is important to recognise that activities do not have to be restricted if a person poses a risk. For example, if they are at risk of self-harming and cannot access a kitchen for a cooking session, the occupational therapist can grade the activity so that the individual takes part in cold food preparation in the ward environment such as a salad or baking. The occupational therapist can put the dish prepared by the individual into the oven so the person does not have to access the kitchen.

Team Working

Within any health and social care setting, team working is an important factor influencing the quality of therapy and care. Within the forensic setting, communication is necessary to ensure the effective management of risk. According to Partridge et al. (2010, p. 69) a 'well-functioning team is stronger than the sum of its parts'. This means if a team has a good understanding of each profession's roles, skills, and professional ethos and the team shared the same direction, then the team as a whole is more likely to be effective than an individual professional. Team members need to feel confident in their own abilities. First, occupational therapists need to be clear about their role, approach to intervention and direction that they are taking. Communicating this effectively with the team is important, rather than making assumptions that other professions have the same shared understanding. Equally, it is important that the occupational therapist is clear about what is not within the professional remit. In forensic and prison services, many occupational therapists find themselves working as lone professionals within teams, so it is important to make sure that occupational therapists do not feel pressurized into practice that is beyond their scope of practice. This can be quite difficult: what is needed is good support from a manager, as well as good clinical supervision from an occupational therapist which may have to be arranged with an external person.

Occupational Therapy Interventions

Occupational therapists use their skills in analysing and adapting environments to enable people to engage in therapy in order to maintain motivation. This can be achieved by promoting choice, supporting skills development and working with individuals towards short-term and long-term goals. Skills development may focus on:

- Anger management
- Budgeting, cooking and independent living skills
- Communication and assertiveness
- Drug and alcohol awareness
- Literacy and education
- Motivation
- Relationship development
- Social skills
- Vocational and skills development (see Ch. 21).

This may be done within the ward environment, at an activity (or resource) centre or in the community. Some occupational therapists find the restricted environment a major barrier and the regime of the unit too institutionalized, meaning that choice making and promoting independence can be difficult (O'Brien and Bannigan 2008). For example, prisons operate differently from hospitals. The daily regime will follow a routine of lock down, where isolation is imposed; this can be difficult for the occupational therapist who is attempting to engage the people in activities. The occupational therapist will have to work carefully with prison officers to promote positive occupational engagement for the inmates. It is the role of the occupational therapist to advocate for the individual and to find ways to support the ward/unit to be able to make individualized plans which allow for skills' development and goal attainment and not just security and risk management.

The approach to occupational therapy is the same in forensic and prison services as it is within non-secure environments (see Chs 22, 23 and 26). However, many occupational therapists within secure settings will adopt a dual perspective to their interventions by considering:

- How does the person's experience of mental health problems/learning disability/personality disorder affect their ability to function independently?
- How does the individual's offence and environment affect their ability to function independently?

Martin (2003) observed that some theories of practice are overly complex and can make straightforward interventions seem complicated. The occupational therapist in the secure setting breaks down interventions into their component parts, so that everyone understands the processes and the reasons the approach used. Within occupational therapy in forensic practice, the Model of Human Occupation (MOHO) continues to be the most commonly used model of practice (O'Connell and Farnworth 2007; Bennett and Manners 2012; COT 2012).

The Model of Human Occupation

MOHO is regarded as a useful model of conceptual practice; this may be due to its evidence base and having a forensic-specific assessment tool (Couldrick and Alred 2003; O'Connell and Farnworth 2007; Duncan 2008). The Occupational Circumstances Assessment Interview Rating Scale (OCAIRS) includes three interview subsections, one of which is a forensic mental health interview tool (Model of Human Occupation 2012). The tool aims to provide a structure for gathering, analysing and reporting information relating to an individual's occupational participation. The three main domains of OCAIRS are:

- *Roles*: family responsibilities, family contact, study, culture and religion
- *Habits*: daily routine patterns, sleep, previous routine patterns, satisfaction with routines
- *Personal causation*: understanding own abilities, what do they feel they do well at, what are they proud of, how successful they feel they are going to be.

The assessment provides insight into an individual's level of motivation and how empowered they feel to be an active participant in their treatment pathways. Occupational therapists adjust and adapt the questions when administering the tool. OCAIRS is one of a number of different assessment tools used by occupational therapists in forensic and prison services; some are occupational therapy specific and others are generic and focus on entities such as mood or

self-esteem. The process of assessment, treatment and evaluation utilized by occupational therapists within forensic settings is iterative and will involve working with the person on a range of areas or needs (see Chs 5 and 6, for a broader discussion of assessment and outcome measurement and intervention planning, respectively).

Occupational Therapists' Use of Occupation-Focused Practice in Secure Hospitals

A review of occupation-focused practice in secure hospitals formed the basis for recent practice guidelines, which were structured using four concepts associated with the Model of Human Occupation (Kielhofner 2004; COT 2012). Table 27-1 indicates the key recommendations. The guidelines indicate that individuals should be supported to engage in meaningful and valued occupations, to limit alienation and antisocial behaviour and connect people to society again (Couldrick and Alred 2003). (See Case study 27-1 for an example of occupational therapy in a secure setting.)

Alternatives to offending and other harmful occupations can be explored within occupational therapy, to meet internal needs and increase satisfaction through health-promoting occupations. Occupational therapy may include vocational rehabilitation in the form of supported employment or prevocational training. (See Case study 27-2 for a practice example and Ch. 21 for a wider discussion of work and vocational pursuits.) There are many barriers that can limit the opportunities for individuals to engage in vocational rehabilitation, including unsuitable facilities, staff shortages and institution-based programmes that do not replicate the work-based setting accurately. The occupational therapist has to be realistic; finding work once back in the community can be difficult because of discrimination and stigma. The period of time spent within a forensic setting can mean that technologies can change and skills that individuals may once have had may have become dated or obsolete. Other challenges associated with vocational rehabilitation in forensic and prison services can include:

- Limited/no social network for opportunities for finding employment
- Employers' perceptions that some crimes are more serious such as violent and sexual offending
- The economic climate leading to a highly competitive employment market.

(LePage et al. 2011).

Black and Minority Ethnic Groups

Just under 27% of the prison population is from a minority ethnic group, with black people comprising 15% of the individuals being stopped by police (Prison Reform Trust 2009). African Caribbean people are over-represented in high- and medium-secure units, as well as in prisons (mentalhealth-foundation.org.uk) and there is an increasing number of asylum seekers and other immigration detainees who are detained under the Immigration Act 1971 (prisonmentalhealth.org) all of whom may present with mental health needs. The services they receive should be culturally sensitive and aim to understand the individual's background, beliefs and goals. Translators should be used to facilitate communication as understanding how a person perceives their mental health problems is crucial. For example, for some cultures, the experience of mental illness is the result of 'witchcraft'; this belief can be confused therefore with a paranoia or delusion. Any practitioner working with people from different backgrounds needs to understand fully the cultural beliefs the individual may hold but without making assumptions. The occupational therapist will need to ensure that interventions that are offered are culturally sensitive, for example it may not be appropriate for a female therapist to engage a Muslim male in an assessment of self-care. Person-centred practice, as in all mental health settings, will enable the therapist to work within the context of individual cultures to design and provide interventions.

Offence-Specific Interventions

Duncan (2008) stated that, while conceptual models such as MOHO may be useful for addressing occupational performance, it has not as yet been used to address offending behaviour specifically. Occupational therapists do participate in programmes relating specifically to offences. Offence-specific interventions will vary across the different forensic and prison settings; many programmes

TABLE 27-1

Key Recommendations for Implementation by Occupational Therapists' Using Occupation-Focused Practice in Secure Hospitals

Volition		
1.	It is recommended that occupational therapists always take into account the gender-specific needs of patients with whom they are working. (Baker and McKay 2001, C)	**1C**
2.	It is recommended that occupational therapists consider the occupational life history of patients, including that at the time of the index offence, and its influences on occupational performance, life satisfaction and criminogenic lifestyle. (Lindstedt et al. 2005, B)	**1B**
3.	It is recommended that occupational therapists establish as part of their assessment, patients' perspectives of their occupational performance and social participation, and work with those perceptions in planning care. (Lindstedt et al. 2004, B)	**1B**
4.	It is recommended that occupational therapists work collaboratively with patients in identifying and planning their care pathways. (Clarke 2002, C)	**1C**
5.	It is recommended that occupational therapists recognize the specific intrinsic value of occupation to individual patients. (Craik et al. 2010, C)	**1C**
6.	It is recommended that occupational therapists facilitate meaningful occupational choices for patients. (Craik et al. 2010, C; Cronin-Davis 2010, C; Mason and Adler 2012, C; Morris 2012, C; O'Connell et al. 2010, D; Stewart and Craik 2007, C)	**1C**
7.	It is recommended that occupational therapists ascertain patients' aspirations towards paid employment at the earliest opportunity, and during rehabilitation. (McQueen 2011, C)	**1C**
Habituation		
8.	It is recommended that occupational therapists consider patients' roles (past, present and future) within treatment planning and interventions. (Schindler 2005, C)	**1C**
9.	It is recommended that occupational therapy facilitates a range of interventions that enable patients to engage in structured and constructive use of time throughout the week, including weekends and evenings. (Bacon et al. 2012, D; Castro et al. 2002, C; Farnworth et al. 2004, C; Jacques et al. 2010, D; Stewart and Craik 2007, C)	**1C**
Performance Capacity		
10.	It is recommended that occupational therapists routinely use standardized outcome measures to assess and demonstrate patients' progress. (Green et al. 2011, C; Clarke 2003, D; Fitzgerald 2011, C; McQueen 2011, C)	**1C**
11.	It is recommended that occupational therapists consider supported employment or prevocational training as part of occupation-based intervention opportunities for patients. (Garner 1995, D; McQueen 2011, C; Smith et al. 2010, D)	**1C**
12.	It is recommended that occupational therapists consider the use of healthy living programmes and exercise as activity to benefit health and wellbeing. (Bacon et al. 2012, D; McQueen 2011, C; Prebble et al. 2011, D; Tetlie et al. 2008, C; Tetlie et al. 2009, C; Teychenne et al. 2010, C)	**1C**

Continued on following page

TABLE 27-1

Key Recommendations for Implementation by Occupational Therapists' Using Occupation-Focused Practice in Secure Hospitals (*Continued*)

13.	It is suggested that occupational therapists include social inclusion programmes as part of their intervention to improve occupational functioning. (Fitzgerald 2011, C)	**2C**
Environmental Considerations		
14.	It is recommended that occupational therapists fully value the therapeutic use of self as being integral to the positive engagement of patients in occupations. (Mason and Adler 2012, C; Tetlie et al. 2009, C)	**1C**
15.	It is recommended that occupational therapists ensure that risk assessment is a dynamic process, in which judgements are made on an ongoing basis in collaboration with patients and members of the multidisciplinary team. (Cordingley and Ryan 2009, C)	**1C**
16.	It is suggested that occupational therapists recognize the role and contribution of carers in the recovery of patients. (Absalom et al. 2010, C; Fitzgerald et al. 2012, D)	**2C**
17.	It is recommended that occupational therapists consider the impact of the environment on quality of life and occupational engagement. (Craik et al. 2010, C; Fitzgerald et al. 2011, D; Long et al. 2008, C; Long et al. 2011, C; Morris 2012, C)	**1C**
18.	It is suggested that occupational therapists liaise with a range of community services to facilitate replication of patients' pro-social behaviours developed during an inpatient stay. (Elbogen et al. 2011, D; Lin et al. 2009, C; Lindstedt et al. 2011, C)	**2C**
19.	It is recommended that occupational therapists demonstrate their competencies (skills and training) to facilitate identified therapeutic groups, enhancing the confidence and participation of patients. (Mason and Adler 2012, C)	**1C**
20.	It is recommended that occupational therapists articulate, to patients and the multidisciplinary team, their role and the contribution of occupational therapy to the overall treatment programme (Cronin-Davis 2010, C)	**1C**

Key: Recommendations are scored according to strength, 1 (strong) or 2 (conditional), and graded from A (high) to D (very low) to indicate the quality of the evidence.

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initially started within the mainstream prison settings and have been further adapted to meet the needs of people within secure units. The following are examples of the range of offence programmes that may be available in England and Wales:

- Sexual offender treatment programmes (SOTP)
- Fire starters' programmes
- Drug and alcohol programmes, for example: ASRO (Addressing Substance Related Offending); ARV (Alcohol Related Violence Programme); P-ASRO (Prison – Addressing Substance Related Offending); LIAP (Low Intensity Alcohol Programme)
- TSP (Thinking Skills Programme): a cognitive behaviour programme that aims to reduce reoffending by encouraging the individual to think about the choices and actions they make
- SCP (Self Change Programme): targeted at violent and repetitive violent offenders and aims to target antisocial attitudes that support violent behaviours.

Occupational therapists within a secure setting may lead on any of the programmes. However they will need specific training to be able to deliver

CASE STUDY 27-1

Paul

Paul was 28 when he was referred to a mental health forensic service for assessment. He had been arrested and placed on remand after allegations were made of sexual assault of a 14-year-old girl. He was seen by the remand psychiatrist initially for low mood. The psychiatrist then made the referral to the forensic service after Paul had displayed symptoms of psychosis. After assessment by the team, he was transferred with the court's approval for further assessment. He was later placed on a hospital treatment order (section 37/41) by the courts, when he was found guilty of the assault.

Paul was placed on the assessment unit where a referral was made to the occupational therapist for a functional assessment in order to identify his abilities and skills levels together with his motivation for engagement.

The occupational therapist met with Paul, he was anxious during the initial assessment, this exacerbated his speech difficulties and resulted in stuttering and not being able to answer questions.

The occupational therapist identified with Paul, using a checklist of interests, that he had an interest in cooking. Having completed a risk assessment with his care team it was identified that he presented minimal risk to himself or others.

Using graded activity, a basic cooking session was planned. The occupational therapist obtained the ingredients for the meal as Paul was not allowed to leave the unit to go to the local shops. Using the cooking session, the occupational therapist was able to assess:

- *Cognitive ability*: sequencing, problem-solving, ability to follow instructions, literacy, numeracy, planning and safety awareness
- *Physical ability*: mobility, movement, coordination and motor skills
- *Interpersonal and intrapersonal ability*: Mood, motivation, interaction, social skills, beliefs, interests, communication, confidence, self-esteem.

The assessment identified that Paul struggled considerably with reading, problem-solving and communication, which all appeared to have an impact on his self-esteem. Further work, through cooking sessions, was used to help build practical skills, teach problem-solving skills and aid confidence. Paul found the sessions beneficial because the cooking sessions were meaningful; meals were provided on the unit with little room for choice. The cooking sessions allowed choice and made Paul feel that he was still able to exert some control over his environment. The use of activity such as cooking can empower individuals, which ultimately enables them to feel in control of their treatment and so increase their benefit from it.

accredited programmes; or they may co-facilitate the programmes with a psychologist. Often occupational therapist will offer sessions to prepare for offence-specific programmes with:

- Purposeful activity groups: developing skills at being in a group, participating, turn-taking and developing listening and cooperation skills
- Skills-based groups: social skills, life skills or problem-solving, all aimed at increasing self-awareness
- Psycho-educational groups, such as drug and alcohol, healthy lifestyles, sexual health and relationship groups.

CHALLENGES ASSOCIATED WITH WORKING IN FORENSIC AND PRISON SERVICES

Working within a secure environment may pose additional challenges to successful engagement with occupational therapy as some people may feel that they have been wrongly detained or are innocent of their alleged crimes and therefore may be unwilling to engage in the therapy on offer (Sheldon and Howells 2010). Forensic and prison services is a practice area that some occupational therapists may have no desire to work within; the moral and personal challenges of working with people who

CASE STUDY 27-2

Barry

Barry is a 42-year-old man with a mild learning disability; he was admitted to a low-secure learning disability service following sexual offences pertaining to children. On the unit, he presented as quiet and shy, frequently choosing solitary occupations such as drawing or writing letters. He would engage in the occasional unit-based occupational therapy group, e.g. art and craft activity, and enjoyed one-to-one cooking sessions. Barry found it difficult to engage with his peer group and would often prefer to engage with the staff, in particular female staff. Attempting to engage Barry in offence-specific groups proved extremely difficult and he frequently refused to participate. He would instead choose to lie in bed all day and was prone to periods of low mood and self-harm. Any attempts to engage him in pre-treatment groups such as understanding emotions or social skills groups, again proved difficult. Trying to attempt to develop a pathway for Barry out of hospital proved difficult for the multidisciplinary team (MDT). The occupational therapist completed the Occupational Circumstances Assessment Interview and Rating Scale (OCAIRS-forensic) and identified that Barry had a keen desire to engage in work-based programmes, as he saw his ultimate goal as: 'To get a job when I leave hospital'.

Using this goal as the starting point, attendance at a work skills group was offered; this was a prerequisite for anyone wishing to take part in working within the unit's shop. The group aimed to help individuals identify their strengths and weaknesses and look at ways of adapting and developing skills as well as building confidence and setting short-term and long-term goals. For the occupational therapist, the group helped identify motivation and levels of ability, to ensure that treatment plans and goals are realistic and risk-assessed. Attendance needed agreement with the team but some staff suggested that Barry might not commit to the group, which ran for 12 weeks. Barry attended every session and participated; he identified that in the past he had some basic work experience from a cafe and was keen to share his experiences. This appeared to increase his self-confidence and by the end of the programme, he was offered a work-based placement within the unit's shop and had jointly identified with the occupational therapist that his goals were to:

- Increase his social skills and be able to talk to customers
- Develop his maths and numeracy skills
- To learn skills that he could then use in the future.

The occupational therapist was able to provide valuable information to the MDT regarding Barry's motivation, social skills and perceptions about the treatment-specific programmes and, through the use of the vocational pathway, Barry was able to see that he would need to engage in his treatment groups if he was to be able to move on and make the most of his vocational skills. The use of the vocational pathway meant that Barry's intrinsic motivation was identified. Completing the 12-week group was positive reinforcement. Gaining a work placement gave him the opportunity to think about his future and how to move forward.

may have committed serious offences can be too stressful for some. For others, the challenges of working with a group of people that is otherwise shunned by society, can be rewarding. Whatever an occupational therapist's motivation for choosing to work within this speciality, the occupational therapist needs to understand the importance of good supervision and support; even the most experienced of practitioners can still find themselves feeling uncomfortable when faced with hearing the details of offences. Equally, some may feel vulnerable if working with sex offenders or uncomfortable, particularly if they have children and are working with child sex offenders. It is important to recognize these feelings are normal but, through good supervision, find ways of dealing with these emotions and identify processes for ensuring a positive therapeutic relationship.

The Therapeutic Environment

Although there can be personal challenges associated with working in forensic and prison services, for many occupational therapists, the biggest challenge is the setting itself. It can be difficult to promote independence and balanced occupations when the therapeutic environment does not allow access to metal cutlery or if day-time activities are limited to rooms on the ward or unit. This affects therapy planning and delivery (see also Ch. 6). Groups such as arts and crafts, require careful planning to ensure that the items are not going to be hazardous, while demonstrating that adequate risk management has been undertaken. For example counting scissors in and out before the group. Many forensic and prison services will operate a range of security checks that are needed prior to, and after, a group (DH 2010). The skill of the occupational therapist is to work adaptively and communicate clearly with the person, team and service. As with any establishment, staffing ratios can be problematic, the occupational therapist may have a community-based group planned only to be cancelled at the last minute or insufficient staff numbers within environments to be able to support the implementation of daily living programmes.

Burnout

Working with complex needs in a restrictive environment can lead to burnout (see Glossary). Burnout has been described as 'tantamount to negligence as burnout is next to impossible to treat once it is established' (Taylor 2005, p. 220). There are warning signs:

- Negative or cynical attitudes or feelings about offenders
- Feeling ineffective
- Emotional exhaustion (The National Offender Management Service, NOMS 2011).

Burnout can occur at any point in a healthcare professional's career (NOMS 2011). For example, a particular challenge may arise where the role of the occupational therapist is new to the service or is misunderstood. However, burnout is a complex problem that is not caused by any one factor; it makes more sense to prevent than treat it (Grosch and Olsen 1994). There is no simple formula for burnout. Steps to prevent it include:

- Ongoing self-assessment. By assessing ourselves regularly we can determine the difference between normal tiredness and early signs of burnout.
- Understanding our patterns of behaviour. Recognize what the issues are that are contributing to burnout, e.g. perfectionism (NOMS 2011).
- Breaking behaviour patterns. Taking action to resolve issues identified, e.g. ensuring enough down time after periods of high stress (NOMS 2011).
- Emotional intelligence. Developing our capacity to manage strong feelings and impulses in the face of stress and anxiety-provoking situations (Grosch and Olsen 1994).

Good support (Dickinson and Wright 2008), working relationships (Nathan et al. 2007) and a balanced approach to work and personal life as well as training, clear and realistic expectations and reflection are key to minimizing the effects that can lead to burnout (see Chs 7 and 12 for related issues).

SUMMARY

This chapter has briefly explored a specialized clinical area where there is a dual focus on mental illness and offending behaviour. It has considered the setting occupational therapists work in and the challenges associated with providing therapy, in an environment where security also has to be maintained. It has highlighted the findings of the practice guidelines about occupational therapists' use of occupation-focused practice in secure hospitals.

The existence of the practice guidelines marks a key difference between this edition of the book and the previous edition. At the time of the last edition, the lack of a robust evidence base had been highlighted (Couldrick and Alred 2003; O'Connell and Farnworth 2007). The evidence underpinning the practice guidelines is contemporary, where previously much of the literature was over 10 years old. However, much of the evidence base for occupational therapy in forensic settings remains weak. So, although the evidence base has increased since the last edition, the quality of the research conducted needs attention (see Ch. 9 for more information about research and evidence-based practice).

USEFUL RESOURCE

Forensic e-discussion group. Available at: http://uk.groups.yahoo.com/group/forensic_occupational_therapy.

This is an e-mail discussion group for anyone interested in forensic occupational therapy.

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28 SUBSTANCE MISUSE

JENNY LANCASTER ■ JOHN CHACKSFIELD

CHAPTER CONTENTS

INTRODUCTION

Occupational therapists in all fields of practice are likely to meet service users who have problems with substance misuse. This chapter is a starting point for occupational therapists interested in the specialism of substance misuse, as well as those who work in other areas of mental health and encounter substance misuse alongside mental health problems. It focuses on the nature and extent of substance misuse in the UK, offering an occupational perspective on why people take drugs and the types of problems the individual drug user may experience. The occupational therapy process is also outlined and the role of the therapist highlighted. Treatment approaches are described as well as specific occupational therapy intervention strategies.

Substance use and misuse are widespread within our society and culture. Some 90% of the adult UK population drink alcohol and about 10% of the population drink above recommended daily guidelines (Strategy Unit 2003). It is estimated that 30–50% of people with severe mental health problems misuse substances (Cabinet Office 2004). The prevalence of illegal drug misuse is harder to assess but it is estimated that 1% of the UK population uses heroin or cocaine (NTA 2002).

Definitions of Substance Misuse

The term 'substance use' generally means the consumption of alcohol or psychoactive drugs that have the potential to be addictive. Substance misuse has been defined as drug and/or alcohol taking that harms the individual, their significant other(s) or the wider community (NTA 2002). Substance dependence or dependence syndrome (first proposed by Edwards and Gross 1976) is a specific diagnostic term describing what is commonly termed addiction (Ashworth et al. 2008; Gerada and Ashworth 2008; DH 2011). Although there are myriad substances that are used and abused due to their psychoactive properties, this chapter will focus on the most harmful ones: heroin and alcohol.

Historical and Cultural Context

The use of addictive substances has been entwined with human occupation throughout humankind's history. Archaeological evidence exists for the use of alcohol in ancient Egypt from as early as 6000 BC (Nunn 1996). In Britain in the 17th century, due to the lack of drinking-water, beer and gin were commonly drunk by the whole population throughout the day, starting at breakfast (Allen 2001; Tyler 1995). One-third of England's farmland was devoted to growing barley for beer and one in seven buildings was a tavern. In the second half of the century, 2000 coffee houses sprang up in London. This had a sobering effect on the population. Instead of getting drunk in taverns, coffee houses provided a safe place to read, play games and engage in political debate. Indeed, the first ballot box was used in the Turk's Head Coffee House in London. This change from the use of a depressant substance (alcohol) to a stimulant (caffeine in coffee) has been associated with increased literacy, political change and improved standards of living (Allen 2001). However, during the Industrial Revolution alcohol use dramatically increased in response to changes in the occupational lives of workers – toiling in factories and mines – and increasing urbanization (Tyler 1995).

From 1950 to 2004, consumption of alcohol *per capita* increased from 3.9 litres of pure alcohol per year to 9.4 litres per year. Although this has reduced slightly since 2004, annual consumption levels have remained above 7 litres since 1980 (BMA 2008). The UK has one of the highest rates of binge drinking in the Europe, particularly among young people (Institute of Alcohol Studies 2010). Binge drinking has been defined as drinking more than double the recommended daily limit of units of alcohol. In the UK, 40% of all drinking episodes for men and 22% for women are defined as binge drinking (Institute of Alcohol Studies 2010). There are vast differences in consumption of alcohol between different religious, ethnic and socioeconomic groups in the UK. For example, 9% of the white British population do not drink alcohol, whereas 90% of those of Pakistani or Bangladeshi origin abstain from alcohol (BMA 2008).

Culture mediates views of substances in terms of how dangerous they are and how legal they should be. For example, the Christian moralist Temperance movement in 19th-century Britain set out to reduce alcohol consumption (Berridge 2005). At the end of the 19th century, cocaine was highly popular and recommended by doctors such as Sigmund Freud. Many cultures use and have used drugs in social, ritual or religious ceremony and for pleasure. In the UK, substance use from the 18th to the early 20th century, was primarily seen as a sin. The drunk and the 'opium sot' were seen as morally depraved. The turn of the 20th century saw this attitude change towards a much more disease-oriented concept, including the notion of treatment and cure. In the 1960s came the concept of dependence – acknowledging psychological reliance on a drug – and in the 1970s, this was developed into the modern dependence syndrome. Over recent years, drug treatment strategies have repeatedly focused on and measured success in terms of reducing the costs to society caused by substance use rather than the personal recovery of people using substances. For example, the frequently quoted Drug Treatment Outcomes Research Study (Donmall et al. 2009) showed that every £1 spent on drug treatment saves society £2.50. Interestingly, analysis of the final report of this study found that 'gains in the patients'

health-related quality of life would normally be considered too small in themselves to justify the cost of treatment' (Drug and Alcohol Findings 2010, p. 5).

DUAL DIAGNOSIS

Dual diagnosis or comorbidity refers to the coexistence of a substance misuse disorder and a separate mental health problem (Kavanagh et al. 2000; Teeson et al. 2000). Research shows that substance users have higher rates of mental health problems than the general population (DoH 2002). Mental health problems may be induced by drug use or drugs are used to self-medicate the symptoms. Recent recommendations by nurse consultants suggest that dual diagnosis is the norm rather than the exception and all mental health professionals should receive training in both issues as a matter of course. When alcohol and drugs are used by people with mental health problems, they can severely exacerbate symptoms and disrupt treatment. They are associated with disrupted lifestyles, suicide (Duke et al. 1994) and violent behaviour (Swanson et al. 1990). The issue of substance misuse by people with a mental health problem has been important within UK government policy, since the Policy Implementation Guide on Dual Diagnosis (DoH 2002).

Valuable guidance documents created by experts and published via the charities Rethink and Turning Point (Rethink and Turning Point 2004; Turning Point 2007) highlight key aspects of treatment for dual diagnosis and recommend various intervention strategies that address the complex combination of issues. There is general agreement that good practice should be *comprehensive* (integrated into one service where possible), *long term*, adopt a *staged* approach to recovery and be focused on developing *self-management skills* and *functional* goals (Drake et al. 2001).

SUBSTANCE MISUSE

Currently in the UK, substances that are misused are categorized as legal or illegal and are subject to restrictions according to age. Substance misuse can lead to social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence (NTA 2002). The health and social consequences of drug and alcohol use are comprehensively summarized in *A summary of the health harms of drugs* (DH 2011), some of which are described later in the chapter.

Frequently, people develop substance misuse problems in an attempt to deal with problems in their lives; such as following the breakdown of a relationship, due to unemployment or as an attempt to relieve the symptoms of mental health problems. It is therefore important to consider the interrelation of three factors in relation to substance misuse (Gossop 2000; Ghodse 2002): the drug, the individual and their environment.

Examining the relationship between the individual and the environment in relation to their occupations is a core component of occupational therapy. When working with service users misusing substances, occupational therapists consider how the substance use (or abstinence from a previously habitually used substance) affects a person's occupations. For example, an individual's alcohol consumption may increase due to changes in their work environment, or an ex-heroin user who, having given up a large network of drug-using friends, may feel they do not have the confidence to engage in new leisure activities alone.

Substance misuse has been described as a chronically relapsing condition (NTA 2002). Research indicates extremely high relapse rates (60%) following an episode of substance misuse treatment (NIDA 2009) and that relapse is most likely within a short period following initial treatment (Hunt et al. 1971; Stephens and Cottrell 1972; Milkman et al. 1984). However, the largest multisite trial in the UK has proved the long-term effectiveness of drug treatment (Donmall et al. 2009).

The costs of drug and alcohol misuse for communities are high. It is estimated that the cost of alcohol misuse in England is £18–25 billion a year and the cost of illegal drug misuse in England is around £15.4 billion per year (HM Government 2010). Therefore drug and alcohol misuse has been high on the political agenda for many years, with numerous policies and the development of links between the criminal justice system and treatment services. For example, the Drug Intervention Programme developed Arrest Referral Schemes (Skodbo et al. 2007).

Since the advent of HIV and the development of structured methadone maintenance programmes, treatment for opiate use has traditionally adopted a harm reduction or harm minimization approach. This is designed to reduce the risk of infection with

blood-borne viruses through sharing injecting equipment, as well as avoiding the risks associated with using contaminated, adulterated street heroin. These approaches include providing needle exchange schemes, providing education for drug users on safer injecting methods, and prescribing medical substitute opiates such as methadone. This has undoubtedly been successful in preventing an epidemic of HIV among injecting drug users and substitute prescribing has enabled many drug users to live productive lives whilst continuing to be prescribed an opiate drug. However, these approaches have caused much debate over what constitutes successful treatment and recovery. There is a longstanding disagreement and debate in the field of drug treatment between supporters of 'harm reduction' approaches and those that follow '12 Step' approaches (Alcoholics Anonymous 2002), with are based on total abstinence. When a BBC report in October 2007 (BBC 2007) reported that only 3% of drug users left treatment free of all drugs (including methadone) despite a huge increase in funding for Drug Treatment, it sparked a debate among many prominent figures in the treatment field (see Drugscope 2009).

National Policies and Guidance

A range of guidelines for treatment have been developed by the National Institute for Health and Care Excellence (NICE) – such as CG115 Alcohol dependence and harmful alcohol use (NICE 2011). These are available at www.nice.org.uk.

The UK government's Drug Strategy (HM Government 2010) marks a change in direction with an increased focus on detoxification and abstinence from substitute prescribing as a goal of treatment. This is not without controversy due to large-scale studies that highlight the increased risk of drug-related deaths after stopping substitute prescribing (Cornish et al. 2010). Once 'tolerance' to opiates is lost through the detoxification process, there is a high risk of death through accidental overdose if the drug user relapses and uses similar amounts as before.

What are Drugs?

Drug Action

Alcohol and drugs act on specific centres of the brain. For example, opiates (such as heroin) act on the opiate receptor in areas of the brain such as the limbic system, specifically the nucleus accumbens and the ventral tegmentum (Carter 1998). Changing the state of these receptors by using drugs creates the pleasurable experiences.

Many drugs are thought to act on the dopamine system. Dopamine is a chemical messenger which plays an important role in the brain's reward centre. It is released when we do pleasurable things, such as eating good food or having sex. Drugs such as cocaine and heroin cause a massive surge of dopamine to be released, creating the sensation of pleasure. Over time, repeated drug use can lead to dopamine receptor sites in the brain being reduced or shut down. Therefore, the drug user finds less effect from using a drug, which leads to an increase in the amount used. The other significant effect is that the drug user may experience a decreased ability to feel pleasure or satisfaction in activities of daily life (Whitten 2009). This can lead to further drug use or thrill-seeking activities. Occupational therapists need to be aware of this because service users who have recently stopped using drugs and have reduced dopamine levels, may struggle to feel satisfaction from the occupations selected as therapeutic media.

Alcohol has a variety of complex actions but is generally a nervous system depressant. The reason alcohol appears to produce euphoria is that it depresses frontal cortex functioning, resulting in loss of inhibition.

Legality

Alcohol is legal for use by people over the age of 18. The legality of other drugs is determined in the UK by the Misuse of Drugs Act (HMSO 1979). This classifies drugs as Class A, B or C. Each class carries particular penalties for using and supplying the drug.

Therapists working with drug users need to be aware of Section 8 of the Misuse of Drugs Act, which makes it an offence to allow drug dealing in any public premises. This Section was used to convict two managers of a charity drop-in centre for the homeless in Cambridge in 2000 (BBC News website 2000). Despite a strict anti-drug use policy they were convicted for refusing to pass on confidential information about their service users to the police and were judged to have not done enough to prevent drug dealing in their centre. Press coverage of the case has been collated on the Innocent website (see Innocent 2000).

Why Do People Use Substances?

People are known to use substances for many and varied reasons (Edwards 1987; Gossop 2000). Alcohol, for example, is widely used as a social lubricant, to reduce tension, to intoxicate as a way of coping with negative feelings or as a sedative. Heroin use is described as offering a warm, dreamy 'cocoon' and, for many users, it serves as an antidote to emotional pain and the stress of a life lacking in meaning (Tyler 1995).

Substance Use: An Occupational Perspective

Substance use is often closely tied to human occupational behaviour. Some of the reasons for substance use can be categorized under the headings below but it is important to note that each individual drug user will have their own specific reasons for taking drugs.

- Enabling occupation: by reducing tension, removing inhibition, stimulating mental alertness, or through imitating others' drug use
- Avoiding occupation: through intoxication, stimulus seeking, denial of responsibility or through escape into drug culture
- As a coping mechanism: to counter anxiety, relieve pain, mask distress, increase confidence and peer acceptance or as self-medication for mental health problems
- To alter perception: to develop a wider understanding of life, for desired spiritual attainment, as part of a religious ritual, to assist creativity, to enjoy drug-induced perception
- To develop meaning in life: through the ritual and habits of drug-taking behaviour, the routine of obtaining drugs or drug-dealing, the excitement of illegal activities, or through interacting and sharing a culture with associates in a drug-using network
- To enhance occupations: by celebrating positive events, enhancing good feelings, or removing negative emotional states
- To manage occupational risk factors: to cope with occupational deprivation and/or boredom ('killing time') or coping with occupational imbalance such as the pressure of too many demands on one's time.

When Does Drug Use Go Wrong?

Many people regulate their use of alcohol and other drugs without causing damage to themselves or others. However, the use of alcohol and other drugs commonly leads to a range of physical, psychological and social problems. Substance use can be *problematic*, disrupting a person's normal lifestyle balance or physical state or leading to *dependence syndrome* (Edwards et al. 1981). Drug or alcohol dependence includes physical withdrawal symptoms as well as compulsive urges to use a substance. See Drummond (1992) for further explanation of the relationship between problems and dependence.

TREATMENT OF SUBSTANCE MISUSE

A Model of Change

Before considering drug and alcohol treatment, it may be useful to present a transtheoretical model of change that can be used with individuals with any addictive behaviour (or anyone working towards behaviour change). The Stages of Change model is a useful tool for guiding treatment goal-setting and interventions (see Fig. 28-1), which can be targeted to help service users progress through the stages of change.

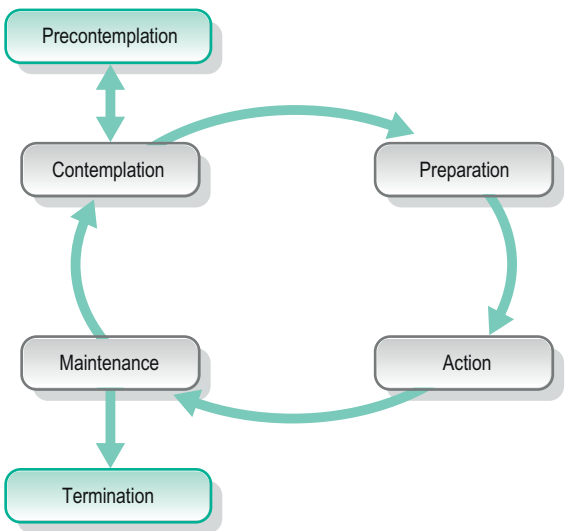

FIGURE 28-1 ■ A model of change. *(Reprinted and adapted from Prochaska J O, DiClemente C C 1986 Towards a comprehensive model of change. In: Miller R J, Heather N (eds) Treating addictive behaviours: processes of change. Plenum, London, with permission from Springer Science + Business Media).*

Prochaska and DiClemente (1982, 1986) and Prochaska et al. (1992) first developed this model with cigarette smokers, who they found reported progression through different stages of change as they attempted to give up. These same stages have since been observed in all other addictive disorders (Gossop 1994). It reflects the reality that it is normal for an individual to go through all the stages several times before achieving lasting behaviour change. Most of us can relate to attempting behaviour changes – such as dieting, exercising regularly or stopping smoking perhaps – where we have not succeeded in maintaining the change at the first attempt. In fact, the smokers in Prochaska and DiClemente's initial study went round the cycle between three and seven times before finally giving up smoking permanently.

The relapses associated with addiction (a chronic relapsing condition) may be seen as normal events that can be learned from, rather than being seen as indications of failure. Although represented as a cycle, it is now conceptualized as a spiral acknowledging that each time the person goes through the stages, they are learning from the experience of previous attempts to change.

Stages of Change

The central concept of this model is that behaviour change takes place through the following discrete stages:

- *Precontemplation*. In this stage, people do not recognize that they have a problem and are therefore outside the model. 'Precontemplators' rarely present for treatment. However, when they do, it is in order to assuage the concerns of others
- *Contemplation*. In this stage, the person recognizes that their behaviour is problematic and considers doing something about it. This change is characterized by ambivalence. Motivational enhancement therapy or motivational interviewing is a useful, evidence-based approach to use during this stage
- *Preparation* The person prepares to change
- *Action*. This stage is about making changes, implementing a plan
- *Maintenance*. This is about sustaining the change, integrating the change into the individual's lifestyle.

In this model, a person may slip back a stage or exit the cycle into precontemplation at any time. Establishing at which stage the individual is, enables the therapist to select the most appropriate intervention. For example, a service user in the maintenance phase may benefit from learning stress management techniques and developing satisfying day-to-day occupations, which are important in boosting confidence and preventing relapse. However, these strategies are likely to be wasted on a 'precontemplator'. Buijsse et al. (1999) give further guidance to occupational therapists using this framework.

The Stages of Change model is an effective means to assess readiness for treatment. This is a significant predictor of engagement and retention (Project MATCH Research Group 1993; Simpson et al. 1997). For alcohol users, a standardized assessment – the Readiness for Change questionnaire (Heather et al. 1991) – can be completed. In addition to assisting in treatment matching, this model is helpful in setting realistic and achievable goals; that is, aiming to move to the next stage in the cycle, rather than trying to stop the behaviour immediately. It is an optimistic approach in that relapse is viewed as a normal part of the process of achieving long-term behaviour change. Occupational therapy is ideally suited to the maintenance phase but the therapist needs to be able to assess at what stage the service user is, and respond accordingly.

Substance Misuse Treatment in Context

Drug and alcohol treatment services are operated by the NHS, Social Services, prisons, private clinics and the voluntary sector. Treatment settings include hospital and community locations, and treatment can commence in either of these.

Triggers to Treatment Entry

Entry into treatment is usually triggered by a crisis. For example, an individual is arrested committing burglary to fund a growing crack cocaine habit, or loses their job after their work performance suffers due to heavy drinking. A crisis often shifts an individual from precontemplation into contemplation. This can provide a window of opportunity to encourage engagement in treatment. Consequently, treatment services often target crises for this reason. For example, specialist alcohol nurses may assess people attending Accident

and Emergency services or drug users may be assessed while in police custody, as described below.

Referral

People with alcohol and drug problems are frequently referred for treatment by their GP, self-refer or are referred after an alcohol-related physical problem is identified, such as in A&E. Others are referred from within the criminal justice systems. Some referrals come from employers or employee assistance programmes.

Referral via the Criminal Justice System. Since 2000, there have been increased links between the criminal justice system and treatment services. Alcohol Treatment Orders and Drug Rehabilitation Requirements (formerly Drug Treatment and Testing Orders) were introduced as part of the Criminal Justice Act 2003 (HMSO 2003). These are treatment orders or suspended sentences for those convicted of a drug- or alcohol-related crime and involve the person agreeing to a programme of drug testing and participation in structured treatment, often as an alternative to a custodial sentence. Arrest referral schemes also operate whereby those held in police custody are offered a brief assessment by a drug or alcohol worker who aims to facilitate entry into treatment for those identified as having problematic drug or alcohol use.

Drug and alcohol misuse within the forensic mental health system has been the subject of several papers (McKeown et al. 1996). Occupational therapy programmes in these settings have been described by Chacksfield and Forshaw (1997) and Chacksfield (2003).

Multidisciplinary Assessments

Assessment needs to be tailored, needs-led and part of an ongoing process (NTA 2002). Many guidelines stress the importance of expressing empathy and a non-judgemental manner (DH et al. 2007; NICE 2011), recognizing both the stigma that service users feel as well as ambivalence about change that is common at the beginning of treatment. A number of assessment techniques may be used, including:

- screening assessments
- structured questionnaires
- interviews
- risk assessment
- observation (for signs of physical withdrawal)
- physiological assessments (e.g. urine and blood analysis, ECG).

Screening Assessments

A number of screening assessments are available. For alcohol, NICE recommends the Alcohol Use Disorders Identification Test (AUDIT), Severity of Alcohol Dependence Questionnaire (SADQ) and Alcohol Problems Questionnaire (APQ) tools (NICE 2011). NHS staff should be competent to identify harmful drinking and alcohol dependence and competent to initially assess the need for an intervention (NICE 2011).

For drug use, there is the Severity of Dependence Scale (Gossop et al. 1995), which is designed to be generic for a range of drugs. It is essential to monitor withdrawal (Edwards 1987) and assessments are often used to assist this, such as the Short Opiate Withdrawal Scale (Gossop 1990). The standard outcome measure in drug treatment services is the Treatment Outcomes Profile (TOP) (Marsden et al. 2007), as required by the National Drug Treatment Monitoring System (NDTMS). This outcome measure is also validated for those with alcohol problems.

Structured Comprehensive Assessments and Interviews

Structured questionnaires aim to investigate the severity of dependence, the range and complexity of problems associated with substance use (including the effects of drug-using behaviour on dependent children) and motivation to engage in treatment or to change substance use behaviour. These can follow a standard mental health interview approach but should also cover the number of different drugs used, the amount used, a typical day of use and a history of use, including the first drug use occasion and changes in use over time. There may also be assessment of anxiety or depression.

NICE recommends that for those with alcohol problems a 'motivational intervention' is carried out using key elements of motivational interviewing – such as helping people to recognize the problems caused by their drinking, resolving ambivalence, encouraging belief in the ability to change and being persuasive and supportive rather than confrontational (NICE 2011).

Occupational Therapy Assessment

Occupational therapy investigates six domains: activity demands, context and environment, performance patterns, performance skills, areas of occupation and client factors (AOTA 2008). These have been grouped into three areas as follows.

Performance Patterns

All categories of human daily activity, such as activities of daily living, leisure, self-maintenance and work/productivity, can be affected by substance use. As described earlier, occupational therapists are concerned that substance misuse and dependence disrupts the balance of work, self-care and leisure (Rotert 1989; Chacksfield 1994; Morgan 1994; Martin et al. 2008). Quantitative research by occupational therapists, such as Mann and Talty (1990), Scaffa (1991), Stoffel et al. (1992) and Chacksfield and Lindsay (1999) has highlighted use of leisure time by alcohol-dependent service users as a key problem area.

Performance Skills and Client Factors

Successful engagement in performance areas requires ability in terms of sensorimotor, cognitive, psychosocial and psychological components. Drug action can have both short- and long-term effects on performance components.

Occupational therapy research has suggested that low motivation and low self-esteem are significant in substance misusers (Viik et al. 1990; Stoffel et al. 1992). Research by Martin et al. (2008) with homeless substance misusers admitted to a residential recovery programme, explored performance capacity issues, as well as their impact on quality of life, using a variety of ratings, including the Occupational Performance History Interview II (OPHI-II) (Kielhofner 2008). Positive changes in occupational competence (based on OPHI-II scores) were associated with recovery at the 6-month stage of follow-up after a dip in scores at 3 months, which the authors attributed to the impact of the environment. The research appears to suggest that occupational competence is a key factor in recovery from addiction.

Context, Environment and Activity Demands

Research into cue exposure (Drummond et al. 1995) shows that environmental cues can trigger addictive behaviour in individuals. Someone returning to an alcohol- or drug-orientated environment on discharge is likely to re-experience the same cues as before and may relapse back into substance use without developing coping strategies to counteract the environmental effects.

Occupational Therapy Assessment Tools. Occupational therapists may wish to supplement the standard initial interview with open questioning to obtain information about how substance use is impacting on the individual's occupational performance areas, components and contexts. The Occupational Circumstances Assessment Interview and Rating Scale (OCAIRS) (Forsyth et al. 2005) is a semi-structured interview often used for this purpose. Other appropriate tools include:

- Occupational Self-Assessment (OSA)
- Rosenberg Self-Esteem Inventory
- Self-Efficacy Scale
- Volitional Questionnaire
- Coping Responses Inventory (CRI)
- Interest Checklist
- Role Checklist
- Assessment of Motor and Process Skills (AMPS)
- Internal/External Locus of Control Scale
- Occupational Performance History Interview (II).

INTERVENTIONS

As described earlier, substance dependence is typically a chronically relapsing condition. Interventions often do not follow a linear path and the Stages of Change Model is useful in assessing treatment readiness and in selecting the most appropriate intervention.

Engagement and Principles of Intervention

Many people with substance misuse problems struggle to engage with treatment services. Feelings of ambivalence, anxieties about change, fluctuating levels of motivation and a chaotic lifestyle are factors in this. Enhancing engagement is pivotal in achieving positive treatment outcomes (NTA 2004; DH 2007; NICE 2011) and the importance of establishing rapport and empathy, and of using motivational enhancement techniques following assessment, must not be underestimated (NTA 2004).

People with drug and/or alcohol problems frequently present with complex needs. They may be clinically depressed, have poor physical health and be homeless. Therefore, it is important that treatment plans are comprehensive, involving other disciplines and agencies as needed (Edwards 1987; DoH 1996). People can also feel that they are overwhelmed and controlled by their addiction. Therefore, it is important to emphasize empowerment and hope in overcoming substance problems or dependence.

Treatment Options

Alcohol Misuse

Medically assisted withdrawal (commonly known as detoxification or detox) followed by abstinence is recommended for people who are physically dependent on alcohol. This usually occurs in the community but may need to be on an inpatient basis if there is a risk of withdrawal seizures.

NICE (2010) recommends that brief interventions (Bien et al. 1993) are offered in a range of settings including primary care and A&E designed to help people reduce alcohol use to less harmful levels. Those with less severe alcohol problems and binge drinkers may opt for controlled drinking. This means keeping alcohol consumption within safe levels by adhering to a set of personal rules, such as not drinking alone, not having more than two drinks a day, and not drinking on consecutive days.

After becoming abstinent or successfully controlling alcohol, NICE (2011) recommends that people are offered:

- Cognitive behavioural therapy (discussed more fully in Ch. 15). This is often provided in the form of a relapse prevention approach, which will be discussed later
- Behavioural therapies such as *cue exposure*, whereby a person is repeatedly exposed to learnt cues to drink alcohol until they habituate to those cues and the cravings to drink are extinguished
- Social network and environment-based therapies, whereby an individual is supported to build a network of family and friends that are supportive of a change in drinking. Recreational, social and vocational activities can be encouraged on the basis that developing a non-substance-using network and developing a role or a positive identity may be key factors in preventing relapse (McIntosh and McKeganey 2000)
- Behavioural couples therapy. This is a manual-based method combining cognitive behavioural therapy with methods that address relationship problems caused by the alcohol use.

Drug Misuse

Frequently, the first stage of treatment for opiate users is stabilization using *substitute prescribing* (such as methadone or buprenorphine). This aims to stop the user experiencing unpleasant withdrawal symptoms but does not provide a 'high'. The rationale behind substitute prescribing is that the drug user no longer has to inject street heroin, with its associated health risks, or be involved in illegal activities in order to fund a habit. Long-term prescription of methadone, or methadone maintenance, aims to allow users to stabilize their drug use and therefore their lives and, combined with psychological and social support, make positive lifestyle changes. It requires close monitoring due to the risk of overdose or harm related to illicit drug or alcohol use.

In practice this stabilization can take a long time to achieve due, for example, to a longstanding chaotic lifestyle, the social environment of drug-using friends, and the continued desire to use drugs to escape from reality. Many service users also have physical, social, legal and psychological problems which need to be addressed as part of a comprehensive treatment plan. Once an individual has achieved stability in their lives, they may consider a 'detox' from substitute opiate medication. This is normally followed by a period of rehabilitation or rehab, usually in a residential or day programme.

Contingency Management. NICE (2007) recommended that contingency management be introduced to drug treatment services. This is a behavioural approach based on operant conditioning, whereby incentives are offered, often in the form of vouchers that can be exchanged for goods or services. Giving the voucher is *contingent* on drug tests being negative regarding illicit drug use. In the contingency management approach, the value of vouchers increases with increasing

periods of continuous abstinence. There is potential for these vouchers to be used to support occupational and recovery-focused goals such as paying for gardening equipment, art materials or sessions in a sports centre. However, since the publication of this guidance, contingency management appears not to have been introduced anywhere in the UK. Despite a clear evidence base demonstrating the cost-effectiveness of this approach (Lussier et al. 2006), this may be due to the resource implications of funding the vouchers, drug testing and administration of these schemes, as well as the political repercussions. For example, health minsters may fear a public backlash, particularly in a time of austerity, against 'paying' drug users to engage in treatment when people with other conditions are not, and may in fact be facing cuts to care services. Nonetheless, Kings College and the Institute for Psychiatry are conducting research into the implementation of contingency management in the UK (King's College 2012).

Approaches to Intervention

There are numerous models of substance misuse treatment and it is beyond the scope of this chapter to cover all of them. However, those of most relevance to occupational therapists will now be described.

Mutual Aid – Self-Help Approaches

These approaches are recommended in national guidelines (NICE 2007, 2011). The most well known by far are the '12 Step' approaches of Alcoholics Anonymous (AA) and its associate Narcotics Anonymous (NA). The 12 Step approach is a self-help movement that offers an extensive support network of group meetings for substance users and their families. In this approach, an individual achieves recovery by progressing through the 12 steps with the support of a *sponsor* (mentor).

Criticism has been levelled at the requirement that those who attend AA or NA must adhere to the idea that dependence is a disease and must constantly remind themselves that they are alcoholic, even when they have been abstinent for many years. Additionally, criticism is directed at the idea that a higher power is responsible for an AA or NA member's abstinence, suggesting that this removes the responsibility for sobriety from the individual. Recent research has found that it is the supportive social network provided by the 12 Step approaches – rather than the associated belief system – that generates good outcomes. This research recommends that treatment providers de-emphasize the philosophy of the 12 Step approaches but encourage attendance as a means of gaining social support that promotes abstinence. Studies show that changing one's role from being someone in need of help to someone who provides help to others and takes an active role in meetings (such as simply making coffee, initially) was associated with positive outcomes, more so than just attending (Pagano et al. 2004; Weiss et al. 2005).

A growing, secular alternative to 12 Step approaches is SMART recovery (Smart Recovery UK 2010). A programme is offered online with a network of meetings and volunteers based on motivational enhancement therapy, cognitive behaviour therapy and rational emotive behaviour therapy.

Relapse Prevention

Relapse prevention (RP) is a widely used intervention based on cognitive behavioural therapy. Marlatt and Gordon (2005) describe RP as a self-management programme designed to enhance the maintenance phase of the Stages of Change model. NICE (2007) recommend that this approach is only routinely offered to those with co-existing anxiety and depression. However, as described earlier in relation to dual diagnosis, it is likely that most service users will present with these additional problems.

RP focuses on 'self-management and the techniques and strategies aimed at enhancing maintenance of habit change'. It is 'a self-control programme that combines behavioural skills training, cognitive interventions and lifestyle change procedures' (Wanigaratne et al. 1990, p. 1). There is a growing body of evidence supporting the effectiveness of RP interventions (Carroll 1996; Irvin et al. 1999).

The RP approach uses cognitive behavioural strategies to help people learn how to anticipate and cope with situations and problems that might lead to a relapse (Wanigaratne et al. 1990). It focuses on the notions of high-risk situations and coping strategies available to the individual.

Research shows that people who are *aware* of potential relapse situations and who use specific strategies can effectively reduce their risk of relapse (Litman 1980; Kirby et al. 1995). Boredom and negative mood

states are most likely to precipitate a relapse. Second comes social pressure and being offered, or talking about, drugs. Other risk factors include interpersonal conflict and environmental cues.

Initial stages of relapse prevention focus on enabling the individual to develop a good awareness of internal and external triggers to craving, such as through diary-keeping. Service users are encouraged to identify their own possible relapse triggers and to work on these with the therapist. The therapist, either in a group setting or individually, helps the individual to analyse these situations. The person will also be taught how to analyse situations on their own. Structured problem-solving techniques are used as well as role-play or rehearsal of relapse situations.

There are specific cognitive behavioural techniques (Marlatt and Gordon 2005; Wanigaratne et al. 1990) used to assist people in preventing relapse – such as *problems of immediate gratification* (PIGs). These techniques see craving as being caused by high-risk situations and external cues. Marlatt (2010) proposes a method for managing urges, called 'urge surfing'. This is based on mindfulness and the facilitation of detachment, whereby the thought 'I notice I am feeling the urge to drink' replaces the act of immediately drinking, on the understanding that the urge will arise and then subside. Coping with the urge by not responding to it at its peak starves it. Coping strategies such as relaxation methods, distraction, biofeedback or other approaches, may assist this technique.

RP also stresses the importance of global lifestyle change, which aims to enable people to:

- arrive at a balanced lifestyle
- learn effective time management (to fill up the vacuum left by giving up the substance)
- discover and take-up positive activities
- identify and change unhealthy habit patterns.

It can be seen from these approaches that relapse prevention fits well with occupational therapy, particularly because it focuses on individuals' lifestyles and the day-to-day situations that cause relapse. In such work, occupational performance areas, components and contexts are critical to treatment success. Developing psychological performance components, such as self-esteem and volition, can help an individual cope with environmental triggers to relapse.

A note on the language of recovery. The term 'recovery' in the field of addiction generally has a different meaning to the way it is used in general mental health practice, and it remains a controversial term according to different treatment approaches. According to the 12 Step approaches, there is an emphasis on defining oneself as being 'in recovery' or as 'a recovering addict' once one has become completely abstinent from *all* drugs and alcohol. Recently the UK Drug Policy Commission (UKDPC 2008) created a description of recovery drawing on different approaches to addiction and the model of recovery in mental health:

> *The process of recovery from problematic substance use is characterized by voluntary control over substance use which maximizes wellbeing and participation in the rights, roles and responsibilities of society*
>
> ***(UKDPC 2008).***

The notion of someone with controlled substance use being 'in recovery' is likely to be considered an anathema from a 12 Step perspective.

OCCUPATIONAL THERAPY AND SUBSTANCE MISUSE

The earliest papers describing occupational therapy with people addicted to alcohol highlight areas of concern similar to those identified within modern evidence-based practice. For example, Rotert (1989) cites Hossack (1952), who highlighted the reduction in former interests, activities and social connections, difficulty concentrating, tension and family problems and suggested that the individual must aim to develop a more fully rounded life with a balance of activity. Doniger (1953, cited by Rotert 1989) suggested unpredictability, elusiveness, relationships, leisure and motivation as areas for concern. The issues raised by these two pioneers of occupational therapy in the field of addiction remain fundamental to the occupational therapy/addictions knowledge-base.

Occupational therapy can have a significant impact in enabling people to develop meaningful occupations, routines and skills that support abstinence and recovery and reduce the risk of relapse. Substance

dependence has an inherently occupational basis, as illustrated by the following diagnostic criteria for substance dependence:

> *A great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects.*
> *Important social, occupational or recreational activities are given up or reduced because of substance abuse.*
> *(American Psychiatric Association 1994, p. 181)*

Many people with substance misuse problems, after being completely focused on their drug/alcohol use, experience a vacuum in their day-to-day lives, when they become abstinent or engage in treatment. This can leave them feeling de-skilled, vulnerable and bored. Occupational therapy can help people to develop skills and coping strategies, as well as a more satisfying, balanced lifestyle. McIntosh and McKeganey (2000) found that it was not enough for ex-users to 'keep busy', but that finding purposeful, meaningful and rewarding activities, which restored personal identity and fostered positive life roles, was essential.

Some of the issues occupational therapy can address may be categorized under the three occupational performance areas: work, self-care and leisure. However, these are not entirely separate domains and all may be addressed simultaneously through engagement in meaningful occupation, as the case example described by Lancaster (2008) and summarized in Case study 28-1 illustrates. (See also Ch. 17 regarding creative activities in occupational therapy.)

Intervention is usually via individual work and group work, aimed at developing performance components in a range of contexts, for example learning to cope with anxieties without alcohol, or saying 'no' if offered drugs. Group contexts and community locations can provide the chance to rehearse performance components. Individual work can focus on enhancing specific components through goal-setting.

Leisure

Leisure is one of the key problem areas for people with substance misuse problems because leisure activities and contexts are where alcohol and drugs are most commonly used. Negative mood states, such as boredom and social pressure are the two most common factors in relapse. Many people who have become dependent on substances will have little or no awareness of leisure activities other than those that involve substance use.

CASE STUDY 28-1

Using Art with an Opiate-Dependent Service User

This case study concerns a service user in treatment for opiate dependence. This intervention involved substitute prescribing, one-to-one occupational therapy and participation in creative art workshops run by the occupational therapy service in partnership with a local community arts organization. The workshops culminated in an art exhibition displaying artwork from various projects, which was opened by the service user with a speech, where she said:

> *When I came to my clinic I was not the person I am today. I wanted to give up drugs, but every attempt had failed miserably. I had been with a treatment clinic before, but all they gave us was medication, and after a few months I was using again. Since I have been with this clinic, I have had huge support and help from everyone who has worked with me, but especially my occupational therapist …. From the day I met my OT my life has got better and better. … The OT-Artspace project helps in ways you wouldn't even imagine: something as simple as getting you out of the house and facing life, instead of sitting alone brooding which in turn creates boredom or depression – both of which can lead straight back to drugs or alcohol … Giving people a routine to stick to and a goal to aim for is one of the most basic things that will put someone on the track to recovery, and a new and better life. Not only does it help in that way, but, meeting people and socialising also gives confidence and self-belief, all of which is taken for granted in most people. But they can be the hardest things to instil into someone whose life has been on the fringe of society for the length of their addiction, which in most cases is years if not decades*
>
> (Lancaster 2008, p. 12–13).

The importance of leisure as an effective component of relapse prevention has been highlighted in a wide range of research literature, including occupational therapy literature (Hodgson et al. 2001). Leisure activities are particularly useful in reducing the frequency of negative thoughts and alcohol craving (Bennett et al. 1998) as well as building self-confidence (Cheung et al. 2003), which reduces the risk of relapse.

The use of physical activities in particular for a variety of therapeutic goals is described in the research literature (Burling et al. 1992; Donaghy and Mutrie 1999) and provides a small but promising evidence base. Ussher et al. (2000) describe the development of a physical activity programme as part of occupational therapy within a community alcohol service. Sport and fitness-related activities will raise self-esteem and confidence and counteract individuals' negative affect. Discovering or rediscovering leisure can help develop motivation for positive change. (See Ch. 14 regarding the impact of physical activities.)

Leisure intervention may form an important part of family therapy, where family-oriented leisure has been involved with, or affected by, substance use. In the authors' clinical experience, activities that help a substance user to engage in adaptive interactions with family members are often highly successful. This is especially so where the individual enjoys and can remember the activity and where it stimulates both service user and family member. Examples include cooking group meals, swimming, playing racket sports, bowling and visiting theatres, cinema or art galleries, even practising magic tricks (as described in Case study 28-2). Activities that individuals can take up as a hobby and talk about with the family are similarly effective.

Work/Productivity

There are three domains within which to consider work and productivity in the field of substance misuse:

- *Work-based substance use* – where there is drug use during the working day in (legal) employment
- *Substance-based productivity* – where drug use or drug-dealing following a similar pattern to paid work and providing similar rewards and meaning to life
- *Vocational interventions* – helping service users gain employment.

CASE STUDY 28-2

Using Leisure Activities with an Alcohol-Dependent Service User

Brian is a 32-year-old man diagnosed with alcohol dependence and with a history of verbal abuse and sometimes physical violence towards his two young children. He values his role as a father but feels he does not know what to talk to his children about. Occupational therapy involves attendance at six weekly group sessions learning magic tricks (involving card and coin tricks). After the 3rd week, he is able to show his children one of the coin tricks he has learned. They are delighted and spend an hour talking to him about it and trying to learn what he can do. He takes up stage magic up as a hobby, earning the admiration of family and friends for his new skills.

Work-Based Substance Use

Where substances are used during a job, this can be subtle and often either linked to peer pressure or to coping with work pressure. Substance use can be considered a part of work where, for example, the entertainment of business clients is part of the working day. Substances are often used covertly at work. Initial experiences of high achievement may reinforce a pattern of substance use but errors of judgement usually ensue and crises may occur. Jobs are often affected negatively or lost altogether once substance misuse patterns become established. Other non-paid work, such as housekeeping and voluntary work, will be similarly affected. Occupational therapy focuses on helping a person to cope with work without using the drug and to develop resistance to relapse triggers in work settings. This may involve liaison with an employer to develop graded re-entry into work.

Substance-Based Productivity

Where maintaining a drug habit becomes 'work', an individual's efforts can be directed to obtaining a regular supply of the substance, selling the substance or engaging in regular criminal activity in order to fund the addiction. These behaviours may display characteristics that are similar to legal employment. Occupational therapy focuses on identifying habit-maintaining skills and transferring these to non-drug-related activities, such as voluntary work, training or employment.

Vocational Interventions

There is an increasing focus within treatment services on helping service users gain employment. While this is part of the wider UK government target of reducing the number of people receiving welfare benefits, it also acknowledges the positive link between employment and recovery from substance dependence (McIntosh and McKeganey 2000; Scottish Executive 2001; NTA 2006).

There is significant evidence that employment, training and education for people with substance misuse problems enhance clinical outcomes by reducing rates of relapse, restricting time of use, and reducing criminality and parole violation (Platt 1995; Jenner 1998; Platt et al. 1998; Room 1998; Valliant 1998; Alverson et al. 2001; Kang et al. 2006). Loss of confidence is a major issue in prolonged substance misuse (Gutman et al. 2003; Morganstern et al. 2003; Chandler et al. 2004) and this research also found that pre-vocational skills (such as confidence, interpersonal skills, time-keeping and budgeting) were necessary in order to improve employment outcomes. A research review by the Effective Interventions Unit (Scottish Executive 2001) also highlighted the importance of 'soft outcomes', or pre-vocational skill development. Occupational therapists are specialists in developing pre-vocational skills using creativity and building on activities of daily living.

A large-scale study undertaken by Kang et al. (2006) highlighted that there is poor compliance with vocational services for methadone-treatment patients if pre-vocational work is not integrated into a specialist work rehabilitation programme. Other research also indicates that delivering a vocational programme in *conjunction* with treatment improves outcomes (Drake et al. 2003). Education, employment or training goals should therefore be included in all treatment plans. Occupational therapists, alongside employment specialists (where present) can act as vocational leads within the multi-professional team, assessing vocational and pre-vocational skills and developing individualized plans.

Self-Maintenance

Self-maintenance activities tend to decrease as substance use increases. The compulsion to use a drug eventually supersedes any awareness of nutrition, health, cleanliness, safety or responsibility for finances. Consequently, daily living becomes chaotic. Drug users, once abstinent or stabilized in treatment, often feel particularly de-skilled in relation to day-to-day household activities such as budgeting or basic time management.

Dental problems and loss of teeth are common consequences of drug use (Edwards 2010), the effect that this has on self-image can pose a barrier to achieving occupational and social goals. Remedial dental work can be a helpful early goal included in a treatment plan to help them construct a 'non-addict identity' and remove perceived barriers to social interaction caused by concerns about appearance (Robinson et al. 2005).

Evaluation of Outcomes

Outcome measurement is possible through a wide range of occupational-therapy-specific and other questionnaires or assessment tools. Some of these are described in the assessment section of this chapter. Most of those described are used before and after phases of intervention. Others can be used on a sessional basis, such as the General Health Questionnaire (Goldberg 1986). The most widely used outcome measurement tool – the Treatment Outcomes Profile (TOP) (Marsden et al. 2007) developed by the NTA – measures:

- Drug and alcohol use
- Injecting risk behaviour
- Offending and criminal involvement
- Health and Social functioning (including training and employment).

SUMMARY

This chapter has focused on the range of issues affecting people who misuse substances and the intervention strategies that are available to address these. Clearly, there is considerable scope for occupational therapists to contribute to substance misuse interventions. Substance misuse occurs at the very centre of human occupation – in work, leisure and self-care – and it gradually takes over as the most central driver of occupational behaviour, changing and damaging performance components as it progresses.

Occupational therapy methods work well with the key clinical approaches already developed in the field of addiction. Furthermore, occupational therapists can enhance practice by tackling the subtle and complex

challenges to day-to-day living that service users experience. Further reading is recommended in this area, as is further education, especially as substance use exists within all areas of mental health practice and is more likely to increase than decrease in everyday practice.

USEFUL CONTACTS

Drugscope Tel: 020 7520 7550 Website: www.drugscope.org.uk Provides information on drugs and drug misuse.

Alcohol Concern Tel: 0207 566 9800 Website: www.alcoholconcern.org.uk.

Alcohol Concern is a national alcohol misuse agency.

Drinkline 0800 917 8282 Alcoholics Anonymous (AA) Tel: 0845 7697555 Website: www.alcoholics-anonymous.org.uk.

Narcotics Anonymous (NA) Helpline: 0300 999 1212 Website: www.ukna.org/.

National Consortium of Consultant Nurses in Dual Diagnosis and Substance Use Website: www.dualdiagnosis.co.uk/.

National Drugs Helpline 0800 776600 Website: www.talktofrank.com.

National Treatment Agency for Substance Misuse Website: http://www.nta.nhs.uk/.

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SERVICE USER COMMENTARY

The key qualities a mental health service user hopes for from the people they encounter in the health service, are compassion and understanding. The service user also needs to feel the person helping them has some relevant tools at their convenience, and to trust that the treatment they are receiving is going to be of benefit.

This chapter explores how occupational therapists work with individuals experiencing mental health problems alongside substance misuse, initially identifying the nature, history and current prevalence of substance misuse in the UK. It is always wise to consider statistics with an element of caution though, as personal research revealed that contrary to the 1% figure cited in this chapter, approximately 3% of adults aged 15–59 in England and Wales use Class A drugs (Home Office 2012).

A useful explanation of dual diagnosis firmly places the needs of mental health service users with substance misuse problems in the health sector, rather than reinforcing an oft-held assumption that they are unconnected issues and should be treated separately. This is not to say all people who misuse substances will necessarily experience mental health problems, but emerging documentation from key UK charities and organizations such as Turning Point, Compass and Drugscope (see below) are increasingly developing essential and comprehensive guidelines for professionals working in this area.

The definitions of substance misuse and available treatment options highlight significant tensions within current policy and practice. Of particular interest is the focus on the 12-Steps approach adopted by several organizations such as Alcoholics Anonymous and Narcotics Anonymous, with its emphasis on a 'higher power', helplessness, abstinence and detoxification. It is reassuring to read in this chapter that this, now over half a century old approach, is increasingly being challenged, with alternative philosophies gaining popularity.

The 'Model of Change' fits neatly into this category, offering a more realistic acknowledgement of the futility of *any* treatment models with individuals unready or unwilling to accept treatment. Additional insight into the relapse/remission nature of substance misuse problems, the likelihood of subsequent difficulties encountered at varying stages, and the importance of accurate ongoing assessment, will hopefully encourage occupational therapists to competently devise well-grounded treatment plans that can accommodate the fluctuating needs of individuals with mental health problems related to substance misuse.

A useful reminder of the importance of three key areas of 'performance' assessment is given, and the remainder of the chapter focuses on tools and interventions that may be utilized. I was especially interested in the behavioural approaches and the recognition of difficulties individuals encounter due to personal, idiosyncratic triggers. Working with an individual must therefore be tailored to the person's life – their experiences, routines, expectations, and aspirations. Everyone will respond to a different approach, but the methods aimed at coping with relapse prevention, and those used to empower individuals and increase their self-esteem, should definitely be endorsed.

Like most individuals experiencing mental health problems, those with the additional difficulties arising from substance misuse deserve respect and a professional approach. This excellent chapter offers theoretical and practical solutions from which to start.

Trish Staples

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29 WORKING ON THE MARGINS: OCCUPATIONAL THERAPY AND SOCIAL INCLUSION

E. MADELEINE DUNCAN ■ JENNIFER CREEK

CHAPTER CONTENTS

INTRODUCTION

A margin is that part of an area that is adjacent to the edge. To marginalize someone is to move them 'to the margin of a sphere of activity, make economically marginal, impoverish' (*Shorter Oxford English Dictionary* 2002). Margins are often understood as problem areas. For occupational therapists, they represent places for exploration and opportunities for contributing to social change through occupation-centred practice. Sometimes, occupational therapists work towards

creating a new centre, through belonging and bringing people together. At other times, occupational therapy is about bringing people into a centre from the margins. And often it is about both. Sometimes, it is about appreciating that what is perceived to be marginal is not marginal at all. In short, occupational therapy on the margins is about being responsive to the social determinants of mental health and human wellbeing.

This chapter commences with a brief overview of global mental health challenges and the implications of these for occupational therapy on the margins in developed and developing countries. Sociology is suggested as a foundation for considering various dimensions of social oppression and the implications these have for humans as occupational beings. The story of Dorcas is used to illustrate social exclusion and inclusion as features of life on the margins. The chapter concludes by describing how occupational therapists working on the margins might orientate themselves, using a number of direction pointers. Pertinent references for additional reading to substantiate the points being made are provided throughout the chapter.

WHY MARGINS MATTER: CHALLENGES IN GLOBAL MENTAL HEALTH

In many countries, the practice of occupational therapy takes place mainly within health services. This has led to the development of mainstream occupational therapy theory, models and methods that focus almost exclusively on individual therapy, with secondary attention given to the socioeconomic, political and historical circumstances that impact on people's health and occupational status. However, there has been a subtle but important shift in professional perspective; one that looks beyond a diagnostic, medical view of individual mental health to the social groups and communities within which people live, become unwell and are expected to recover. A methodological middle way is unfolding, in which occupational therapists recognize and address the interplay between personal troubles (individual biographies) and public issues (history and structure of the society within which the individual is located). The central commitment of this perspective is to build socially inclusive, egalitarian communities through recognizing the power of occupation for individual and collective human development and wellbeing (Kronenberg et al. 2011; Whiteford and Hocking 2012).

Different Worlds

This chapter was written by two occupational therapists: one based in an industrialized and developed country and the other in a developing African nation. Reflecting on the similarities and differences of mental health occupational therapy in the UK and South Africa, we were reminded of the roles that history, economics and politics play in shaping what the profession is able to offer in a particular society. The personalized mental healthcare packages promoted in developed countries are based on the availability of operational and resourced service infrastructures and regulated profession-specific functions, outputs and outcomes (Trentham et al. 2007; Slade and Davidson 2011). Occupational therapists employed by statutory mental health services in these contexts are structurally supported as they work in partnership with individuals and other stakeholders in the delivery of person-centred recovery programmes.

A different service trajectory is likely to exist for occupational therapy in low- and middle-income countries (LAMIC), due to under-developed mental healthcare systems and resource constraints associated with poverty and social inequality (Patel 2003; Lund et al. 2007). In these countries, mental health services, if available, are usually merged within primary healthcare and delivered through grassroots community structures to populations rather than individuals (Petersen et al. 2010). The emphasis of primary healthcare is on preventing disease and disorders, eradicating malnutrition, providing adequate shelter, opening access to basic education and creating jobs, as fundamental human rights and as social precursors for health and wellbeing (Farmer 2008).

Local Circumstances

Writing about mental health services in low- and middle-income countries (LAMIC), Murthy (2011, p. 333) stated that:

> development of mental health services all over the world, countries rich and poor alike, have been the product of larger social situations, specifically

> the importance society gives to the rights of disadvantaged/marginalised groups. Economically rich countries have addressed the movement from institutionalised care to community care, building on the strengths of their social institutions. LAMIC have begun this process in a different way and have made significant progress. There is a need to continue the process by *widening the scope of the mental health interventions, increasing the involvement of all available community resources, and rooting the interventions in the historical, social and cultural roots of countries.* (Italics added)

Murthy (2011) argues for a broader scope of action that is both socially inclusive and contextually relevant. To achieve this requires identification of priorities for research and intervention, and contextually responsive mechanisms for implementation put in place, with consideration given to local circumstances. One example is the *Grand Challenges in Global Mental Health* initiative, which identified 25 top global challenges and six priority goals for research and intervention that will make an impact on the lives of people living with, or at risk for, mental, neurological and substance-use disorders (Collins et al. 2011).

Of particular interest to occupational therapists are the priority goals, which are briefly discussed in the next section.

Risks Across the Life Course

The first principle promotes a life-course approach because mental health problems, neurological and substance use disorders either begin or manifest early in life. This risk may be averted by building mental capital, which is defined as 'the cognitive and emotional resources that influence how well an individual is able to contribute to society and experience a high quality of life' (Collins et al. 2011, p. 28). Early interventions aimed at developing mental, emotional and occupational capitals have been shown to interrupt the social drift of vulnerable people towards the margins of society (Twemlow and Fonagy 2006; Mental Health and Poverty Project 2008). Working within communities and in collaboration with community-based organizations, occupational therapy can be a mental health promotion and prevention service concerned with facilitating the optimal person–occupation–environment interface (American Occupational Therapy Association 2010; Scaffa et al. 2010; Thew et al. 2011; Whiteford and Hocking 2012).

System-Wide Approaches

The second principle is the use of system-wide approaches to alleviate human suffering by incorporating a mental health component into all social services. Occupational therapy contributes to this system-wide approach by extending services to: people in refugee camps, migrant hostels, slums, prisons, orphanages, homeless shelters, first people's and third nation reserves, shelters for abused women and children and facilities for child soldiers and asylum seekers; people displaced by natural disasters, civil unrest and war, and other marginalized groups (Kronenberg et al. 2011).

Environmental Influences

The third principle underscores the importance of understanding and addressing environmental influences on mental health: 'Extreme poverty, war and natural disasters affect large swathes of the world, and we do not fully understand the mechanisms by which mental disorders might be averted or precipitated in those settings' (Collins et al. 2011, p. 30). Occupational therapists are beginning to address the occupational implications of natural and man-made disasters and, in so doing, are contributing to the body of knowledge associated with mental health and human geography (Wilcock 2006; Thomas and Rushford 2013).

Multi-Pronged Solutions

The fourth principle is that all mental healthcare and treatment should be evidence-based so that programme planners, policy-makers and clinicians know what to target for the best possible outcomes. The research agenda to establish evidence for mental health occupational therapy on the margins requires greater commitment to transdisciplinarity and strategic positioning of the profession within global–national–local research consortiums (Illot et al. 2006; Richardson and Duncan 2013).

Occupational therapists can contribute to these and other Grand Challenge themes by adopting a critical stance towards the social contexts within which they work. A wider vision than the remediation of illness or disability is indicated, however important functional

outcomes might be for individuals and their families. Townsend and colleagues (2007, p. 155) suggested that 'outcomes of interest to occupational therapists in enabling social change may be to advance occupational rights'. Turner (2011, p. 320) wrote of a 'hinterland of need' in which increasing numbers of people in need of support and long-term help are likely to fall outside the remit of statutory care services. A critical stance is facilitated when occupational therapists become reflexively aware of the social dynamics associated with margins.

UNDERSTANDING THE MARGINS

In this section, a discussion of margins as a sociological concept is structured through a series of questions.

What are Margins?

Margins are conceptualized as fluid spaces or positions that social groups occupy on the basis of difference. A social group is a 'collective of persons differentiated from at least one other group by cultural forms, practices or way of life' (Young 2000, p. 37). A margin can be a physical place, a social space or a personal experience on the periphery of the social mainstream or dominant order. For every margin, there is a centre or core that represents some form or position of authority, power and privilege. Margins exist wherever humans congregate; they affect every form of social grouping, including families, communities, organizations and society, and are constantly changing in response to sociopolitical, economic, cultural and other forces that marginalize people on the basis of perceived difference.

Social Exclusion

Social exclusion is an alternative term used to refer to marginalization and has been defined as forms of disadvantage brought about by the cultural devaluation of groups or categories of people in society based on who they are perceived to be.

> The concept of Social Exclusion captures the experience of certain groups who are 'set apart' or 'locked out' of participation in social life. Moreover, it brings attention to *processes* (italics added) of exclusion. This means understanding how disadvantage is produced through the active dynamics of social interaction, rather than through anonymous processes of impoverishment and marginalization.
>
> ***(Kabeer 2000, p. 1)***

Human Differences

There are many vectors and combinations of perceived and imposed difference involving complex constructs such as gender, race, class, ethnicity, ability, sexual identity and others. When differences become socially significant, they cause stratifications and divisions that elevate some people above others, giving them a disproportionate amount of resources, power and prestige. Social diversity and stratification are key organizing features of all societies. Certain categories, strata or groups of people are positioned on the continuum between centre and margin and are ranked in a hierarchy of social status which, from an occupational perspective, influences the forms and functions of occupation in society (Whiteford and Hocking 2012).

Assumptions

People everywhere, including occupational therapists, tend to think that their own positioning and way of life is how life is or should be for everyone else (Whalley Hammell 2011). This assumption can make them unaware, dismissive or critical of the lifestyles and social practices of those who are different from them, so that people participate in oppression either inadvertently or deliberately. Thus, social strata or divisions create margins which may lead to different forms of oppression (Young 2000).

Why do Margins Exist?

Margins exist because human difference is used as the basis for oppression (Macionis and Plummer 2008). Oppression refers to 'the vast and deep injustices some groups suffer as a consequence of often unconscious assumptions of well meaning people in ordinary interactions, media and cultural stereotypes, structural features of bureaucratic hierarchies and mark mechanisms, in short the normal processes of everyday life' (Young 2000, p. 36). The consequences of oppression for humans as occupational beings are important because oppressed people are prevented every day from developing and exercising their capacities and potential

through what they do. Young (2000) differentiated five faces of oppression: exploitation, marginalization, powerlessness, cultural imperialism and violence.

Exploitation

Relations of power and inequality are enacted through the social process of exploitation, which occurs when the results of the labour of one social group are regularly transferred to benefit another. The powerful also get to make the social rules about what work is, who does what for whom and how work is compensated. For example, farm workers on some wine estates in South Africa owned by wealthy land barons used to be paid through the *dop* system, which entails wages in the form of wine rather than money. The health and social repercussions of the *dop* system are still evident in post-apartheid South Africa, where there is a high incidence of fetal alcohol syndrome and poor mental health among some farm workers (London 2003; McKinstry 2005; Cloete 2012).

Marginalization

Marginalization is the process by which 'a whole category of people is expelled from useful participation in social life' (Young 2000, p. 41). To be marginalized means to be different, excluded, unequal and potentially subjected to material deprivation or even extermination. As individuals, we all experience social marginality or exclusion from time to time but for some categories of people, such as immigrants, refugees, gays, lesbians and transgendered people, people with disabilities, the homeless and older people, being marginalized is part of daily life. Marginalization influences the type of occupations and range of opportunities for occupational engagement that are available to certain groups of people (Watson and Duncan 2010).

Disability theorists and activists argue that marginalization is a social issue rather than an individual problem experienced by disabled people. It is evident in the lack of access to public spaces, discrimination in the workplace and denial of the resources necessary for independent living and participation in society (Galvin 2003; Oliver and Barnes 2012). Occupational therapists believe that marginalization occurs when the 'need for humans to exert micro, everyday choices about occupations' is blocked by 'normative standardization of expectations about how, when and where people "should" participate' (Townsend and Wilcock 2004, p. 81). The impact of marginalization on occupation has been described as a form of occupational injustice (Townsend and Wilcock 2004; Wilcock 2006, pp. 221–243; Wright et al. 2006; World Federation of Occupational Therapists 2010).

Powerlessness

Powerlessness is a process by which people come to 'lack authority, status, a sense of self' (Young 1990, p. 57). Since politics is concerned with power and authority, it is the politics of a society that determines which groups of people become powerless and which groups are given access to power. Political power is dominance exerted by one group of people over another through authority or status; for example, the power of the medical profession to diagnose illness. People with power are distinguished from others in three ways:

- They experience progress through the acquisition of specialized privileges, such as knowledge and resources
- They are able to influence the course of events because of their status
- They are treated with respect because they have some level of authority, expertise or position.

Poverty creates particular forms of powerlessness and ill-being. In a study of the experiences of poor people in 58 countries in the developing and transitional world, Narayan and colleagues (2000, p. 2) identified 10 interlocking dimensions of ill-being associated with poverty:

1. The body is hungry, exhausted, sick and poor in appearance
2. Capabilities are weak because of lack of information, education, skills and confidence
3. Security is lacking in both protection and peace of mind
4. Livelihoods and assets are precarious, seasonal and inadequate
5. Gender relations are troubled and unequal
6. Places of the poor are isolated, risky, unserviced and stigmatized
7. Social relations are discriminating and isolating
8. Behaviours of the more powerful are marked by disregard and abuse

9. Institutions are disempowering and excluding
10. Organizations of the poor are weak and disconnected.

Occupational therapists work towards poverty alleviation by researching and addressing the social determinants of health and social inclusion (COTEC 2010; Smythe et al. 2011; van Bruggen 2011). However, occupational therapy has only recently begun to consider political practice as a basis for promoting social inclusion (Pollard et al. 2008).

Cultural Imperialism

Cultural imperialism occurs when the 'dominant group in society imposes their own experiences, values, goals and achievements as the social norm' (Young 2000, p. 43). When people deviate from this socially imposed norm, they are defined as inferior or their ways of doing and being are negated, marking them as the *other*. Being *othered* reinforces social difference and marginalization by imposing dominant discourses, lifestyles and worldviews.

Theorists of occupation have been challenged on the grounds of cultural imperialism and of short-sightedness for orienting their theories in terms of middle-class, white, able-bodied experiences (Whalley Hammell 2011). Occupational therapists have also been cautioned about uncritically assuming the validity of views, theories and practice models developed by dominant worldviews (Kondo 2004).

Violence

Violence is a social practice in which the social context makes it possible, and even acceptable, to act violently against certain categories of people. Members of certain groups live with the knowledge that they must fear random, unprovoked attacks on their persons or property, which have no other motive than to damage, humiliate or destroy, because of who they are or who they represent. Young (2000) argued that violence is directed at individuals simply because they are members of a group and that this deprives them of freedom and dignity. She suggested that violence directed at a particular group is also systemic because cultural imperialism affects how groups are viewed, leading to fear or hatred of the *othered* group, which is then embodied in harassment and irrational, violent acts.

Harassment is illustrated by the following example. A young man with learning difficulties used buses to travel around his local area. He would often try to strike up a conversation with people he did not know, which was well intentioned but not always socially appropriate. One group of youths taunted him for his naivety until he hit one of them, then they called the police. The youths thought that taunting a person with learning difficulties was harmless fun but the young man lacked the social skills to deal with his tormentors without resorting to physical violence.

Occupational therapists work towards understanding the impact of violence on occupation, researching effective interventions, creating collaborations and advocating for occupation-based public health and social services for youth and other groups at risk (Cage 2007; Goertz 2008).

How are Margins Experienced?

Margins are experienced subjectively in uniquely different ways. There is, for example, no single way of experiencing a psychotic episode, being a woman, being a person of colour or being poor. We should, therefore, avoid conflating people's social positions, identities and values and refrain from essentializing their experiences of the margins.

Essentializing

Essentializing is a form of cultural imperialism in which dominant constructions of the world and of particular groups of people come to be reiterated, solidified and accepted as reality. It involves generating 'internal categories of personhood that are unchanging and timeless, that come to be inescapable, and that bear a determining influence of sorts on the person in question' (Parker 2004, p. 140). Therapists may essentialize when they draw conclusions about people's experiences of being marginalized, based on clinical expertise or having worked with particular groups of people. The ability to make informed clinical judgements about a person's mental state or level of functioning should not be conflated with understanding their experience.

Intersectionality

Experiences on the margins, including those arising from occupational engagement, have direct implications for identity. Identities 'exist at the level of

representation, being expressed in images and symbols, texts and ideologies, including those to do with legislation' (Yuval-Davis 2006, p. 198). People's identities and subjective experiences are shaped by the intersection of different social divisions such as class, race, gender, ethnicity, sex, ability and age (McCall 2005). The term *intersectionality* was first introduced to women's studies by Crenshaw (1989) as a theoretical paradigm grounded in identity categories. It is used to 'describe the relationships among multiple dimensions and modalities of social relations, subject formations and categories of analysis' (McCall 2005, p. 1777). Intersectionality is highly complex, creating a wide range of different experiences, identities and social locations that fail to fit into any single master category of social difference (McCall 2005) (see Ch. 13).

Oppression

While people's experiences of being marginal or socially excluded will be uniquely their own, they may nevertheless be subject to the social dynamics of oppression. For example, they may experience:

- *Disabilism*, which excludes and stereotypes people for their bodies, mental faculties or general health
- *Racism*, which is a powerful type of prejudice that asserts that one race is innately superior or inferior to another
- *Prejudice*, which is an inflexible and distorted generalization about a category of people.

In short, different social positions create hierarchies of access to economic, political, cultural and other resources for living, including opportunities for occupation. The perception of being positioned on the margins influences what people think and feel about themselves and the occupational choices they make (Galvaan 2012). The impact of these structural conditions on people's occupations and occupational engagement is illustrated in a case study later in the chapter.

Why do Margins Persist, Change or Expand?

In the preceding section, intersectionality was discussed in terms of personal characteristics. In this section, intersectionality is considered from a structural perspective in which geographic, economic, political and cultural conditions intersect to create, maintain or shift margins within and across societies.

Volatile Systems

Not all governments wish to give all their citizens a say in how the country is run, or work towards equal opportunities for everyone. This means that democracy cannot be assumed as an overarching political dispensation supporting professional initiatives for social inclusion. Different forms of social inequality can occur in different regions of the same country, as well as across countries and continents. For example, in some countries, geographic and political-historical circumstances have resulted in long-running civil unrest and even wars, which carry major consequences for the health and wellbeing of citizens and for public services, including occupational therapy. Of relevance to mental health occupational therapy will be the increasingly significant and visible impact of global events on national governance and, ultimately, at local level on what the profession has to offer individuals and constituencies with mental health concerns.

Development Surge

In the 21st century, the world has experienced a surge in social development due to technological advances (see national and regional United Nations Human Development Reports 1990–2012). However, existing margins will not only persist but become exaggerated. For example, in the coming decades, the development surge will be evidenced by three major social changes (Morris 2010):

- Large-scale urbanization, as people migrate in search of work or to seek relief from famine, disease and poverty
- Increased energy use that will exacerbate current levels of climate change and environmental degradation
- Advances in information technology that will speed up globalization and proliferation of war-making capacity.

Most of the world's poorest people live in an 'arc of instability' (Morris 2010, p. 602), which is what the US National Intelligence Council calls the region stretching from central Africa in a rainbow-shaped arc across the

Middle East to South-east Asia. Much of what happens environmentally, politically and socially in this region will reverberate across the world and influence how professions such as occupational therapy respond nationally and internationally to socioenvironmental imperatives.

Global Trends

Historians and sociologists suggest that the next 40 years will be the most important in global history, with top priorities being the avoidance of all-out nuclear war, slowing down global ecological deterioration and managing mass human mobility (Morris 2010). For example, the number of people facing food and water shortages is predicted to leap from 600 million to 1.4 billion, most of them living in and migrating from the arc (Morris 2010, p. 601). With declining harvests in the region, food shortages will create 200 million famine and climate migrants across the globe, five times larger than the world's entire refugee population in 2008. In short, the scope of need created by marginalized populations will increase across the globe between 2008 and 2025.

How do People on the Margins Respond?

How people respond and what they are able to do depends on their circumstances, such as the amount of freedom they have to act to their advantage, their ability to transform resources into valuable activities, the distribution of opportunities within society and the balance of materialistic and non-materialistic factors affecting their welfare (Anand et al. 2005). For example, adequate food and shelter are prerequisites for bodily health; safety and security are necessary for bodily integrity; affiliations with other people depend on being respected and having some control over one's environment requires access to personal, material and political resources (Nussbaum 2000). Individual and collective forms of agency, resilience and resistance characterize people's responses to their various capabilities.

Agency

Agency is the ability to take action towards a desired end or to produce an effect (*Shorter Oxford English Dictionary* 2002). An agent is someone who acts and brings about change, whose achievements can be evaluated in terms of his or her own values and objectives (Sen 1999). Agency is therefore crucial to assessment of a person's capabilities, allowing for an examination of whether or not economic, social and/or political barriers impede their ability to pursue the things they need and want to do that give expression to their being (Sen 1999).

Resilience

Resilience has three defining characteristics: the amount of change that a system (such as a person, household or community) can undergo and still retain some control over its function and structure; the degree to which the system is capable of self-organization, and the extent to which the system is able to learn and adapt (Berkes et al. 2003, p. 13). Emotional resilience is particularly important for mental health under the adverse personal and social circumstances associated with marginalization. It refers to the range of protective mechanisms and processes that enable people to withstand the potentially damaging effects of stress (Rutter 1987). A word of caution is indicated. Implicit in some discourses of agency and resilience is a tacit acceptance of the oppressive ways in which society functions (Duncan et al. 2011b, p. 68). Appreciating the resilience and agency of people on the margins should not divert attention away from resisting the social inequality to which oppressed groups are subject.

Resistance

To resist is to strive against, to withstand or to be in opposition to something. Resistance can take various forms: individual or collective, passive or active, violent or non-violent. People facing similar forms of oppression and social injustice may resist by mobilizing civic action for their rights through various forms of activism, including lobby groups, social movements, protest action and even riots (Deutsch 2006). A ground swell of resistance for social change can bring about substantive shifts in policy formulation, resource distribution and power alignment. See, for example, the impact of the Cuenca Declaration (People's Health Movement 2005) in South Africa and other parts of the world and the Mental Health Resistance Network in the UK.

OCCUPATION ON THE MARGINS

Occupational therapy has long been concerned with using occupation to promote development as a life course process synonymous with the unfolding of human potential and bio-psychosocial maturation (Clark 1979). However, the profession is also concerned with

using occupation as a means for community development in a socio-political process synonymous with democracy, pluralism, justice, equity and respect for a universal code of human rights (Galheigo 2011). Occupational therapy practice on the margins aims to address both individual and social forms of development (Kronenberg et al. 2011). This requires the occupational therapist to remain aware of the impact of biography (personal stories), history (a society's story) and structure (prevailing governance systems and social environments) on people's occupations. Four aspects of the numerous ways in which occupations can be affected by marginalization are discussed here.

Occupational Injustice

Prevailing sociopolitical influences determine the form and degree of occupational injustice that exists among different groups of marginalized people. Hence, occupational deprivation, alienation and imbalance, and other forms of occupational injustice, including occupational apartheid, manifest differently in different societies and contexts. These terms are defined in Chapter 3.

Intergenerational Transfer of Occupations

People develop shared identities and consciousness of their social category over generations because parents confer their social position and repertoire of occupations on their children (Young 2000). For example, the unfairness of an inferior education may be perpetuated across generations, with illiterate or semi-literate parents being ill-equipped to guide their children towards optimal performance when studying. Particular cultural knowledge, values and histories, therefore, advantage or disadvantage students from differently privileged backgrounds (Price 2011). Even the particular valorization of some ways of knowing over others (e.g. science and empiricism over religion and cultural mythology) and ways of acquiring knowledge (e.g. individual achievement and competitiveness over shared knowledge and collective achievement) may confer advantage or disadvantage in the education system.

Inequity of Opportunity to Access Preferred Occupations

For society to function well, it requires hundreds of different occupations, the performance of which becomes categorized according to social divisions such as class, gender and race. Hence, some sociologists argue that social stratification has beneficial consequences for the operation of a society (Macionis and Plummer 2008). Occupations hold positions of varying importance because they require different levels of knowledge and competence; for example, while removing garbage is considered to be an unskilled or semiskilled job, a long training is needed for acquiring the skills to design and build a bridge. Difficult and scarce talent requires extensive education so the more functionally significant a job is, the more society will reward the person who performs it with income, prestige and power. Social history and strata determine the range of opportunities for learning and developing through occupation available to certain categories of people; for example, youths in wealthy families are more likely than those born into poverty to achieve education and pursue their aspirations in terms of the types of occupations they are able to participate in. Personal and social histories combined with intersectionality have a profound impact on the occupational choices that are available to people (Galvaan 2012).

Inequity of Occupational Choice

People can be trapped on the margins where they are forced by circumstances beyond their control to make certain choices about what they do every day. Consider, for example, the people who live on the garbage dumps of large cities, the forced labour of child soldiers or people bound by caste or disability to perform occupations such as begging. Subject to complex social dynamics, some may resort to, find themselves forced to, or even choose to participate in antisocial occupations (Twinley and Addidle 2011) such as those associated with tagging, gangsterism and drug pedalling. Young (2000, p. 42) has also brought inequity of occupational choice into well-resourced spaces, stating that 'even if marginals were provided a comfortable material life within institutions that respected their freedom and dignity, injustices of marginality would remain in the form of uselessness, boredom and lack of self-respect'.

The next section illustrates some of the ways in which biography, history and structure operate at an individual level and the strategies that a person might develop to overcome them.

Biography on the Margins (Case study 29-1)

Dorcas (Case study 29-1) was one of five people who participated in a study investigating the dynamics between chronic poverty, psychiatric disability and occupation in households living in peri-urban slums near Cape Town, South Africa (Duncan et al. 2011a, b).

Dorcas experiences the intersectionality of several biographical, historical and structural barriers in her attempts to live a full and healthy life. These include: the maladaptive behaviour and disability associated with her illness; poverty, which is exacerbated by her gender, age and limited education, and discrimination from people who do not understand the causes or nature of mental illness. However, Dorcas also demonstrates agency and resilience that have enabled her to develop strategies for minimizing or circumventing the oppression and social exclusion she encounters. These strategies utilize both personal strengths

CASE STUDY 29-1

Dorcas' Story

Dorcas, aged 55, was born and raised near Mount Frere in the rural Eastern Cape, South Africa. As in so many other households at that time, her father worked on the mines in Johannesburg and sent remittances home whenever he could. Her mother contributed to the family income by selling indigenous medicinal plants foraged in the nearby mountains. The youngest of five children, Dorcas learned from an early age how to tend the soil, plant and harvest maize and vegetables, mind livestock, raise poultry, crochet scarves, knit jerseys and run a homestead. Living in a bartering economy, each family member was allotted chores and everyone contributed to the livelihood of the household, irrespective of age. Dorcas' older brother, working at a dairy in Cape Town, sent home second-hand clothes for his sisters to sell. Dorcas learned how to trade clothes. After her father's death, when Dorcas was 12 years old, the five siblings were distributed, by her mother, among the extended family because she could no longer support them. Dorcas lived with an aunt and completed Grade 7 at a Catholic school.

Dorcas married a shepherd with whom she had two children. She was expected to move to his clan location where she had to serve the older women, while continuing to secure an income by cultivating and selling vegetables and crocheted goods. Dorcas had her first psychotic episode when she was 28 years old. Hearing voices and believing she was bewitched, she set fire to two huts, causing her husband's family significant loss of material assets. She was tied up and locked away for 2 days in a mud hut until her family sent an ambulance to take her to a psychiatric hospital, where she stayed for a period of time. The marriage ended in divorce and Dorcas moved from the rural village to the city with her two children in search of work. Both the children grew up and left home.

Dorcas lived in a two-roomed shanty dwelling made of corrugated iron and cardboard sheeting in Khayelitsha, Cape Town. Like many of her neighbours, she had no access to electricity, used wood or paraffin for fuel and had to share a communal tap and toilet with many other households. Most people in this community were unemployed, very poor and migrated between the city and their rural homes in search of work. Dorcas survived on a disability grant (approximately £100 per month). She had a number of admissions to hospital for psychotic behaviour, such as running around naked in public and becoming unruly and irrational. She received monthly antipsychotic medication, which causes extra-pyramidal symptoms such as hand tremors, a drooling mouth and fatigue. She found the side-effects of medication almost as debilitating as the mental disorder itself. Her older brother was willing to take responsibility for her when she was ill and she had one close friend, Modloko, who supported her in running a small informal business selling second-hand clothes. Dorcas reported stigma and social exclusion:

> even when I go to the tap to get water the children make fun of me, calling me 'rakie' (mad person) … sometimes people take their waste shit and put their toilet in a plastic bag and put it by my front door.

and social structures, and include: recapitulation of income-generating occupations learned during childhood; cultural values and beliefs; a stable support system, and access to mental health services.

Recapitulating Occupation

A first factor supporting Dorcas' agency and productivity, in the presence of a disabling chronic illness, is the ability to recapitulate a range of informal income-generating occupations learnt during early childhood, such as trading second-hand clothes and growing vegetables. She is still able to access a set of skills that support her resilience in the context of poverty and social exclusion.

> I learnt how to do clothes selling when I was a child. I liked the way my mother did [informal income-generating occupations] and wished that I could raise my children like she did us.

Values and Beliefs

A second factor directing her agency is the cultural values and beliefs that provide a rationale for her illness behaviour and direct her occupational choices.

> I was bewitched. My man wanted to get rich and got himself a big snake from a witchdoctor that he believed would bring him wealth. I was not supposed to see that snake and when I saw it I became ill. The spirit of the snake shocked me purely because I did not agree with what my husband was doing and we fought about it daily … I left him and doing business now plays a role in my wellbeing.

Support Systems

A third factor enabling Dorcas' resilience is her access to a support system that helps her manage her illness behaviour, the demands of her business and the consequences of social stigmatization and marginalization. She acknowledges the significance of her friendship with Modloko, who is also her business partner:

> when the illness starts I pray that Modloko will come and lock me up here at home and give me my medication, and I lie down so that I do not make a nuisance of myself …. When I am ill I am not a good sight …. I take off my clothes and try to run away.

Access to Mental Health Services

Dorcas has had to adapt her occupational performance according to her fluctuating mental and physical health, accepting help from her friend, family and public mental health services which, in South Africa, are structured according to the primary healthcare approach.

> I am restless but if I sit with someone [on the pavement selling second-hand clothes] then I sit still. I get injections then I can work better.

During hospitalization, Dorcas may have participated in an occupational therapy programme. If the hospital occupational therapist was using a conventional occupational therapy model, intervention would have focused on Dorcas' mental health needs, offering her therapeutic and rehabilitative interventions aimed at mitigating the impact of psychosis on her functioning, occupational performance and social participation.

However, margins are fluid positions, not static physical spaces, so there is also the potential for the occupational therapist to consider the context within which Dorcas lives. In doing so, Dorcas' experiences may be framed as forms of occupational injustice. This would lead to a wider focus on the political, social and economic conditions that exacerbate her difficulties and direct the occupational therapist to address the structural factors that contribute to Dorcas' social exclusion. These might include community attitudes towards mental illness, policies for disability-inclusive development and local government support for informal traders.

In the next section, a way of working on the margins is proposed.

DIRECTION FINDING ON THE MARGINS

This section introduces some pointers that might be useful for thinking about what direction to take with those for whom the conditions of society are major barriers to function, performance and participation. The pointers offered here are not intended to give a comprehensive overview of the current state of knowledge or to be a definitive guide to practice on the

margins; they provide a starting point for therapists to develop, add to and refine their own compass when tackling some of the social conditions that impact on their clients.

- **Sociological imagination** about the biographies, history and structure associated with individuals and social groupings
- **Reflexivity** as a way of 'being' that locates the therapist as an active co-participant in social change
- **Values** to support a socially just practice
- **Partnership** with stakeholders concerned with particular public issues
- **Theory** that is contextually relevant for practice, education and research
- **Policy** orientation with knowledge of current local, national and international developments
- **Occupation** as a route to health, wellbeing and social inclusion.

Sociological Imagination

C. Wright Mills (1916–1962), a 20th century social thinker, was an American Marxist and sociologist who introduced the concept of sociological imagination (Mills 1967). Sociological imagination is a quality of mind that discerns intricate connections between individual stories and the stories of the particular society and history within which individuals are located. As a way of thinking, sociological imagination recognizes how social contexts contribute to the creation and perpetuation of personal problems. Mills believed that neither the life of an individual nor the history of a society can be understood without understanding both. For Mills (1967, p. 4), sociological imagination transforms personal problems into public and political issues and consequently helps people become agents of social change. By linking biography, history and structure, the interconnectedness between individuals and society becomes obvious, enabling people to identify critical points of action. He suggested that practitioners therefore need to keep their eyes open to both human variety and the social norms of the time: 'many personal troubles cannot be solved merely as troubles, but must be understood in terms of public issues – and in terms of the problems of history making' (Mills 1967, pp. 225–226; orig. 1957).

Sociological imagination guides occupational therapists to make links between individual biographies, the social structures that determine people's occupations and the unfolding public issues that shape history, such as politics, policy and resource distribution. It helps therapists to see individual troubles or triumphs in relation to the wider social context, that is, to think about personal problems as problems of society and vice versa. The challenges faced by individuals experiencing mental health problems must be *understood* and *addressed* within prevailing sociohistoric contexts. Sociological imagination opens up avenues for occupational therapists to recognize and address the occupational dimensions of social structures that compromise health, including mental wellbeing.

Consider, for example, cases of post-traumatic stress disorder and attempted suicide among ex-combatants. Sociological imagination compels consideration of the prevailing sociohistoric conditions that precipitate and perpetuate mental ill-health in the biographies of these individuals. This leads to the creation of occupation-centred pathways for traumatized ex-combatants that are integrated with conventional one-to-one hospital and community-based mental health occupational therapy approaches, to enable them to reclaim a place in society (Nell and Shapiro 2012, p. 27; Fossey 2012, p. 21–23).

Reflexivity

Reflexivity refers to the bidirectional relationships between cause and effect. A reflexive occupational therapist understands and actively engages with the two-way influence between self and other. Both therapist and client (individual, group, community) are shaped by the circumstances of their lives and the ways that they respond to the opportunities and challenges presented to them. Reflexivity involves critical self-awareness and self-reflection on the part of the occupational therapist, in a way that shapes *his or her own* norms, tastes, politics, desires and so on (Finlay and Gough 2003). Recognizing the interconnectedness between individual lives and the social structures within which people are occupied opens the possibility of co-creating realistic alternative futures.

Occupational therapists are trained to assess, interpret and address individual biographies that are affected by processes of mental ill-being, in particular

people's functioning and participation in valued occupations. Thinking involves interpretation of behaviour and reasoning about practical solutions to personal problems. In doing so, occupational therapists use reflection in and on action, focusing on clinical efficiency and effectiveness, to reach identified intervention goals (Mattingly and Fleming 1994). In essence, the therapist knows and is responsible for implementing an occupational therapy process.

Reflection and reflexivity are not the same. While both mental processes may occur in practice, reflexivity requires the suspension of *knowing* and of *being the therapist*. As mutually accountable actors, everyone in the field of action on the margins knows equally but differently, each contribution adding value to the emergent tasks at hand. Working in partnership with various stakeholders, occupational therapists become occupation-focused activists, addressing the social structures and determinants of health (van Bruggen 2011; Whiteford and Townsend 2011; Whiteford and Hocking 2012). In doing so, they think and act sociologically and politically (Jones et al. 1998; Pollard et al. 2008). A reflexive and sociopolitical way of thinking is indicated that provides occupational therapists with four general benefits:

- An ability to challenge commonly held assumptions about occupation and humans as occupational beings
- An ability to discern opportunities for, and constraints on, occupational engagement
- A means for becoming critical, imaginative and active in relation to human occupation
- A lens for understanding how human differences and human suffering influence what people do every day and for recognizing the relative strengths and challenges of diverse lifestyles.

Values

Values are culturally defined standards by which people assess desirability, goodness and beauty, and which serve as broad guidelines for social living (Macionis and Plummer 2008). The values of a particular culture tell us what is morally right and indicate how we should act to bring about good outcomes. The practitioner working within a statutory service setting, such as a hospital, may find that the dominant values of the institution do not align with the values expressed in occupational therapy codes of ethics, leading to a dilemma over which set of values should be given precedence (see Ch. 10).

Working on the margins entails, among other attitudes, valuing social justice and human rights (World Federation of Occupational Therapists 2010). Both require occupational therapists to think about the national and global consequences of their actions, not just the outcomes for the immediate community (Whiteford and Townsend 2011). For example, when we work to increase the wealth of a particular group of people, is this at the expense of another group whose needs are equally pressing?

We have to be prepared to subject our personal and professional values and principles to critical examination to find out if they 'reflect local preconceptions and prejudices, which may not survive reasoned confrontation with others not restricted by the same parochialism' (Sen 2009, p. viii). Such critical scrutiny and reflexivity will enable occupational therapy practice, education and research to resist cultural imperialism, avoid ideological dominance and be aligned with culturally defined standards for social living.

Partnership

Those occupational therapists who wish to pursue occupational justice (see Chs 3 and 13) at a macro-level 'need to build on their abilities in working co-operatively and in partnership with communities' (Pollard et al. 2008, p. 27). However, communities are contested sites of meaning, in which constant change and complex social processes create all sorts of margins, boundaries, borders and stratifications that may confound co-operation and partnerships. To meet these challenges, occupational therapists practicing on the margins find ways of engaging communities and working reflexively with them, paying due attention to the social processes described throughout this chapter.

Partnership is a complex process that best unfolds through longitudinal mutual engagement. It may be facilitated through a range of strategies, such as dialogical methods for restorative justice and action learning for engaged citizenship (see Senge 2006 for learning organizations; Kaplan 1999; Appadurai 2004 and Freire 2006 for development practice). The focus of occupational therapy partnerships is on social inclusion through the interface between individual and

collective occupation (Kronenberg and Ramugondo 2011). Participatory methods can enable vulnerable individuals and groups to make occupational choices that promote health and participation in safe, productive and socially acceptable activities (Galvaan 2012).

Theory

Occupational therapy practice has to be localized and contextualized yet, since the 1980s, the profession has tried to find universal theories and processes based on an assumed universal science of human biology, behaviour and society. This is because modern social science presents itself as universal knowledge, depicting the world as seen from the perspectives of the global metropole, that is, the rich, capital-exporting countries of Europe and North America (Connell 2007; Whalley Hammell 2011). The professional or service agency that uses universal theories or models is likely to define problems and develop strategies within particular ways of seeing the world. The presupposition of knowledge as objective and generalizable favours practices that are didactic and authoritarian. For example, home-care programmes that provide special services to individuals living in the community often deliver the services that the providers are set up to offer rather than those that communities want (Nelson et al. 2001).

Practice on the margins moves beyond knowledge consumption to critically engaged and active scholarship. The therapist looks in different places and at different things when trying to understand a phenomenon, operating on the premise that the generation of knowledge has consequences, especially in naturalistic environments. Submerged local (including indigenous) knowledge is brought to the surface through mental processes of interpretation which are influenced by and interact with social contexts (see for example Alers and Crouch 2010). Theory supporting practice remains uncertain; everything is open to questioning, multiple explanations and interpretations. In short, theory building is a localized, communal process that is informed, scrutinized and/or endorsed by multiple participants (Santos 2007).

Policy

Policy includes national and international legislation, conventions, position statements and practice guidelines pertinent to different stakeholder groups, for example, the Convention on the Rights of Disabled People (United Nations 2006). Being familiar with the appropriate policies for a particular context (see for example Grob 2011) enables the occupational therapist to frame mental health occupational therapy services in ways that will be recognized and promoted by governing structures.

Occupational therapists can lobby for more effective policies to promote social justice at local and national levels by joining forces with other interested bodies, such as mental health consumer and family organizations and governmental structures (Funk et al. 2006). Occupational therapists can also promote the access of marginalized constituencies to high-quality care, including those services offered by the profession, by joining research consortiums that are concerned with the social determinants of mental health (Richardson and Duncan 2013).

Policy also indicates acceptable standards of mental health occupational therapy practice and sets benchmarks for action on the margins. Examples include the World Federation of Occupational Therapists Position Statement on Human Rights (WFOT 2010), the World Health Organization Mental Health Policy and Service Guidance Package (WHO 2007), the Council of Occupational Therapists in European Countries' Position Statement on Social Inclusion (COTEC 2010) and the World Federation of Occupational Therapists Position Paper on Community Based Rehabilitation (Kronenberg et al. 2005).

Occupation

The conditions necessary for social inclusion include legislation and policy, financial resources, accessibility and opportunities (National Social Inclusion Programme 2009; National Development Team for Inclusion 2010). Although these conditions may be enhanced by the institutions of government, such as social services and welfare provision, people must feel and be actively engaged as citizens rather than passively supported if they are to experience inclusion (van Bruggen 2011; Whiteford and Pereira 2012). Occupation is a critical tool for creating the conditions necessary for social inclusion. It is a means for learning how to participate or regaining confidence in participating in society, for example buying food from the local market, cooking a meal with friends or playing a team sport.

Occupation creates interactive spaces where people can experience a feeling of connectedness to others 'such as safety, trust in others, having the opportunity to grow, or to be yourself' (ELSiTO 2011, p. 10). As an end in itself, occupation also works against discrimination, exclusion and marginalization in several ways and on many levels (Leclair 2010). Collective occupation provides the biographical, historical and structural context through which people can share in the same rights, privileges and activities (Kronenberg and Ramugondo 2011). People participate in their communities through collective occupation, for example, by working, voting, socializing or volunteering. Occupational therapy on the margins uses occupation as both a means and an end to effect social change at individual and communal levels.

SUMMARY

This chapter provided an overview of some of the social dynamics that shape people's identities, determine where they are positioned in society and influence their choices and opportunities for occupational engagement. It described sociological imagination as a means for appreciating how the personal, the social and the historical intersect in shaping human development, wellbeing and occupational profiles. A number of pointers for addressing social exclusion were suggested for occupational therapy practice with marginalized people. Sociological imagination and reflexivity were introduced as ways of thinking on the margins. The importance of remaining grounded in values that include social justice and human rights was confirmed, as was the role of theory, policy and partnerships in contextually relevant occupation-based and occupation-centred practice.

In conclusion, individuals who take a stand against social injustice can mobilize social change. When occupational therapists stand in solidarity with marginalized groups and communities, new horizons beyond traditional hospital and social care practice settings begin to open up. Taking a step back from familiar ways of doing mental health occupational therapy means questioning taken-for-granted perspectives on what the profession has to offer society and exploring how a different skill set may be used to address people's needs and aspirations through occupation.

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GLOSSARY

Ability: A personal characteristic that supports occupational performance (Creek 2010).

Acceptance and Commitment Therapy (ACT): A mindfulness-based behavioural therapy that teaches people to notice thoughts and judgements and to accept situations as they are in the moment.

Activity adaptation: Adjusting or modifying the activity to suit the individual's needs, skills, values and interests.

Activity analysis: The process of 'breaking up an activity into the components that influence how it is chosen, organised and carried out in interaction with the environment' (Creek 2010).

Activity grading: Adapting an activity so that it becomes progressively more demanding as a person's skills improve, or less demanding as an individual's function deteriorates.

Activity sequencing: 'Finding or designing a sequence of different but related activities that will incrementally increase the demands made on the individual as her/his performance improves or decrease them as her/his performance deteriorates. It is used as an adjunct or alternative to activity grading' (Creek 2003, p. 38)

Activity synthesis: Involves 'combining activity components and features of the environment to produce a new activity that will enable performance to be assessed or achieve a desired therapeutic outcome' (Creek 2003, p. 50).

Activity: A structured series of actions or tasks that contribute to occupations (Creek 2010).

Adherence: Complying with instructions and the recommended regimen for taking medication.

Affective spectrum disorder: The overarching term to describe a wide range of mental health problems, which include those typically associated with intense changes in mood or extremes of mood affecting thoughts and behaviours, such as depression, bipolar disorder and general anxiety disorders.

Anecdote: A short and amusing or interesting story about a real incident or person.

Animation: The rapid display of a sequence of static images and/or objects to create an illusion of movement.

Antipsychiatry: A movement that questioned the legitimacy of custodial care and highlighted the dangers of a total institution.

Appreciative enquiry: Aims to build positively on what has worked well in the past to seek solutions to issues, using learning and creativity (Rubin et al. 2011).

Approach: 'The method by which theories are put into practice and treatment is administered' (Creek 2003). The terms *frame of reference* and *approach* are sometimes used synonymously.

Arts health: An adjunct to conventional therapies. They involve activities facilitated by artists and musicians for example, rather than occupational therapists or arts therapists, and are frequently accessed by people living in the community with mild to moderate health problems (London Arts in Health Forum 2010).

Arts therapies: Involve combining artistic expression with psychotherapy to promote healing, wellness and personal change.

Assessment: Assessment is used by occupational therapists to identify a person's strengths and the barriers to occupational performance and engagement.

Assistive technology: Technology developed to support people with disabilities, and their carers, to manage their daily activities and to enhance safety.

Attention deficit hyperactivity disorder (ADHD): A common condition, seen in children and young people in mental health settings, characterized by the symptoms of inattention and hyperactivity that impairs everyday life.

Audit trail (or decision trail): A technique used in qualitative research to demonstrate trustworthiness. It involves 'The systematic collection and documentation of material that allows an independent auditor to draw conclusions about the data' (Polit and Hungler 1995, p. 636).

Autism: People with 'a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them' (National Autistic Society 2011a).

Autistic spectrum disorder: This term recognizes that autism may affect people in different ways. Some people with autism are able to live relatively independent lives but others may have accompanying learning disabilities (National Autistic Society 2011a). People with either of these diagnoses generally come under the umbrella of learning disability services, while those with a diagnosis of *Asperger* (or *Asperger's syndrome*) do not (National Autistic Society 2011b).

Autonomy: The freedom to make choices based on consideration of internal and external circumstances and to act on those choices (Creek 2010).

Belonging: 'A shared group identity' (Mynard et al 2009, p. 267).

Biopsychosocial model: 'In this model, disability is not an inevitable consequence of something that has happened to an individual, but as a result of a combination of adverse factors in the individual's life, including medical, physical, psychological and social factors' (Hagedorn 2001, p. 13).

Blinding (or masking): Blinding (sometimes called masking) is used in research to reduce or eliminate bias. It is achieved through allocation concealment. It involves keeping study participants and/or those collecting and analysing clinical data unaware of the assigned treatment, so that they are not influenced by knowing which group a participant is in. Single or double blinding depends on whether one or both groups are blinded to the treatment (Day and Altman 2000).

Burnout: Burnout is a serious issue for health and social care professionals. There are three main symptoms: emotional, exhaustion, loss of rapport and achievement. People experiencing burnout have described themselves as feeling used up, emotionally exhausted, seeing the people they work with as problems rather than as people, and feeling that all the energy they are putting into their job is not achieving much (Taylor 2005). It has been likened to a feeling of 'just going through the motions' (Gundersen 2001). Burnout is a complex problem that is not caused by any one factor so it makes more sense to prevent it rather than treat it (Grosch and Olsen 1994).

Care coordinator: An identified mental health professional who is responsible for ensuring an individualized care plan is in place for people with complex needs, under the care programme approach (CPA).

Care programme approach (CPA): An integrated approach to provide the optimum level of care for people with complex needs who require services from a number of agencies and/or professionals, involving assessment, planning and review.

Carer: 'A carer is someone of any age who provides unpaid support to family or friends who could not manage without this help. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems' (Carers Trust 2012).

Client-centred occupational therapy: A collaborative process in which everyone involved aims to negotiate and share choice and control.

Clinical audit: 'Audit is a cyclical process of setting standards, checking practice against the standards, identifying areas for change, making those changes and then re-auditing. This enables the continual improvement of services' (COT 2011).

Clinical effectiveness: Involves using interventions that are known to work, whether for a particular individual or for a population, in the real-life situation, so as to achieve the greatest possible health gain within available resources.

Clinical governance: 'a framework through which … organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish' (DoH 1998).

Clinical reasoning: 'The mental strategies and high level cognitive patterns and processes that underlie the process of naming, framing and solving problems and that enable the therapist to reach decisions about the best course of action' (Creek 2003, p. 51).

Clinical recovery: Recovery from illness.

Cognition: 'The mental action or process of acquiring knowledge through thought, experience, and the senses' (Oxford English Dictionary 2004).

Cognitive behavioural therapy: Short-term psychotherapy for depression, developed by Aaron Beck, which is predicated on the fact that by changing one's thinking, one can change one's emotions and the responses one makes (Greenberger and Padesky 1995). It focuses on five key areas: thoughts, behaviours, emotion/mood, physiological responses and the environment.

Cognitive social capital: The feeling of belonging that a person gets from participating in the life of their community that has been internalized.

Community development: A population approach that involves the therapist working in partnership with the community to bring about internal and external change (Watson 2004).

Comorbidity: See Dual diagnosis.

Competence: 'Skilled and adequately successful completion of a piece of performance, task or activity' (Hagedorn 2000, p. 308).

Complexity: 'The richness and variety of structure and behaviour that arises from interactions between components of a system' (Whiteford et al. 2005, p. 5).

Concept: A mental representation of an object or idea (Creek 2003).

Confidentiality: An ethical precept that occupational therapists adhere to, which means they do not disclose information to third parties without permission.

Confirmability: 'A criterion for evaluating data quality with qualitative data referring to the objectivity or neutrality of the data' (Polit and Hungler 1995, p. 638).

Consent: 'A voluntary agreement to or acquiescence in what another proposes or desires; compliance, concurrence, permission' (Oxford English Dictionary 2012).

Context: The *context* for action refers to the relationships between environment, personal factors and events that influence the meaning of a task, activity or occupation for the performer (Creek 2010).

Continuing professional development: 'A range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice' (Health Professions Council 2006, p. 1).

Control group: 'Subjects in an experiment who do not receive the experimental treatment and whose performance provides a baseline against which the effects of the treatment can be measured' (Polit and Hungler 1995, p. 638).

Core skills: 'The expert knowledge and abilities that are shared by all occupational therapists, irrespective of their field or level of practice' (COT 2009, p. 4).

Create: From the Latin word *creare* meaning to make and the Greek *krainein* meaning to fulfil. To be creative is to have the ability to create or 'to bring into existence' (Merriam-Webster's Dictionary 2011).

Creative therapies: A range of interventions that aim to tap into the client's own creative potential.

Creative thinking: 'Creativity is a special kind of thinking process. It requires the ability to conceptualise outcomes from actions, which enables innovative productivity in most field endeavour' (Schmid 2005a, p. 27).

Creativity: 'The innate capacity to think and act in original ways, to be inventive, to be imaginative and to find new and original solutions to needs, problems and forms of expression. It can be used in all activities. Its processes and outcomes are meaningful to its user and generate positive feelings' (Schmid 2005b, p. 6).

Credibility: 'A criterion for evaluating the data quality of qualitative data, referring to confidence in the truth of data' (Polit and Hungler 1995, p. 639).

Cultural competence: 'An awareness of, sensitivity to, and knowledge of the meaning of culture, including a willingness to learn about cultural issues, including one's own bias' (Dillard et al. 1992, p. 722).

Culture: 'The patterns of values, beliefs, symbols, perceptions and learnt behaviours shared by members of a group and passed on from one generation to another' (Hasselkus 2002, p. 42).

Dementia: A disorder in which there is a progressive decline in the cognitive functioning of an individual outside of the normal ageing process – such as in Alzheimer's disease (APA 2000). It is characterized by multiple cognitive deficits including memory loss, attention deficit and disorientation of people, place and time.

Dependability: 'A criterion for evaluating data quality in qualitative data, referring to the stability of data over time and over conditions' (Polit and Hungler 1995, p. 640).

Dependence: The condition of needing support in order to be able to perform everyday activities to a satisfactory level (Creek 2010).

Dialectical behaviour therapy (DBT): A comprehensive cognitive behavioural approach 'for the treatment of chronically suicidal individuals' (Dimeff and Linehan 2001, p. 10), who also meet the criteria for borderline personality disorder (BPD). It has also now been extended to other mental health problems, including substance misuse, eating disorders and suicidal/depressed adolescents. DBT is used in community settings, in hospital settings and prisons. It differs from CBT in that it combines the basic behavioural techniques with Eastern mindfulness practices.

Digital story telling: A short form of digital media production that allows everyday people to share aspects of their life story.

Disability: 'An umbrella term for impairments, activity limitations or participation restrictions' (WHO 2001, p. 3).

Discrimination: 'Attitude, policy, or practice that knowingly excludes a person or group of persons from full participation and benefits' (Wells and Black 2000, p. 279).

Dual diagnosis (or comorbidity): The co-existence of a mental health problem and substance misuse disorder (DH 2006). In learning disability services, the term is more often used to describe the co-existence of mental health problem and learning disability (Bernal and Hollins 1995).

Dysfunction: 'A temporary or chronic inability to meet performance demands adaptively and competently and to engage in the repertoire of roles, relationships and occupations expected or required in daily life' (Creek 2003, p. 52).

Emotion dysregulation: An inability to regulate emotions, particularly negative emotions, and a high sensitivity to emotional stimuli with a slow return to an emotional baseline (Linehan 1993).

Enablement: The process of creating opportunities 'to participate in life's tasks and occupations irrespective of physical or mental impairment or environmental challenges' (Christiansen and Townsend 2004, p. 276).

Engagement: A sense of involvement, choice, positive meaning and commitment while performing an occupation or activity (Creek 2010).

Environment: External physical, sociocultural and temporal factors that demand and shape occupational performance (Creek 2010).

Environmental adaptation: Assessing, analysing and modifying physical and social environments to increase function and social participation.

Ethical reasoning: A process of thinking about the moral dimension of a situation in order to reach the best decision.

Ethics: How individuals make sense of the world they live in based on their beliefs, values and experiences which influence the moral judgements we make (Hendrick 2004).

Ethnicity: A cultural concept that is shared by a group which has a common religious belief, genealogy, language, culture or traditions. This term is used to refer to a group of individuals with shared racial origins, cultural norms and language that are ethnically rooted but not governed by nationality.

Evidence-based practice (EBP): EBP requires that any decisions made about health and social care be 'based on the best available, current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within context of available resources' (Dawes et al. 2005, p. 4).

Extrinsic motivation: 'The drive to avoid harm and meet needs' (Creek 2007a, p. 129).

Flow: Conceptualizes optimal human experience (Csíkszentmihályi 1975). When in a state of flow a person may feel deep enjoyment, or they may be unaware of any emotion, being completely focused on the task at hand. A person becomes so absorbed by the activity that 'self consciousness is lost and worries or negative thoughts disappear' (Wright et al. 2007, p. 136).

Forensic: 'Relates to or denotes the application of scientific methods and techniques to the investigation of crime or relating to courts of law' (Soanes 2008).

Frame of reference: 'A collection of ideas or theories that provide a coherent conceptual foundation for practice' (Creek 2003, p. 53). The terms *frame of reference* and *approach* are sometimes used synonymously.

Function 1: The underlying physical and psychological components that support occupational performance.

Function 2: The capacity to use occupational performance components to carry out a task, activity or occupation (Creek 2010).

Functional assessment/functional analysis: Part of the assessment process that looks at how the individual manages the normal range of daily life activities; a wide-spectrum assessment that allows the therapist and client to identify the client's strengths, problems, sociocultural environment and personal view of life.

Functioning: 'An umbrella term encompassing all body functions, activities and participation' (WHO 2001, p. 3).

Goal: The specific and positive result to be attained by an individual from planned therapeutic interventions.

Goal-setting: The collaborative process, involving the therapist and the person they are working with, of negotiating, agreeing and documenting the goals of intervention.

Green care: Health and social care interventions that intentionally harness nature in their approaches that are designed, intentional and occupation-based.

Grounded theory: A research design that is used to develop theories and theoretical propositions grounded in real-world observations.

Group dynamics: The 'forces, social structures, behaviours, relationships and processes which occur in groups' (Finlay 2002, p. 256).

Group leadership: 'The process of influencing group activities toward goal achievement' (Shaw 1981, p. 317).

Habit: A performance pattern in daily life, acquired by frequent repetition, that does not require attention and allows efficient function (Creek 2010).

Happiness: The feeling of pleasure or contentment (Allen 1990); it is a correlate of wellbeing. Wellbeing is sometimes described as 'An individual perception of a state of happiness, physical and mental health, peace, confidence, and self-esteem that for many is associated with occupations, relationships, and environments' (Wilcock 2005, p. 134).

Health condition: Diseases and disorders are called health conditions.

Health promotion: Focuses on 'improving quality of life and potential for health rather than the amelioration of symptoms and deficits' (WHO 2002, p. 8).

Health: A person's capacity to adapt and self-manage in the face of social, physical and emotional challenges, with fulfilment and a sense of wellbeing.

Hope: Feeling confident about the future. It 'is central to recovery and can be enhanced by each person seeing how they can have more active control over their lives ('agency') and by seeing how others have found a way forward' (Shepherd et al. 2008, p. 2).

Human developmental frame of reference (or lifespan development frame of reference): A frame of reference based on theories of human development covering all skill areas: physical, sensorimotor, intellectual, language, psychosocial, psychosexual, moral and spiritual development.

Humanism: Humanism views people as 'growing, developing, creating being(s), with the ability to take full self-responsibility' (Cracknell 1984, p. 73). This includes taking responsibility for maintaining their own health and for making choices that determine what they become.

Illness: A person's subjective experience of having a health condition. The word *illness* is sometimes used synonymously with disease but is more often used

to refer to a person's subjective experience of having a health condition.

Independence: The condition of being able to perform everyday activities to a satisfactory level (Creek 2010).

In-reach: 'An individual or a team who actively case manage a patient out of hospital or the service they are receiving to their end point destination. In-reach may be used to provide specialist advice prior to decisions to transfer or discharge patients' (Rooney 2006, p. 3).

Institutional racism: 'A collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origins' (Macpherson 1999, p. 4262-i).

Interdependence: The condition of mutual dependence and influence between members of a social group.

Interests: An 'individual's preferences for occupations based on the experience of pleasure and satisfaction in participating in those activities' (Kielhofner 1992, p. 157).

Intersectionality: A paradigm which reveals the complex interactions among multiple social categories such as gender, race, class, culture, age, ability and sexuality.

Intrinsic motivation: An innate predisposition to explore and act on the environment and to use one's capacities.

Leadership: Focuses on 'setting the direction of travel' for the organization and realizing its vision through leading teams and individuals and influencing them to follow that direction.

Learning disability: 'The presence of:

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- a reduced ability to cope independently (impaired social functioning);
- which started before adulthood, with a lasting effect on development'

(DoH 2001 p. 14).

In practice, the terms 'learning difficulty' and 'learning disability' are often used interchangeably (Emerson and Heslop 2010) and other terms such as *intellectual disability* or *developmental disability* may also be used.

Life skills: A broad term that has been used for a range of tasks and activities that support occupational and role performance. They are 'the skills required to fulfil the roles required of individuals in the setting in which they choose to reside' (Mairs and Bradshaw 2004, p. 217).

Lifelong learning: 'The continuous pursuit of improvement in understanding, knowledge, skills and reasoning that improves practice to the benefit of those with whom the learner comes into contact' (COT 2010, p. 3).

Lifespan development frame of reference: See Human developmental frame of reference.

Lifestyle: The configuration of an individual's activities that links with both personal needs and the expectations of society.

Management: In health and social care systems, it is seen as accomplishing a series of tasks often through the effort of others, i.e. it is not oriented around a production line; it is about people conducting the business as well as managing the resources.

Marginalization: The process by which 'a whole category of people is expelled from useful participation in social life' (Young 2000, p. 41).

Meaning: The significance or importance that an activity has for an individual or a social group and, at the heart of recovery 'is a set of values about a person's right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms' (Shepherd et al 2008).

Medical humanities: An interdisciplinary academic discipline, which explores a person's subjective experiences of medical care and draws on areas such as philosophy, the history of medicine, anthropology, social sciences, history, literature, the arts and theology (Smith et al. 2006).

Mental capacity: A legal term referring to a person's ability to make autonomous decisions.

Mental capital: 'The totality of an individual's cognitive and emotional resources, including their cognitive capability, flexibility and efficiency of learning, emotional intelligence (e.g. empathy and social cognition), and resilience in the face of stress' (Kirkwood et al. 2008, p. 19).

Mental health: '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' (WHO 2001).

Mindfulness: 'The awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to things as they are' (Williams et al. 2007, p. 47).

Model for practice: A *model for practice* acts as a guide for the practitioner, providing 'an explanation of clinical phenomena and [suggesting] the type of intervention the therapist should make' (Feaver and Creek 1993, p. 59).

Model: 'A simplified representation of the structure and content of a phenomenon or system that describes or explains certain data or relationships and integrates elements of theory and practice' (Creek 2003, p. 55).

Moral treatment movement: A 19th century movement that reformed the treatment of the mentally ill so that psychological, rather than physical, treatments were used based on moral principles.

Motivation: The energy source for action, the 'drive that directs a person's actions towards meeting needs' (Creek 2010).

Neoliberalism: Political ideology promoting market mechanisms and individual autonomy, minimizing state provision in health and welfare.

Non-standardized assessment: An assessment that has not been norm-referenced and does not require standardized administration. It may, or may not, have been tested for reliability and validity.

Occupation performance components: Abilities and skills that enable and affect engagement in tasks, activities and occupations. These can be categorized, for example, as physical, cognitive, psychosocial and affective (Creek 2010).

Occupation/activity/task performance: Choosing, organizing and carrying out occupations/activities/tasks in interaction with the environment (Creek 2010).

Occupation: 'A group of activities that has personal and sociocultural meaning, is named within a culture and supports participation in society. Occupations can be categorized as self-care, productivity and/or leisure' (Creek 2010).

Occupational alienation: 'A sense that one's occupations are meaningless and unfulfilling, typically associated with feelings of powerlessness to alter the situation' (Hagedorn 2001, p. 166).

Occupational apartheid: The 'more or less chronic established environmental (systemic) conditions that deny marginalized people rightful access to participation in occupations that they value as meaningful and useful to them' (Kronenberg and Pollard 2005, p. 65).

Occupational balance: Occupational therapists understand *occupational balance* as 'managing [occupation] in a way that is personally fulfilling … and meets role demands' (Reed and Sanderson 1999, p. 99). The balance of occupations in a person's life is determined by personal interests and abilities, social expectations, age, environment and personal circumstances.

Occupational behaviour: The entire developmental continuum of play and work that evolves throughout the life cycle (Reilly 1969).

Occupational choice: The process of choosing a job or career.

Occupational deprivation: 'A state of prolonged preclusion from engagement in occupations of necessity or meaning due to factors outside the control of an individual, such as through geographic isolation, incarceration or disability' (Christiansen and Townsend 2004, p. 278).

Occupational disruption: 'A transient or temporary condition of being restricted from participation in necessary or meaningful occupations, such as that caused by illness, temporary relocation, or temporary unemployment' (Christiansen and Townsend 2004, p. 278).

Occupational form: The established format of rules, procedures, equipment and environment for performing an occupation.

Occupational genesis: 'The evolving adaptive process in which humans engage in purposeful activities that are meaningful to their lives as their world and their experiences change' (Breines 1995).

Occupational history: An interview to assess whether an individual's roles and occupations have been

disrupted or whether they have developed supportive and helpful habits and routines.

Occupational imbalance: The inability to manage occupations in a way that is personally fulfilling and meets role demands.

Occupational injustice: A consequence of restricted access to occupation for specific groups of people, indicated by occupational risk factors of alienation, apartheid, deprivation, imbalance and marginalization.

Occupational justice: The human rights relating to occupation for all groups of people.

Occupational performance areas: Categories of tasks, activities and occupations that are typically part of daily life. They are usually called self-care, productivity and leisure (Creek 2010).

Occupational performance frame of reference: A frame of reference that focuses on occupation and combines knowledge of the neurosciences with theories of intrinsic motivation and social psychology.

Occupational performance: 'The task-oriented, completion or doing aspect of occupations, often, but not exclusively, involving observable movement' (Christiansen and Townsend 2004, p. 278).

Occupational science: The academic discipline that studies people as occupational beings (Yerxa 2000).

Occupational therapy ethics: 'The analytical activity in which the concepts, assumptions, beliefs, attitudes, emotions, reasons and arguments underlying medicomoral decision making are examined critically' (Gillon 1985/1986, p. 2).

Occupational therapy process: The recognizable sequence of steps or actions taken by the therapist towards achieving desired outcomes.

Occupational therapy: 'The art and science of directing man's participation in selected tasks to restore, reinforce and enhance performance' (AOTA 1972, p. 204).

Offence-specific interventions: Interventions that target offending behaviours specifically.

Outcome goal: The statements of measureable changes that the intervention is designed to bring about.

Outcome measurement: 'Evaluation of the nature and degree of change brought about by intervention, or the extent to which a goal has been reached or an outcome has been achieved' (Creek 2003, p. 56).

Outcome: This refers to two different things: the changes that are expected to occur as a result of intervention – the intended outcomes, and the results of intervention – the actual outcomes.

Paradigm: 'The profession's world view that encompasses philosophies, theories, frames of reference and models for practice' (Creek and Feaver 1993).

Participation: Participation is defined in the ICF as 'involvement in a life situation' (WHO 2001, p. 10). The ENOTHE terminology group added two elements to this definition: activity and social context (Creek 2010).

Peer review: A process of evaluation conducted by one or more experts in a given field; it is widely used by journal publishers for checking scientific standards within research studies.

Peer support worker: Someone who has lived experiences of mental health problems, who works alongside service users to help facilitate recovery through promoting hope and providing support based on common experiences.

Performance enablers: Intrinsic factors that enable or support occupational performance (Christiansen and Baum 1997).

Person-centred care (for people with dementia): Person-centred care = V + I + P + S, where V = *V*alues people with dementia; I = treats people as *I*ndividuals, P = *P*erspective of the person with dementia, and S = supportive *S*ocial psychology (Kitwood 1997).

Personalization: An approach to providing social care which emphasizes individualized support.

Person-centred planning (for people with learning disabilities): 'A way for people with learning disabilities to plan for what they want now and in the future, with the people in their lives who they like and trust' (Kirklees Council 2008). It helps the person engage fully with their plan, emphasizing their strengths and abilities and enlisting support from family and friends.

Pharmacological revolution: The period in the 1950s, when psychotropic (or psychoactive) medication was developed that was effective in managing symptoms. This meant service users were able to be more receptive to rehabilitation and so precipitated the move of services from hospital to the community.

Physical activity: 'Any bodily movement produced by skeletal muscles that results in energy expenditure' (Caspersen et al. 1985, p. 126).

Play: Play is the primary occupation of children and young people, making it a domain of concern for the occupational therapist.

Player: A child's engagement in different types of play over time and which reflect the context, for example parallel play with a peer at the sand pit or constructional and solitary play with blocks at home (Rigby and Rodger 2006).

Positive risk-taking: See Therapeutic risk-taking.

Power: In social science and politics, power is the ability to influence the behaviour of people. The term *authority* is often used for power perceived as legitimate by the social structure. Power can be seen as evil or unjust, but the exercise of power is accepted as endemic to humans as social beings.

Practice: The actions taken by the therapist to serve the needs of the people they work with (Agyris and Schon 1974).

Pragmatism: 'The philosophy of "common sense", problem solving, activity, and adaptation' (Breines 1986, p. 56). Pragmatism stresses the relationship between theory and action (Audi 1999). Pragmatism 'recognizes the inextricable influences on each other of the mental and physical aspects of human beings, their artifacts, their environments, and the societies and times in which they live' (Breines 1995, p. 16).

Problem formulation: 'The process of identifying and recording the difficulties an individual is having which may require action' (Creek 2003, p. 57).

Problem-solving: A process involving a set of cognitive strategies that are used to identify occupational performance problems, resolve difficulties and decide on an appropriate course of action.

Process goals: The conditions to be achieved during an intervention, such as an individual arriving on time for their sessions.

Productivity: One of three major categories of occupations, and refers to 'occupations that make an economic and social contribution or that provide for economic sustenance' (Canadian Association of Occupational Therapists 2002, p. 37).

Professional accountability: The evidence of, and justification for, provision of services at the scrutiny of others.

Professional philosophy: The system of beliefs and values shared by members of a profession. Philosophical assumptions are the basic beliefs which make up this system and show how members of a particular profession view the world and their own goals and function within it (Mosey 1986).

Psychodynamic approach: Focuses on both intrapersonal aspects of the person, that is how the individual relates to him/herself, and interpersonal aspects, how they relate to other people (Atkinson and Wells 2000).

Psychosis: The overarching term for a number of mental health problems, including schizophrenia, bipolar disorder and schizoaffective disorder. The term *psychosis* describes a set of symptoms that includes delusions, hallucinations (auditory or visual), disorganized speech and confused or disturbed thoughts with a loss of contact with reality (APA 2000).

Purpose: 'The reason for which something is done or made, or for which it exists' (Creek 2003, p. 58) and, recovery in mental health involves the development of new meaning and purpose in life (Anthony 1993).

Random allocation: The procedures used to ensure that each subject in a research study has an equal chance of being allocated to either the intervention or control group.

Randomized controlled trial: A research design that involves participants being randomly allocated to one group or another, to receive or not to receive one, or more, interventions that are being compared. The results are assessed by comparing outcomes in the treatment and control groups (Bury and Jerosch-Herold 1998).

Recovery/Recovery in mental health: Recovery is about discovering – or re-discovering – a sense of personal identity, separate from illness or disability. Recovery of a meaningful life which will include occupation. which may be in the form of roles such as paid employment or parenting or activities (NIMHE 2005).

Reductionism: Based on the belief that the structure and function of the whole can best be understood from a detailed study of the parts by observation and experiment (Smith 1983).

Reflection: Subjective awareness and appreciation of activity and its impact on the individual and the

environment; a way of making sense of those situations, commonly encountered in practice, that are characterized by complexity, uncertainty and uniqueness.

Reflexivity: A 'process of seeing and a process of being. To be reflexive means that we are fully conscious of the lenses through which we view the world. We understand both our situationality and our positionality, our circumstances and our locations' (Kaufman 2013, p. 2).

Relapse prevention: Relapse prevention involves exploring what led up to the admission and what behaviours were associated with this time. The aim is to put support in place to prevent another acute episode.

Reliability: Consistency; if a tool is reliable its results will not be affected by when it is administered or who administers it.

Research awareness (or research appreciation or research-mindedness): Concerned with the knowledge needed to understand research issues rather than conducting research. It implies a:

- critical, questioning approach to one's own work;
- desire and ability to assess value of research to recognition of the importance of research to the profession and to patient care;
- willingness to support occupational therapy researchers in their work (Wilson and Butterworth 2000).

Research methodology: The techniques used by a researcher to collect data in a research study.

Research: 'A structured activity which is intended to provide new knowledge which is generalisable (i.e. of value to others in a similar situation) and intended for wider dissemination' (DoH 2002).

Resilience: The capacity to maintain and restore one's equilibrium through coping and social connectedness.

Risk: 'A chance or possibility of danger, loss, injury, or other adverse consequences' (Allen 1990, p. 1040). In mental health, the adverse consequences can involve suicide, self-harm, aggression and violence and the neglect, abuse and exploitation by self or others (Morgan 2004).

Risk assessment: An assessment to exploring risk factors in relation to the individual and others both historically and currently, as well as what factors or management plans can be implemented to reduce risk. The assessment is not static but dynamic and ever-changing.

Risk management: Involves identifying potential hazards or negative incidents and providing adaptive strategies to reduce the likelihood of these occurring or minimizing harm caused if they do (National Risk Management Programme 2007).

Role: Roles are allocated by society and adopted by the individual so that a role is both a social position and a set of tasks performed by the individual. Each person will interpret a role in a unique way.

Routine: 'An established and predictable sequence of tasks' (Creek 2010).

Safeguarding: Seeks to ensure that no vulnerable adult or child is exploited or harmed by others. This includes physical, sexual, financial and emotional abuse.

Schema: The emotional and cognitive patterns that developed early in life and which then repeat throughout life; they include memories, emotions, cognitions and internal body sensations.

Self-acceptance: Rooted in the humanist concept of unconditional positive regard. It entails accepting yourself fully, even if there are things you would like to change, without judging your value or worth as a person (Nichols 2012).

Self-efficacy: Belief in oneself, which plays a central role in building good health habits and maintaining social relationships.

Self-esteem: To have self-esteem is to have 'a good opinion of oneself' (Allen 1990, p. 1098) and it is an important factor in the development and maintenance of good mental health (MacInnes 2006).

Sensory defensive or hyper-reactive behaviours: People may exhibit strong reactions to 'triggers' such as withdrawal or aggression (sensory defensive or hyper-reactive behaviours).

Sensory processing: Sensory processing refers to the way messages from the senses are processed by the nervous system so they can inform motor and behavioural responses (Dunn 2009).

Sensory seeking or hypo-reactive behaviour: Some sensations may not be registered at all, prompting extreme behaviours to try to gain extra sensory input (such as self-injurious or destructive behaviours), known as sensory seeking or hypo-reactive behaviours (Townsend 2009).

Service evaluation: A method used to review the performance of an existing service; it is not usually considered to be research, so does not require formal ethical approval.

Setting: The *setting* for action is the immediate environment in which the person or group is performing, such as the treatment setting, work setting or community setting.

Skill: An ability developed through practice, which enables effective occupational performance (Creek 2010).

Social and therapeutic horticulture: Participation by vulnerable people in groups and communities whose activities are centred on horticulture and gardening.

Social capital: The degree of social cohesion which exists in communities.

Social exclusion: Non-participation in the key activities of the society in which a person lives (Burchardt et al. 2002).

Social identity: Social identity is that part of self-identity that comes from one's membership and roles in a variety of social groups (Sani 2012).

Social inclusion: The process by which people are engaged with their community and services, including those that are mainstream services and available for everyone in the community.

Social inequity: The result of structural arrangements, which are systematic, socially produced and unfair.

Social model of disability: The experience of disability is caused by society's response and can be addressed by a social response rather than individual efforts.

Social networks: The relations between individuals that may provide access to, or mobilization of, social support.

Social psychiatry: Emphasizes the social as the primary source of the causes and meanings of mental health and illness (Pilgrim 2009).

Social support: *Social support* is the assistance available to individuals and groups from within communities that can provide a buffer against adverse life events and living conditions, and be a positive resource for enhancing quality of life.

Sociological imagination: A quality of mind that discerns intricate connections, between individual stories and the stories of the particular society and history within which individuals are located.

Spectrum disorder: Implies a vast range of symptoms that may be present and the difficulties an individual may experience, which can vary from mild to very severe.

Spirituality: A sensitivity to the presence of the spirit that resides in people, is shaped by the environment and gives meaning to occupations (Townsend and Polatajko 2007).

Standardized assessment: A reliable and valid assessment which is standardized for the population.

Strengths: Personal factors that enable a person to function effectively.

Structural social capital: The availability of networks and relationships in a given area.

Substance dependence: Substance dependence or 'dependence syndrome' is a specific diagnostic term describing what is commonly termed *addiction* (Gerada and Ashworth 2008). See also Substance misuse.

Substance misuse: Substance misuse has been defined as drug and/or alcohol taking that harms the individual, their significant other(s) or the wider community (NTA 2002) and it is a chronically relapsing condition (NTA 2002). See also Substance dependence.

Systematic review: A research method which 'attempts to identify, appraise and synthesize all the empirical evidence that meets pre-specified eligibility criteria to answer a given research question. Researchers conducting systematic reviews use explicit methods aimed at minimizing bias, in order to produce more reliable findings that can be used to inform decision making' (The Cochrane Library 2012).

Tacit knowledge: Explicit or propositional knowledge, i.e. things that we know how to do but perhaps do not know how to explain (Polanyi 1958).

Task: A series of structured steps (actions and/or thoughts) intended to accomplish a specific goal. This goal could either be: (1) The performance of an activity or (2) A piece of work the individual is expected to do (Creek 2010).

Task analysis: Used to discover the sequence of steps or tasks that make up an activity.

Temporal adaptation: The normal use of time in a purposeful daily routine of activities.

Theory/Theories: Conceptual systems or frameworks used to organize knowledge in order to understand or shape reality.

Therapeutic community: A therapeutic community creates an environment to facilitate therapy through a participative, group-based approach. It involves all members of the community, service users and staff, in the running of the community as well as contributing to the mental health of the others in community.

Therapeutic risk-taking (or positive risk-taking): Therapeutic risk-taking involves working positively and constructively with risk, based on a full appreciation of the service user's strengths. It usually involves a carefully thought-out strategy for managing a specific situation or set of circumstances by 'weighing up the potential benefits and harms of exercising one choice of action over another. It involves using available resources and support to achieve desired outcomes, and to minimise potential harmful outcomes' (Morgan 2004, p. 18).

Therapeutic use of self: The process of the therapist evaluating the effect of her characteristics, values and practice in interactions with others, and the extent to which this brings development and insight for the client (Freshwater 2002).

Thinking skills: 'The mental actions used by the therapist in framing problems and working out the best solutions' (Creek 2007b, p. 4).

Thinking: Using the mind, including such mental actions as applying rules, choosing, conceptualizing, evaluating, judging, justifying, knowing, perceiving and understanding (Creek 2007b).

Transferability: '(1) A criterion for evaluating the quality of qualitative data, referring to the extent to which the findings from the data can be transferred to other settings or groups – analogous to generalisability; (2) also, a criterion used in assessing implementation potential in the context of a utilisation project' (Polit and Hungler 1995, p. 655).

Triage: An intensive process aiming to assess, stabilize and determine the best course of action for a person in an emergency or crisis situation.

Trustworthiness: 'A term used in the evaluation of qualitative data, assessed using the criteria of credibility, transferability, dependability, and confirmability' (Polit and Hungler 1995, p. 655).

Two body practice: Combines a disease perspective that focuses on the identification and treatment of disease-related problems and an illness perspective that considers the ways a health condition affects a person's life.

Utility: Refers to how practical a measurement scale is for use in practice; it is considered alongside reliability and validity when selecting an outcome measure to use to assess a service user.

Validity: Refers to whether an assessment measures what it is intended to measure. Validation involves checking that the procedure measures what it is intended to measure.

Values: Values are culturally defined standards by which people assess desirability, goodness and beauty, and which serve as broad guidelines for social living (Macionis and Plummer 2008).

Volition: The ability to choose to do or continue to do something, together with an awareness that the performance of the activity is voluntary (Creek 2010).

Wellbeing: A contested social construct with no fixed meaning; it requires an appreciation of human life, as it is lived in relation to others; it is a psychosocial phenomenon. An occupational perspective on wellbeing describes it as 'a flourishing condition that derives from a life where there is congruence among the persons' occupations and their values and meaning' (Pentland and MacColl 2009, p. 169).

Wellness: A process of caring for oneself, including care for the body, the emotions, personal identity and the spiritual self.

Whole person approach: Assumes that people can only be understood by seeing the relationships between body, mind, spirit and environment, over time.

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