Psychiatric Bulletin (1992), **16**, 180–183

The College

Occupational therapy and mental disorder

Consensus Statement by the Royal College of Psychiatrists and the College of Occupational Therapists

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"Absence of occupation is not rest
A mind quite vacant is a mind distressed"
William Cowper (1731–1800)

The Royal College of Psychiatrists and College of Occupational Therapists Liaison Committee was established in January 1988 with the remit to promote closer professional links and understanding of common concerns. The document which this paper summarises reviews current and future topics in occupational therapy.

Occupational therapy originated in psychiatric hospitals with the recognition that lack of activity and stimulation was harmful and occupation and activity were beneficial. Casualties from World War I gave impetus to occupational therapy in mental and physical rehabilitation.

Psychiatrists and occupational therapists have many complementary skills which make them natural colleagues.

Multidisciplinary teamwork

The roles of psychiatrists are in science, research, management, teaching, innovation and clinical medicine, which embraces diagnostic formulation, psychological and pharmacological treatment and prognosis. They are responsible for enlisting the skills of the therapeutic team.

The special skills of occupational therapists are:

(a) assisting diagnosis and assessment
(b) understanding and implementing task analysis, which evaluates the materials, tools and steps required to carry out an activity, the social and environmental context in which it takes place and the way in which each of these components can be modified to increase or decrease the demand on individual patients for physical or mental action in the lights of their handicaps (Finlay, 1988). Having made this analysis, occupational therapists can devise treatments for patients to develop and practise work, domestic, interactive, interpersonal, social, leisure and other coping skills
(c) enabling patients to learn or relearn behaviours necessary for daily life and to unlearn those which are harmful or maladaptive
(d) helping patients to carry out these adaptive behaviours in their own environment
(e) through creative media such as art, crafts, drama, dance and writing to enable the patient either to explore non-verbal communication for self-expression or to acquire specific skills
(f) teaching strategies for coping with many and varied circumstances.

These skills and the versatility of occupational therapists should make them essential and valued members of every psychiatric team, whether its function is in the community or hospital, for the mentally ill or mentally handicapped or general or specialised. Occupational therapists have a vital role in the assessment and treatment of physical disabilities in psychiatric patients, notably children, adolescents and the elderly.

The plans for patients about to be discharged from hospital should be consistent with their goals, functional abilities and weaknesses and prognosis, their families' goals, community resources and other environmental factors (College of Occupational Therapists, 1989). National Health Service and Local Authorities' Social Services occupational therapists should liaise to ensure that psychiatric patients receive appropriate services.

Education

The traditional route to qualification as an occupational therapist is a three year diploma course at a recognised school of occupational therapy, although graduates can qualify in two years. Some centres now

https://doi.org/10.1192/pb.16.3.180 Published online by Cambridge University Press

offer a four year course and by 1992 all full-time courses will lead to a degree.

There is a move to arrange courses in units which, if accrued within a defined time, lead to a diploma or degree. This format would be particularly suitable for students who, because of domestic and other commitments, cannot study consecutively.

The syllabus, determined by the College of Occupational Therapists, includes anatomy, physiology, social sciences, psychology, medicine, surgery, psychiatry, communication, management, the principles of education and research and the philosophy and practice of occupational therapy, among which are task analysis; work and domestic skills; activities of daily living; personal care; information technology; creativity; art; physical and recreational activities; therapeutic sensory development; social skills training; relaxation and other techniques for anxiety management; behavioural therapy; and the adaptation of these methods to the treatment of patients in the community. Students spend a substantial time in clinical settings.

For qualified occupational therapists there should be recognised courses to enable them to keep abreast of current practice and acquire new skills, provide for registration of expertise in psychiatric subspecialities and encourage those who have left the profession to re-enter it.

Occupational therapy assistants can gain a diploma after a four year part-time in-service programme. For them and technical instructors the College of Occupational Therapists has for many years operated a one year day release scheme. However, in accordance with government policy (Department of Employment and Department of Education and Science, 1986) these workers, like many others in the National Health Service, will aim for an appropriate level of competence in the National Vocational Qualification.

Support and supervision

There should be provision for professional support and supervision of occupational therapists, whether students or qualified, by their senior colleagues.

Manpower

Recruitment

Occupational therapy has been such an attractive career that it has not needed to advertise and applicants have generally exceeded student places by 3 to 1. Students aged over 25, for whom the profession is very suitable, now account for a third of the annual intake and another 10% are graduates. However, for various reasons, such as relatively low pay for occupational therapists, the intake is likely to fall.

In 1989 the Department of Health funded 750 of 982 full-time occupational therapy students. Local Authorities' Social Services provide less than 3% of the total training costs, although they employ some 20% of practising occupational therapists.

In recent years the Department of Health has raised its funding for education in occupational therapy but devolution of funding from the Department of Health to Regional Authorities (Department of Health, 1989) is fuelling competition for this funding. It is unlikely to keep pace with the greater demand for qualified occupational therapists which will ensue from changes in the therapeutic axis from hospital to community and dependence to independence; epidemiological trends, notably the greater proportion of elderly in the population; and the widening scope and a growing appreciation of the value of occupational therapy. The Department of Health Manpower Planning Advisory Group has estimated that the increase in demand for occupational therapists between 1984 and 1994 will finally be 73.4%. Moreover a Commission of Inquiry (1989) recommends that the College of Occupational Therapists should aim for and 80% expansion in the number of qualified occupational therapists by the end of the century.

The level for funding for education in occupational therapy should be raised in order to increase the number of students.

Staffing levels

Mental health staffing levels should be based on population variables such as the proportions of children aged under five, one parent families, elderly living alone, unskilled, unemployed; overcrowding; ethnic variables; and moves of house (Jarman, 1983).

The Commission of Inquiry (1989) recommended that an initial occupational therapy staffing 'norm' should be 0.25 per thousand population and pointed out that occupational therapist/patient ratios should be assessed urgently and in detail for different types of patient. This assessment is particularly important for psychiatry, in which the Commission found that of all occupational therapy posts in mental illness and mental handicap less than 50% were qualified occupational therapists, whereas for medicine, surgery and paediatrics this statistic was between 73% and 87%. The commission believes that the ratio in psychiatry should be much higher.

This ratio – of support staff, who include adult education teachers as well as assistants and technical instructors, to qualified occupational therapists – should be carefully monitored.

Occupational therapy has for many years suffered from staff shortage. In an annual staffing survey, based on a 95% response from area and district occupational therapists on 31 March 1988, shortage

https://doi.org/10.1192/pb.16.3.180 Published online by Cambridge University Press

of the number of funded vacant posts for qualified occupational therapists in mental illness and mental handicap was 22.8%

Local authority staffing, far from compensating for this shortage, seems to have been even more dilapidated because the Association of Directors of Social Services found in a survey in the same year that 35% of occupational therapy posts were vacant and that 18% had been so for more than six months.

Even when establishments are filled the proportion of occupational posts for psychiatry is small compared with similar posts for physical ability.

The absence or intermittent supply of qualified occupational therapists frustrates everyone concerned. It disrupts patient care, prevents the smooth development of services and induces workers other than occupational therapists to use simplistic models and other unsatisfactory compromises and ignore rehabilitation.

Retention

Relatively low levels of pay adversely affect morale and the retention of occupational therapists. Moreover, because the profession is predominantly female, career breaks, often terminal, for family commitments are frequent. Also the career structure does not properly reward clinical expertise because the higher salaries are currently reserved for those who relinquish clinical work and move into management and administration. Representatives of the British Association of Occupational Therapists on the Whitley Professional and Technical 'A' Council have pressed for changing the career structure whereby clinicians can reach these higher grades and continue to do clinical work.

To raise the retention rate there should be provision for care of the children of occupational therapists, flexible work programmes and vocationally and financially attractive and rewarding career structures. Another 12% of those who left did so to take up different careers.

Management

The components of an occupational therapy service are patients, staff, materials, facilities and operational structure. Each influences the other. Their sensitive structure combination requires the expertise of experienced occupational therapists to administer, monitor, support and develop the service, so that it is efficient, effective, and rapidly responsive to change.

Moreover experience indicates that occupational therapy functions best when control of the budget remains within the discipline and occupational therapists are organisationally accountable to an occupational therapist with managerial responsibility.

These practices should be implemented.

Research and evaluation

Despite comparisons of models of rehabilitation (Test, 1989), research into and evaluation of occupational therapy in psychiatry has hitherto been regrettably scarce.

Occupational therapists and psychiatrists should collaborate in research to yield vital information on methods of assessment and treatment and evaluation of forms of service delivery.

Teaching other disciplines

Occupational therapists should regularly impart their knowledge and skills to other mental health workers, especially medical students, psychiatric trainees, nurses, family carers and voluntary workers.

Many doctors are poorly informed about the services which occupational therapists can provide. Medical students should be assigned patients whose treatment includes working closely with occupational therapists. Psychiatric trainees, as well as visiting therapy units and attending some of their meetings, should collaborate with occupational therapists is assessment, treatment and rehabilitation of patients and joint case presentations.

Planning

The expertise of occupational therapists has mainly been neglected when plans are being made for psychiatric services. Occupational therapists should contribute at every level of planning and development of these services, for example, accommodation and day care units.

Members of Committee

The chairman is Professor Ben Sacks, Department of Mental Handicap, Charing Cross and Westminster Medical School, and the secretary Miss Judith Reid, Head Occupational Therapist, Maudsley Hospital.

The psychiatric members are Drs Brian Anstee, Mounir Ekdawi, Norman Kaye and Geoffrey Wallis. Occupational therapy members are Mrs Sally Ann Defriez, Mrs Margaret Ellis, Ms Alison Middleton and Miss Christine Peck.

The full report

Copies of the full report will be available from the Royal College of Psychiatrists at a small cost.

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https://doi.org/10.1192/pb.16.3.180 Published online by Cambridge University Press

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This portrait of Dr Jim Birley, President of the Royal College of Psychiatrists from 1987–1990, now hangs in the Council Room of the College with portraits of other past Presidents. The Officers are grateful to those Members who contributed to the Portrait Fund.

Cumulated Index Medicus

Now that the Library has Medline on CD Rom, it is no longer necessary to hold the hard copies of *Cumulated Index Medicus*. At its last meeting, the Library Committee agreed that these volumes, which cover the period 1981 to 1989, should be offered to other libraries.

Anyone interested in having them should contact the Librarian. The books occupy some six metres of shelf space.

https://doi.org/10.1192/pb.16.3.180 Published online by Cambridge University Press