

**Towards an understanding of occupational therapy  
professional practice knowledge in mental health services**

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## Statement of authorship

I, Lynne Maree Adamson, hereby declare that the work contained within this document is my own and no other person's work has been used without due acknowledgement. This work has not been submitted to any other university or institution as a part or a whole requirement for any higher degree.

A handwritten signature in black ink, appearing to read 'L. M. Adamson'.

Lynne Maree Adamson  
29 August 2011

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## **Abstract**

This study critiqued historical, philosophical and political factors influencing occupational therapy (OT) professional practice knowledge in the context of public mental health services located in Victoria, Australia. The research was situated within the interpretive paradigm of scientific inquiry, using a hermeneutic process to construct and interpret five texts portraying the evolution of OT in mental health services. A series of conversations with key occupational therapists yielded material for further critical interpretation. Ethical approval was received from the Human Ethics Committee, University of Sydney.

The first constructed and interpreted text situated early mental health services within the unique background of Australian convict settlements, 1788 - 1868. OT emerged within institutional environments echoing this past. The second and third texts interpreted OT professional literature, presenting a timeline of practice within mental health services. Occupational therapists implemented their craft-based practice within the psychiatric institutions of the 1940s and 1950s. Through the next two decades, occupational therapists made efforts to align practice with medical paradigms of knowledge before returning to occupation as a core of practice knowledge in later decades. Following closure of institutions during the 1990s, occupational therapists were challenged by relocation of services to community-based, multidisciplinary environments. The fourth text portrayed an interpretation of four transitions of practice, reflecting challenges influencing professional practice knowledge through five decades of practice. The final text interpreted six strands of professional practice knowledge, representing unifying threads woven through these decades.

The study concluded that OT had a quiet, yet consistent role within mental health services in Victoria. Gender, changing social views and practice environments were significant influences on the evolution of occupation as a core of practice. The study adds to deeper understanding of the importance of practice knowledge for the development of the profession in complex socio-political environments.

## Conference presentations related to this study

- Adamson, L., Higgs, J., & Mullavey O'Byrne, C. (2007). Contradictions and connections: philosophy and theory in mental health practice. *AQR Conference: Qualitative Research and the Professions*. 13 – 14 November. Melbourne: Monash University.
- Adamson, L., Higgs, J., & Mullavey O'Byrne, C. (2009). Convicts to community: mental health and occupation. *University of Sydney Faculty of Health Sciences Postgraduate Conference*. 4 November, Lidcombe, NSW: University of Sydney.
- Adamson, L., and Higgs, J. (2010). Mental Health Practice: who makes the team? *Proceedings of All Together Better Health 5 International interprofessional conference. Seeing things differently: evidence and innovation in interprofessional learning and practice*. (p. 215). 6 – 9 April. Manly, NSW.
- Adamson, L. (2010). From convicts to community action: tracing stories of mental health and occupation. *Proceedings of 15th international congress of the World Federation of Occupational Therapists: Sharing the world of occupation from Latin America* (p. 22). 4 – 7 May. Santiago, Chile.
- Adamson, L. & de Leeuw, E. (2010). What we do is our health. *Proceedings of the International Union for Health Promotion and Education World Conference on Health Promotion: Health, Equity and Sustainable Development* (p. 52). 11-15 July. Geneva.

## Acronyms

AAOT	Australian Association of Occupational Therapists
ACL	Allen's Cognitive Levels
AHMAC	Australian Health Ministers Advisory Council
AJOT	American Journal of Occupational Therapy
AOTJ	Australian Occupational Therapy Journal
AOTA	American Occupational Therapy Association
APA	American Psychiatric Association
CAOT	Canadian Association of Occupational Therapists
CATS	Crisis Assessment and Treatment Services
CCU	Community Care Units
CDT	Cognitive Disability Theory
CJOT	Canadian Journal of Occupational Therapy
COAG	Council of Australian Governments
CRS	Commonwealth Rehabilitation Service
EBP	Evidence-based Practice
ICF	International Classification of Functioning, Disability and Health
MOHO	Model of Human Occupation
MSTS	Mobile Support and Treatment Services
MTM	Methods Time Measurement
NGO	Non government organisation
NMHETAG	National Mental Health Education and Training Advisory Group
NMHWG	National Mental Health Working Group
NSPOT	National Society for the Promotion of Occupational Therapy
OT	Occupational Therapy
PDRSS	Psychiatric Disability Rehabilitation Support Services
PEOP	Person Environment Occupation Participation
TAFE	Tertiary and Further Education
UN	United Nations
VATMI	Victorian Association for the Mentally Ill
VICSERV	Psychiatric Disability Services of Victoria
WFOT	World Federation of Occupational Therapists
WHO	World Health Organization

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# Chapter 1

## Introduction

*For the things we have to learn before we can do them, we learn by doing them, e.g. men become builders by building and lyreplayers by playing the lyre; so too we become just by doing just acts, temperate by doing temperate acts, brave by doing brave acts. (Aristotle, Book II, Moral Virtue, Chapter 1)*

*Perhaps the most spectacular achievement [in mental health] by auxiliary effort has been the institution of occupational therapy classes at Mont Park, Kew, Sunbury and Ballarat (Pardy, 1937, p. 29).*

### 1.1 Mental Health Services and Health Professions

#### 1.1.1 The emergence of occupational therapy as a profession.

The 'spectacular achievement' heralded by Pardy (1937) signalled early steps towards the emergence of occupational therapy (OT) as a health profession within mental health services in the state of Victoria. These early classes, staffed by nurses, were celebrated as a significant change in the treatment of the thousands of patients residing in mental hospitals at the time. Aiming to bring a more humane approach to treatment, the auxiliaries<sup>1</sup> recognised that people being 'treated for disordered and broken minds instead of disordered hearts and lungs, and broken bones' were responsive to 'concerts, motor drives, visitors and the facilities for craft work' (Pardy, 1937, p. 28).

In the more than 70 years since auxiliaries began lobbying for better living conditions for patients in psychiatric hospitals, much has changed. Current mental health services in Victoria bear little resemblance to the services of the 1930s. OT, as envisaged by these early promoters of occupation as therapy, began to emerge as a formal health profession during the 1940s. A training

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<sup>1</sup> The term auxiliaries refers to voluntary groups who were hospital visitors attending mental hospitals as early as 1878, to provide personal comfort items and to raise funds for better conditions for patients. They later formed into associations which advocated improved services, and in many cases evolved into community-based non-government services (Dax, 1992; Lewis, 1988).

program was developed; first as a diploma, later as a bachelor degree. More recently, education programs have diversified, with degree programs and graduate entry as well as postgraduate and professional development courses offered at several universities and through the professional association: OT Australia. OT services expanded within psychiatric hospitals during the 1960s, only to be redefined as these hospitals were closed during the 1990s. At this stage the mental health OT departments contracted in size, and therapists moved to community-based settings where they were employed in multi-disciplinary teams. In this community practice context, occupational therapists aimed to offer client-centred intervention, linking individual interests and goals with opportunities for engagement in meaningful activities.

The OT profession claims the practice of psychiatry as the historical base for the profession internationally, and identifies mental health as a significant area of practice today. However, while OT is recognised as offering legitimate and valued mental health care interventions, challenges still exist for the profession in maintaining its professional knowledge base in this field and its credibility within a framework of evidence-based health practice. Perusal of the recently proposed Mental Health Act for Victoria (2010) might suggest that the profession of OT has not yet reached its goal of recognition and worth within mental health services. OT is not one of the named health professions in the field of mental health practice (Mental Health Act, Exposure Draft, 2010). In the definition of mental health practitioners, psychologists, nurses and social workers are named, but occupational therapists, who *were* included in the previous legislation (Mental Health Act 1986), are excluded. Omission from the proposed legislation may be a fleeting oversight or 'an unjustifiable omission' (Brophy, 2010, para. 1); in either case, during a review of new legislation, twenty five years after the existing legislation was formed and more than seventy years since Parry's statement, it is timely to review OT's place in mental health practice. The proposed Mental Health Act may be one instance of wider systemic issues that present ongoing challenges for the profession to remain relevant in health care.

### **1.1.2 Professions, knowledge and responsibility.**

At the time occupational therapists first emerged, the term 'profession' applied to members of the well-established fields of medicine, law and religion (Griffin, 1988). Professions were groups of people with recognised qualifications, entrusted by society to take care of the medical, legal and spiritual wellbeing of the population (Freidson, 1988). Since the 1960s, conceptualisations of 'profession' changed as many occupations, particularly those with a service focus, sought professional identity. An occupation must have certain characteristics to substantiate its claim to professional status; the most common of these are that practitioners have ownership of a knowledge base, the authority and autonomy to practise according to this knowledge, and altruism, in that their practice is for the purpose of social good (Freidson, 1988). Expanded education and changes to the organisation of work and regulation processes post 1960 led occupational groups to consider themselves professions in what was becoming a knowledge-based society (Wilensky, 1964). Within Australian health services, there was movement from the position that doctors were the only leaders for nurses and the 'paramedical' staff of emerging groups that included physiotherapy, social work, speech pathology and OT. From an activity associated with nursing and institutional care, 'professionalisation' of OT took place, and is a key factor for examination in this study.

A key feature and social responsibility of a profession is to develop and use 'professional knowledge' (Eraut, 1994; Freidson, 1988). The knowledge base of a profession holds significance for recognition by society:

The power and status of professional workers depend to a significant extent on their claims to unique forms of expertise, which are not shared with other occupational groups and the value placed on that expertise (Eraut, 1994, p.14).

Along with the power and status accorded to a health profession comes the social responsibility to continue to monitor its work, according to ethical and technical standards, and to critique and engage in knowledge generation to meet the changing needs of society and evolving practice contexts (Eraut, 1994).



It is therefore appropriate to consider the professional practice knowledge, which is the basis both of the contribution OT makes to understandings of mental health and of the opportunities it offers for intervention in the context of current and future mental health services. Professional practice knowledge is knowledge that is grounded in practice and underpins the creation and implementation of that practice. However, practice is not separate from knowledge; both realise each other (Higgs, 2006). This study addressed the interaction between knowledge, the practice of the OT profession, and the contexts in which OT practice has occurred across a span of five decades.

### **1.1.3 Statement of the research topic.**

Occupational therapists have been part of mental health services within Australia since the mid-twentieth century, a period spanning more than 70 years. My goal was to present historical and emerging perspectives of OT as it evolved within psychiatric hospitals and, later, community-based services. I aimed to discuss how the role developed into a profession with a focus on what it means to engage in *occupation*. In doing so, I sought to understand the knowledge used in the practice of OT within mental health services and to make propositions to guide future directions for the role of OT in mental health services. An overall question guided the study:

*What factors shaped OT professional practice knowledge as it evolved in mental health services in Victoria, and how did this knowledge emerge to guide current and future OT mental health practice?*

Specifically, the study aimed to examine a set of interrelated perspectives in order to

- describe the evolution of OT practice in mental health services in Victoria since its introduction until the present;
- identify factors that influenced the practice of OT in mental health services, including connections and tensions that might exist between philosophical and theoretical perspectives of OT and the services in which occupational therapists practice;

- interpret OT in mental health practices from the perspective of the professional practice knowledge that underpins these practices;
- propose future considerations for education and practice of occupational therapists that build on historical perspectives, with a focus on professional practice knowledge; and
- propose key targets for future research in this field.

#### **1.1.4 Significance of the study.**

This study entered a time and space in the history of OT and mental health that called for reflection on the errors and successes of the past as well as consideration of future directions. The study provided a resource for this reflection and consideration by addressing the goals above. In particular, by emphasising the practice knowledge of OT mental health, the study addressed the big questions: Why does OT mental health care follow its current strategies? Are these strategies and the underpinning rationale and knowledge the basis for optimal care into the future? What actions or changes should be adopted to enhance the preparation of future OT practitioners (plus researchers and educators) for their roles in delivering and shaping OT mental health care, and to enhance the mental health care models and strategies of current occupational therapists working in mental health care?

My study was based on the argument that understanding historical paths leading to current practice will facilitate the generation of further knowledge and inform future practice. As Richardson, Higgs and Abrandt-Dahlgren argued:

Understanding practice knowledge and how it is developed is of vital importance to the quality and effectiveness of professional practice in a changing world (2004, p. 2).

Further, I have argued that sharing professional practice knowledge across generations enriched practice by shaping options and choices to deal with challenges in professional practice and education. The outcomes of the study will contribute to continuing professional practice knowledge by illuminating possible paths for the future, setting out ways forward for practice and education. In particular, the strengths of the profession that led to a proactive

involvement in change within mental health services are raised as core contributors to professional practice knowledge that may be significant for dealing with current tensions and debates around generic versus discipline-specific roles within mental health services. I have proposed that a critique of the development of professional practice knowledge will illuminate future possibilities and stimulate discussion within the profession. Future health care will bring challenges related to relationships between the knowledge, leadership and political influence of OT. How professional practice knowledge is interpreted and presented to future generations lies at the heart of successfully addressing these challenges.

## **1.2 Background to the Study: Mental Health in Society**

### **1.2.1 An international context for mental health services.**

At its inception in the 1940s, the World Health Organization (WHO) set an international agenda for health, embedding health in the organisation's constitution as a human right:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. (WHO, 1946, p. 1)

In its ongoing efforts to promote health in communities, WHO recognised that health is only one aspect of wellbeing: being occupied, or being able to do what is valued, is also important:

To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. (WHO, 1986, p. 1)

Defining health sets the parameters for the subsequent definition of mental health as

a state of well-being 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. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community. (WHO, 2005, p.5)

The definition is consistent with the approach of WHO to facilitate initiatives that promote health and encourage communities to address challenges to mental health in individuals and communities before dysfunction occurs. The broad psycho-social approach and the trend towards prevention of illness are in marked contrast to the earlier days of mental health practice, which will be outlined in this report.

A further significant influence on services for people with mental illness is the political context of each country. The United Nations (UN) released a statement on human rights in 1991, which sets out 'Principles for the Protection of People with Mental Illness and for the Improvement of Mental Health Care'. This international agreement requires signatories, of which Australia is one, to work to remove discrimination within society for people with mental illness and to provide appropriate intervention in the 'least restrictive environment' (UN, 2004).

### **1.2.2 Australian mental health services.**

Mental illness is reported to affect approximately 45.5% of the Australian population at some time in their life (Slade et al., 2009). During a twelve-month period, up to 20% of the population may be affected with one or more mental disorders, with those in younger age groups reporting greater incidences. Fewer men (17.6%) than women (22.3%) report experiencing mental disorders in any twelve-month period. Severe mental illness, measured by its reported impact on a person's daily life, is experienced by approximately 4.1% of the Australian population in a twelve-month period (Slade et al., 2009, p. 6).

In Australia, government responsibilities and programs for mental health are outlined in an agreement between State and Federal governments, the *National Mental Health Policy*, first endorsed in 1992. This policy is implemented through National Mental Health Plans which are updated through the regular Australian Health Ministers' Advisory Council (AHMAC). The most recent mental health plan by Australian governments, the National Action Plan 2006–2011, aims to achieve four outcomes:

1. reduce the prevalence and severity of mental illness in Australia;
2. reduce the prevalence of risk factors that contribute to the onset of mental illness and prevent longer-term recovery;
3. provide access the right health care and other relevant community services at the right time for an increasing proportion of people with an emerging or established mental illness, with a particular focus on early intervention; and
4. increase the ability of people with a mental illness to participate in community activities, employment, education and training, including increasing access to stable accommodation (COAG, 2006, p.5).

My study investigated OT practice relating primarily to services established to meet the third and fourth of these outcomes. These two outcomes are the focus of community-based mental health teams in which occupational therapists in public mental health services are employed. Community-based services employ health professionals to provide treatment of illness, rehabilitation to meet the goals of community participation, and ongoing support.

### **1.2.3 Public mental health services in Victoria.**

Australian health services are funded through a mix of Federal, State or Territory funding. Following one aim of the National Mental Health Plan (1992) there has been a decrease in hospital-based services over the last twenty years. Community-based care has grown, supported by increased funding of 158% during the period 1993–2003 (Henderson & Walter, 2009). In Australia, the National Mental Health Plan identifies OT as one of five core professions making

up the mental health workforce (National Mental Health Education and Training Advisory Group, 2002).

Victorian mental health services are organised according to two main parameters: clinical services, and psychiatric disability rehabilitation and support services (PDRSS) (Department of Human Services, 2006). Clinical and PDRSS are organised on a regional basis, with Victoria divided into nine regions. Occupational therapists are employed in both streams, although continuing shortages and issues with recruitment and retention are reported (Department of Human Services, 2002; Hayes, Bull, Hargreaves, & Shakespeare, 2008).

### **1.3 OT: A Health Profession**

#### **1.3.1 Description and definition.**

OT is defined in the Macquarie Dictionary as ‘a method of therapy which uses self-care, work and play activities to increase development and independent function, and to prevent disability’, and by Mosby as ‘A health rehabilitation profession designed to help people of all ages with physical, developmental, social or emotional deficits regain and build skills that are important for functional independence, health and wellbeing’ (Harris, Nagy & Vardaxis, 2006, p. 1215). During the 1950s, occupational therapists established international links through a representative organisation, the World Federation of Occupational Therapists (WFOT, 2009), which regulates the profession through accreditation of educational programs and defined OT as

a profession concerned with promoting health and well being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday living. Occupational therapists achieve this outcome by enabling people to do things that will enhance their ability to participate or by modifying the environment to better support participation. (WFOT, 2009)

#### **1.3.2 Occupational therapy fields of practice.**

Occupational therapists work in diverse environments and within a range of service models. Commonly, services can be classified by setting (acute hospitals,

rehabilitation programs or community health centres), by age group (paediatrics, adolescent or aged care services), or by medical condition. A smaller number of occupational therapists work in non-direct service provision roles, including health promotion, injury prevention and policy development (Farnworth & Allen, 2009).

The beginning of the OT profession in Australia lay in mental health services of the early to mid-20<sup>th</sup> century where OT practice started within large psychiatric institutions and private psychiatric practices. Services today differ markedly from those early beginnings, although many ideological characteristics remain, including a goal that can be expressed simply as linking what people do with their experience of health and within their everyday routines.

### **1.3.3 Professional beginnings in the 20<sup>th</sup> century.**

The development of OT as a profession is initially identified with a group of people in the USA who, in 1917, established the National Society for the Promotion of Occupational Therapy (NSPOT) (Schwartz, 2003, p. 5).

Interestingly, this group's members were from a diverse range of professional backgrounds, including physicians, architects, nurses and teachers. They shared a vision for the creation of a new profession, based on their conviction that there should be more humane treatment of people with mental illness, as well as their belief in the power of science and the therapeutic benefit of activities used in treatment (Schwartz, 2003). From the 1920s, the profession grew across the USA and extended to Britain, with links through psychiatrists promoting expansion within psychiatric services, as I will describe in Chapter Four.

Almost half a century after OT treatment emerged, Mary Reilly, an American occupational therapist and early advocate of consolidating 'occupational behaviour' as a theoretical concept underpinning OT, made her often-cited statement that 'occupational therapy can be one of the great ideas of 20<sup>th</sup> century medicine' (1961, p. 80). From the 1920s to the 1960s, the profession of OT was firmly established within health practice, developing from its beginnings in psychiatric services into broad fields of rehabilitation across

many diagnostic groups, age ranges and practice settings. Despite these achievements, Reilly questioned whether the profession had established its value as a 'vital and unique service for medicine to support and society to reward' (1961, p. 80). Now, fifty years after Reilly's statement of hope for the profession and well into a new century, there are still questions whether the profession of OT has lived up to the promise and hope of the 20<sup>th</sup> century, or whether the case continues, as in 1961, that the 'value of occupational therapy exists in a controversial state' (Reilly, 1961, p. 80).

#### **1.3.4 Professional challenge: From institution to community-based care.**

One of the most significant developments within mental health services internationally since the 1980s has been the move to community-based care, with growing emphasis on the need to facilitate re-settlement of people with mental illness into community living. The focus of OT in many countries moved from providing treatment within the institutions to rehabilitation, which was defined as 'the process through which a person is helped to adjust to the limitations of his disability' (Hume & Pullen 1986, p. 43). It required participation by the person as well as their 'family and friends, fellow patients and staff' and aimed to 'restore the individual to his maximum level of independence, psychologically, socially, physically and economically' (Hume & Pullen, p. 43). A community living focus therefore extended the scope of services beyond a hospital setting, involved a broader group of people around the patient and established an approach that recognised more than an illness or medical model of care. Within this changing health care environment, occupational therapists expressed concern about their roles and their capacity to meet the demand for services. Lloyd, Bassett and King (2002) questioned whether occupational therapists were adequately prepared through their education and also in terms of the number of therapists working in mental health services. Recruitment and retention of occupational therapists remained a problem into the 21<sup>st</sup> century, despite the profession's core interest in mental health and the identification of an important role for occupational therapists, especially in rehabilitation (Lim, Morris & Craik 2007).



Following the transition to community-based programs, a case management model of service delivery was introduced within mental health in many Western countries. This model intended to have a focus revolving around individual needs and a generic approach to team roles, taking away some of the traditional boundaries between disciplines. Pettican & Bryant (2007) criticised the move towards generic roles and the possible loss of the unique focus that occupational therapists have on occupation. They maintained that the generic team model was at odds with the concept of client-centred practice, as was the economic pressure on services shaped by the availability of staff rather than the needs of service users. The transition from the familiar base of institutional care and the origins of the professional group therefore challenged the very core of OT practice, that of its knowledge base. For OT in Australia, a period spanning almost seventy years and less than four generations of practitioners resulted in significant changes in practice environments.

## **1.4 Historical Perspectives of Health Practice**

### **1.4.1 History informing the present.**

My primary rationale for undertaking a study of historical developments within OT professional practice was the proposition that a review of past experience can enhance the understanding of current practice. Seeking to put current practice within socially constructed historical perspectives will indicate aspirations for both individual practitioners and the profession. The health 'problems' of humans require attention and action, drawing on human capacities to develop knowledge, understand the world around us and to build on our experiences. For 'good or evil', history as a social task shapes the memory and 'collective consciousness of groups of humans':

A meaningful understanding of the present requires that it be seen in the light of the past from which it has emerged and of the future which it is bringing forth. Every situation that man has faced and every problem that he has had to solve have been the product of historical developments. Furthermore, the way in which we act in a given situation is, in large measure, determined by the mental image of the past that we have. To

understand the problems of our own society and to be capable of playing an intelligent role in shaping our civilization we must have a sense of continuity in time, an awareness that one cannot advance intelligently into the future without a willingness to look attentively at the past, we must have knowledge of the past and how it brought the present into being.

(Rosen, 1958/1993, p. xxxix)

Documenting history involves a range of approaches, starting with a systematic recording of dates, events and people, judged significant. In contrast, learning from history and building a future practice based on the past involves critical analysis, reflection and acknowledgement of the complex relationships between many factors that shape social responses to illness and influence health care services. Porter (1994) located the history of public health within the 'social history of biology and culture' (1994, p. 5). Through a critique of multiple perspectives across many national contexts, Porter outlined a framework showing political, social, economic, philosophical and professional factors as elements of a historical analysis of state responses to illness and disease, and the development of services in response to changing demands for health care. This framework of factors informed my study, contributing to the conceptual framework that is outlined in Section 1.7.2.

Early histories of health, and in particular medicine, were in the form of biographical studies, primarily of 'great men' (Rose, 2002, p. 35). Other histories served the purpose of recording progress, often within a field of practice related to a specific disease, and were primarily written by doctors using their clinical notes, observations and personal experiences to herald the 'triumphant march of conquering disease' (p. 35). 'Great' events in the mental health treatment of the past reflect developments in scientific knowledge, but are open to critique from many perspectives. Dates and locations may set the scene for historical accounts of events, but consideration from diverse views, including socio-cultural, gender and economic perspectives, give a far deeper picture of mental health at individual and community levels (Micale & Lerner, 2001).

### **1.4.2 Mental health histories.**

Asylum histories figure strongly in the literature of mental health history. 'Lunatic asylums' were a product of 19<sup>th</sup>-century changes in the social view of mental illness when more humane approaches to care of the insane were promoted. Within Western societies, these mental institutions were intended to be places of fresh air, rest and care. Treatment and/or cures were not necessarily the aims of asylums: rationales for their establishment included protection of the insane from harm by others as well as protection for local communities from the insane. The gaze of history and the application of diverse analytical frameworks and methodological approaches has since created a rich picture that enhances, and in many cases questions, the memory of individuals and the wide acceptance of such well-intentioned approaches to care.

Philosophers and historians have contributed to the study of health and illness, bringing diverse perspectives and challenging the dominance of previous heroic and triumphant accounts of social progress in health. Critical perspectives challenge the view of both state and professions, contributing to positive outcomes in the provision of health services. Foucault (1961/2001) identified power and repression within the dominant model of Western scientific medicine. He maintained that the discourse of medicine created the view of illness as social deviance. A result of a medicalised view of social behaviour was the creation of institutionalised approaches to care, trapping both individuals and professionals within highly controlled social environments. Occupation in asylums, while presented from the time of 'moral treatment' of the 18<sup>th</sup> and 19<sup>th</sup> centuries as a positive and humane approach to treatment of inmates of the asylum, was critiqued by Foucault as a powerful part of the repression of the institution:

In itself, work possesses a constraining power superior to all forms of physical coercion, in that the regularity of hours, the requirements of attention, the obligation to produce a result detach the sufferer from a liberty of mind that would be fatal and engage him in a system of responsibilities. (Foucault, 1961/2001, p. 235)

The 'anti-psychiatry' movement of the 1960s challenged the diagnosis and treatment of mental illness from a strictly medical model that operated from biological perspectives and did not consider other dimensions of human behaviour such as social, intellectual or cultural factors. Primarily a movement within the field of psychiatry itself, anti-psychiatry provided a platform for questioning many core tenets of psychiatry. Moreover, anti-psychiatrists

examined and criticised the social control function which [psychiatry] performs within society, arguing that even those techniques of psychiatry deemed more humane, such as psycho-analysis and psychotherapy, may in fact be subtle control mechanisms (Crossley, 1998, p. 878).

Goffman (1968) also made a strong case against the benevolence of asylums in his work *Asylums*, by questioning what occurred behind the walls and closed doors of the institutions that separated members of a society from their communities, including mental hospitals. Goffman's work gave credibility to the worst-held fears of many people that, despite their place as 'medical establishments', asylums were dangerous places in which to reside and work.

Physicians have recorded new developments in scientific understanding of neuroscience and biochemistry, heralding introduction of successful drug regimes (Cade, 1979). Medical perspectives are recorded concerning the transformation of public health services (Dax, 1961) or the personal experiences of work in the locked institutions of the past (Cawte, 1998; Ellery, 1956). Very few of the medical histories of mental health services mention other professional groups except in passing mention of the need for other therapies. These histories are primarily personal stories reflecting on journeys in a career and highlighting significant contributions to mental health services in the context of state and private mental health services.

Historical critiques of mental health services in Australia first appeared in scholarly studies during the 1980s, perhaps fostered by the lead-up to the bicentennial year of 1988 when the colonial past was in the spotlight. Analysis of the role of asylum care, the impact of social attitudes, and political action addressing mental health care emerged as areas of critique (see Garton, 1988,

2003; Lewis, 1988). By the end of the 20<sup>th</sup> century and early 21<sup>st</sup> century, the history of psychiatry was established as a recognised element of the history of medicine, and worthy of interdisciplinary collaboration (Coleborne & MacKinnon, 2003).

Matthews (1984) provided a feminist perspective on the lives of women in Australia, and in particular those considered mad because they deviated from social norms. This is not a glorious tale of history: Matthews described a maze of gender stereotypes, economic barriers to the participation of women in society, and patriarchal medical and professional control that dictated the fate of women, often resulting in their admission to a psychiatric hospital. Matthews used medical case histories as the basis for her analysis, noting that in society, few other situations existed where detailed personal notes were kept on individuals. Analysis of these personal histories contributed to a far broader analysis of the forces impacting on women's health and lives within the historical context of Australian society in the mid-20<sup>th</sup> century. Matthews concluded that the 'realisation of the historical construction of our individual sense of failure can open up new possibilities that we are not afraid to try' (p. 201).

Women professionals are generally absent in medico-historical accounts of mental health services except in passing references to social workers, nurses and occasionally occupational therapists. Historical accounts of these professions are located within the literature of the professions and through personal accounts. Foley (2010), for instance, situated her study within the mental health service of Western Australia, using analysis of institutional documents, oral histories and her personal experience to present historical insights into the challenges of a profession embedded within institutional settings. Her story began at a time during the 1960s when the superintendent

insisted that the social work role should be confined to mundane welfare oriented issues of the patient within the hospital and very much opposed involvement in the treatment regime of patients. Neither did he encourage ongoing contact outside the hospital walls. (Foley, 2010, p. 3)

Nursing histories within mental health services are identified as unique within that profession because 'psychiatric nurses within Australia do not share a common cultural history with other branches of nursing' (Goodwin & Happell, 2007, p. 56). The origins of psychiatric nursing in Australia date to the penal colonies of early white settlement and the subsequent asylum era when those responsible for maintaining order were considered little higher in social rank than the inmates, and were named accordingly: "lunatic attendant", "keeper" and "warden" (Goodwin & Happell, p. 56). Training and examinations for attendants commenced, hesitantly, late in the 19<sup>th</sup> century, but it was not until well into the 20<sup>th</sup> century that 'Psychiatric nursing began to be seen as a more credible and worthwhile branch of nursing' (Goodwin & Happell, p. 58). OT shares a similar link with historical developments through the use of occupation in the penal settlements and the asylums of Victoria, and in not being recognised as a professional practice until the mid-20<sup>th</sup> century.

#### **1.4.3 Occupational therapy in historical accounts of mental health services.**

A comprehensive history of OT in mental health services is yet to be written (MacKinnon, 2009). There are occasional brief references to OT in historical accounts of the lives and contributions of medical practitioners. Clarke (1997) in his critique of the contribution to British psychiatry made by psychiatrist Joshua Bierer (1901– 1985) identified Bierer's support of OT, outlining his positive contribution to the community hospital setting while at the same time reinforcing the subservience of OT to the medical profession.

Bierer made a special place for the role of occupational therapy in rehabilitation. His suggestion that information from various sources should be shared with occupational therapists, to enhance patient care, further clarifies his belief that therapy is synonymous with the wider activities of hospital living. At the same time, he warns of the harm which occupational therapists can do and his tentative involvement with them contains elements of a medical mentor and expert guide. But he probably boosted their status overall, especially by insisting that their work should never be hobby-oriented or humdrum, he advocated work which would be

meaningful as well as being consistent with the historical social worlds of the patients. (Clarke, 1997, p. 321)

Bierer was a proponent of the importance of environmental conditions in the therapy of people with mental illness (Clarke, 1997). While controversial in some aspects of his work (as were many professional pioneers), Bierer practised at a time when greater recognition was being given to the 'therapeutic milieu', the development of therapeutic communities and greater involvement of people in deciding the care they received, well ahead of de-institutionalisation and the development of international perspectives of mental health within society.

Reference to occupational therapists or OT rarely appear in more than one or two sentences of medical histories in Australia, and usually after the 'successful' treatment of physicians has been described. For example, in Cade (1979) OT is described as a treatment for the effects of institutionalisation:

Then again a patient may be successfully treated for his illness but suffer demoralizing effects that hospitalization, especially when it is involuntary, tends to have. As a result of this he may be socially incapacitated and require the skills of an occupational therapist in treating or retraining in social competence and confidence. (Cade, 1979, p. 4)

Bircanin and Short (1995) recorded life at the four psychiatric institutions situated in the northern suburbs of Melbourne at the Bundoora site, which housed several hospitals. They described in detail the development of each of the facilities through the eras of segregation of male and female wards and therapies, the development of farming and other activities to support the institutions and the introduction of OT from the early use of handcrafts, concerts and outings beyond the walls. Anderson and Bell (1988) compiled the most comprehensive history of OT in Australia to date, documenting the profession's development from the 1930s until the 1980s, situating their historical critique within the context of Australian history, as I discuss further in Section 1.6.2. Anderson and Bell identified mental health as the first area of practice for occupational therapists in Australia, with the beginning of practice

by therapists returning home after training in the USA. Such historical accounts of OT practice outline timeframes, areas of practice, and the social environment influencing development of the profession. To date, there is limited attention to historical perspectives of the ways in which knowledge for practice has developed.

## **1.5 OT Professional Practice Knowledge**

### **1.5.1 Defining forms of knowledge.**

A starting point for considering knowledge is the early Greek definitions of three forms of knowledge, *episteme*, *techne* and *phronesis*, described by Aristotle. 'The term *episteme* represents scientific knowledge, theoretical knowledge. *Techne* is used in connection with knowledge used in the process of production and creativity ... and *phronesis* represents practical knowledge or wisdom, and is the knowledge used in the process of social interaction' (Gustavsson, 2004, p. 36).

Eraut (2000) defines two 'parallel' types of knowledge. The first, *codified knowledge*, is knowledge that is held publicly; it is also referred to by other authors as *propositional knowledge*. This knowledge is:

- subject to quality control by editors, peer review and debate; and
- given status by incorporation into educational programmes, examinations and courses. (Eraut, 2000, p. 114)

The second form of knowledge defined by Eraut is that of *personal knowledge*, 'the cognitive resource which a person brings to a situation that enables them to think and perform' (2000, p. 114). Personal knowledge incorporates, at a personal level, the learning and adoption of codified knowledge brought by the individual to their practice, and is demonstrated through their behaviour and the skills they use to enact their knowledge.

Eraut (1994, 2003) described experiential learning as an important part of practice knowledge, and an influence on developing professional competence. Schön (1983) identified the complex nature of professional practice created through the uncertainties and the hidden nature of factors that influence



decisions and actions of a practitioner in the practice environment. What is learnt, and even practised, could change in response to the situation confronted by the practitioner. According to Schön, learning occurred through reflection during and after the practice, i.e. reflection-in-action and reflection-on-action. The use of reflection by the practitioner enhances building of knowledge and skills for effective practice. Abrandt Dahlgren, Richardson and Kalman (2004), arguing for the 'need for a renewed and critical understanding of the concept of reflective practice' (p. 15) proposed an extension to the reflection in-and-on action model to incorporate reflection *about* practice, so that practitioners could contribute to ongoing critique of professional practice and generation of professional knowledge based on learning from practice.

Higgs and Titchen (2000) established three types of knowledge as core to professional practice. Firstly, *propositional knowledge* referring to 'theoretical or research knowledge which has been ratified or supported by the field' (p. 27) through research and scholarship that creates findings which are potentially applicable across areas of practice. Two forms of *non-propositional knowledge*, derived through practice and not necessarily intended for generalising beyond individual practice, were also identified as relevant for health practice. *Professional craft knowledge*, described as incorporating the 'knowing how' and the 'notions of clinical intuitive knowledge or professional judgement and the cognitive aspects of practical knowledge and experiential knowledge' (p.28). *Personal knowledge* is derived from the individual practitioner's experience and the personal characteristics brought to the professional practice situation and was defined as a 'unique frame of reference and knowledge of self which is central to the individual's sense of self' (p. 28).

These forms of knowledge inform the decisions made in practice by practitioners through clinical reasoning processes. Taking a broader perspective, it is possible to view knowledge within the context of the professional group, that is, the practice knowledge that forms part of the knowledge base belonging to a recognised group acknowledged as accepting the social accountability ascribed to the role of profession, as discussed above.

### 1.5.2 Practice knowledge

Working as an occupational therapist requires a qualification recognised within an educational framework, identification with the profession's responsibility and function in different practice settings, and knowledge and skills accepted by the professional group as signifying competence to practice (Kielhofner, 2009). For occupational therapists, three types of knowledge, each making up professional practice, are identified as the conceptual foundation of the profession:

- knowledge that defines the nature, purpose, scope, and value of occupational therapy practice (paradigm);
- knowledge that enables them to understand the problems their clients are having and to know how to work with their clients to overcome those problems (conceptual practice models); and
- knowledge borrowed from other fields that also informs what they do in their practice (related knowledge) (Kielhofner, 2009, p. 10).

Higgs, Andresen and Fish (2004) maintained that the 'primacy of practice' reinforces the dynamic relationship between theory and practice so that in health workplaces 'the use and creating of knowledge and the activities of practice are inextricable' (Higgs, Andresen & Fish, 2004, p. 52).

For this study, I adopted the term professional practice knowledge to refer to the body of knowledge influencing, supporting and being derived from practice of the OT profession, the *paradigm* described by Kielhofner (2009), and the highly interconnected pattern of knowledge, reasoning and practice experience described by Higgs, Andresen and Fish (2004). Use of the term professional practice knowledge is also consistent with the notion of the combination of theories and propositions, some 'tested', others being formed, resembling what Kuhn (1970) described as paradigms and linked by Lave and Wenger (1991) to the notion of communities of practice, a term they used to represent the complex knowledge and behaviour a group of professionals share. Specifically the community of practice offers learning and socialisation for new participants,

or learners, who are joining the group of practitioners. As such they are places for 'shared histories of learning' (Wenger, 1998, p. 86). The combination of shared knowledge and shared history formed a significant part of the conceptual framework for my study.

### **1.5.3 Occupation as a basis for professional practice knowledge.**

Links between occupation and health are not new, with documented history going as far back as the Egyptians (see Wilcock, 2001). OT as a profession, however, grew from the beliefs of psychiatrists of the late 19<sup>th</sup> century who developed theories to propose the benefits of occupation as part of treatment for people with mental illness. Reform movements of the 19<sup>th</sup> century in Europe and the United States responded to social changes brought about by industrialisation, urbanisation and developments within medical science. Moral treatment, promoted by physician Philippe Pinel in France, and the humane approach advocated by Quakers in England, sought to apply psychological and social approaches to encourage the return of reason and health within patients suffering mental illness. A core of both approaches was the routine of the day and the positive benefit of being active, in both work and leisure, within pleasant surroundings (Ikiugi, 2007).

Building on such 19<sup>th</sup>-century ideals, physicians and social activists of early 20<sup>th</sup>-century America established the OT profession with education programs, professional standards and scientific journals advocating the therapeutic application of occupation (Gordon, 2009). Influenced by the emergence of the Arts and Crafts movement, a response to the dehumanising effects attributed to industrialisation and mechanisation, advocates of OT saw the use of handcrafts as a means to restore links with nature, thus creating harmony within the individual (Ikiugi, 2007).

### **1.5.4 Professional practice knowledge: journals.**

Eraut (2003) identified academic journals as a primary source for exploring theories related to practice:

Academic writing for publication is one particular context of use, characterized by the way in which the use of a theory has to be tailored to

the norms and expectations of the anticipated readers or editors, and situated within the discussion of a particular paragraph or longer section of writing. (Eraut, 2003, p. 61)

Craik (1998), in preparation for a British OT statement about mental health services, investigated four professional journals to ascertain the scope of practice within OT. Her report noted the limited scope of articles and the sparsity of topics within the field of mental health. Considering this a reflection of transmission of professional knowledge, she concluded that

there were few recurring subjects ... this is a major deficiency for the profession because it does not demonstrate the development of practice based on previous publications (Craik, 1998, p. 186).

Historical accounts of mental health practice have included investigations into journal publications over time. Pincus, Henderson, Blackwood and Dial (1993) set out to quantify research publications in the *American Journal of Psychiatry Archives of General Psychiatry*, based on their premise that 'published research literature provides an open and concrete composite picture of research in psychiatry. It exists as a historical record that can be evaluated over time to assess trends' (Pincus et al., 1993, p. 135).

Moncrieff (1999) traced developments in psychiatric drug treatments through review of the *Journal of Mental Science* (later to become the *British Journal of Psychiatry*), as this journal was, until the 1950s, the 'only exclusively psychiatric journal' published in Britain (p. 478). A later study by Moncrieff and Crawford (2001) used the same journal, the principal publication of the professional association of psychiatrists in Britain, to examine 'change and continuity in the concerns and practices of psychiatry in Britain during the 20<sup>th</sup> century' (p. 349).

The *Australian Occupational Therapy Journal* is the recognised publication of the professional association for occupational therapists in Australia. It commenced in 1944 as 'The Bulletin', a newsletter for the first group of occupational therapists meeting regularly to consolidate the new profession. With development of the profession, 'The Bulletin' was renamed the *Australian Occupational Therapy Journal* in 1952 and has continued as the only formal

journal representing the profession of OT in Australia. As such, it offers a valuable resource for examination of historical perspectives to portray evolution of professional practice knowledge of occupational therapists working in mental health services.

## **1.6 Studying Occupational Therapy Practice in Mental Health Services**

### **1.6.1 Establishing parameters for the study: scope and boundaries.**

This study of a health profession (OT) was intended to address the complexity of issues impacting on the knowledge base developed by the profession. It came from an epistemological standpoint that seeks to find and understand meanings of practice. For this reason, an interpretive research paradigm was appropriate for guiding the methods and processes to be used. In designing the research process to address my aims, I determined that both historical and current factors impact on the professional practice knowledge of OT. The recent history of the profession has influenced many current practices, and we are not far distant from the pioneer era of developments. While I aimed to seek understanding of the current professional practice knowledge, I also wished to acknowledge the influence of the historical, cultural and social settings in which Australian practice is situated. Further, my own standpoint as a practitioner and researcher influenced the lens through which I viewed the data gathered to address my research questions. I have worked as an occupational therapist in both acute and community mental health settings, giving me a mixed perspective derived from both medical and psychosocial approaches to mental health intervention. As a researcher, I learnt about community-based practice and specifically about consumer focused services. Exposure to the Clubhouse model of psychosocial rehabilitation influenced my previous research in mental health and heightened my awareness of consumer-led services (see Mullavey O'Byrne & Adamson, 2008). At the same time, I learnt about the complexity of the many issues faced by people accessing mental health services.

My previous research experience had highlighted the challenges of gaining research access to essential medical treatment as well as managing the

everyday demands and aspirations of life, reinforcing my 'occupational' focus on the contribution that occupational therapists might make in mental health services. I sought a research approach that would enable me to reflect on multiple perspectives, acknowledging cultural, social and historical influences and involving the critique of my own experience. I considered this to involve an interpretive approach and selected hermeneutics (the construction and interpretation of texts) as a credible research methodology to shape the methods and processes used to interpret the history and texts of OT practice.

### **1.6.2 Using the past to guide the future.**

As I have discussed, the study of the history of medical services is an established discipline within both medical science and the broader study of social history. Despite a significant body of knowledge and a range of historical works examining mental health practice, 'how extraordinary it is how little we know about nurses, occupational therapists or *patients*' (Clarke, 2004, p. 15).

Occupational therapists are interested in professional pasts as a guide to current and future practice, but must take responsibility for their part in historical reviews of practice. During the mid-20<sup>th</sup> century, occupational therapists began to question their philosophical backgrounds and seek autonomy in their practice. This process continues today and is the background for this interpretation of underlying beliefs and approaches to practice learnt through tradition. Reflection on the past and using the lessons learned from these experiences has become tradition for many national professional groups. Keynote addresses at national conferences recognise significant historical figures in most member countries of the World Federation of Occupational Therapists. In Australia, the biannual national address, the Sylvia Docker Lecture, is intended to build on historical perspectives, with a view to inspiring future directions in practice. The lectures have served as a record of professional interests, concerns and aspirations for more than five decades since their inception in 1966.

In addition to the recording of practice within the *Australian Occupational Therapy Journal*, a limited number of historical accounts of the profession exist

in Australia. Anderson and Bell (1988) presented the major written history of the OT profession in Australia, documenting the 'origin of occupational therapy and the formal beginnings of the profession during the years of World War II up to the start of the sixties' (p. xii.). They completed their work at a time when they had access to 'pioneers' of the profession; people who were instrumental in setting up professional networks, the professional association, and the publication that was to become the *Australian Occupational Therapy Journal*. The account of OT's beginnings presented by Anderson and Bell situated the professional history in the context of Australian history. The conceptual framework included social, political and economic factors influencing the genesis and development of the professional group. A major focus of their critique was the role women played within the context of the male-dominated medical services.

Cameron (n.d.) documented the early days of education for occupational therapists in Victoria, writing in great detail of the OT school in Victoria and its transition from a temporary location at a boys' club to a school in the Lincoln Institute of Health Sciences. Cameron was keen to record the experiences of students and staff through her reminiscences and of those of others involved throughout the thirty years captured in this account. Bearup (1996) presented personal stories of fourteen occupational therapists and three OT assistants who worked during the 1940s and 1950s, highlighting their efforts during the war years. Her stories recorded the challenges of setting up services when resources were scarce and the overriding motivation of therapists to contribute to a national goal. She noted that recognition of the profession through membership of the Australian Army Medical Corps added to an increase in OT positions, with thirty occupational therapists employed across ten military hospitals by the end of World War II.

### **1.6.3 Geographical context.**

The geographical location of this study was selected for several reasons. Firstly, Victoria was a setting of early OT practice in Australia. The State had several institutions that emerged from the 1800s into the 20<sup>th</sup> century still influenced by the shadow of convict settlement and the harsh conditions of the 'asylum

era'. These were the sites of early OT departments and of the subsequent move beyond institutional walls into community-based practice. Secondly, while I have practised in other states, Victoria was my place of education and early practice, including experience in mental health services. This gave me an interest in both the origins and the challenges that emerged in Victoria from the 1970s until the present time. Pragmatically, it also meant I was reasonably familiar with the services of the past era, and knew practitioners who could provide an historical perspective for this work. In terms of logistics, the location also proved practical for managing the research process.

Most significantly, siting the study primarily within one state recognised the federated nature of health services in Australia. While significant funding for mental health services is allocated by the Commonwealth Government and national planning and strategic directions dictate the general direction of mental health services, particularly since the introduction of the National Mental Health Policy in 1992, states and territories have considerable discretion in the shaping of services and employment of health professionals.

#### **1.6.4 Language and terminology.**

In writing within different time contexts, I have aimed to use the terminology of the era, as reflected in the publications and programs selected for this study. While acknowledging what might be an overlay of my current perspective, I have attempted to reflect the changing use of terms within healthcare. Changes in terminology have been significant across the periods described in this study. For example, descriptions of the asylum era will involve discussion of 'lunatics' or 'inmates', while the move to mental hospitals creates 'patients'. Language became even more critical with the emergence of 'normalisation' and the disability movement of the later part of the 20<sup>th</sup> century, and especially following 1981, the International Year for Disabled Persons (UN, 2004) when terminology including 'consumers' and 'clients' of health care appeared, reflecting models of care informed by service models. While 'patient' was still accepted by many within other medical services, health professionals paid more attention to the significance of labelling and its impact on behaviour.



## **1.7 Conceptual Framework**

### **1.7.1 Practitioner as researcher.**

My own practice background was relevant for this project. My roles as practitioner and educator have led me to be curious about past practice and to question our professional plans for the future. I have over thirty years' experience in a range of settings across two Australian states. This work has included hospital-based mental health programs and community-based services. I have had roles in acute psychiatry, rehabilitation and policy development. These experiences formed my personal knowledge, incorporating skills and experience in individual and group work, as well as at a 'whole of community' level. My specific interest and experience have been in programs supporting people who had been discharged from mental health institutions and were aiming to remain in community living. My professional education occurred in an era of change, when occupational therapists still worked in locked wards of large institutions that I refer to in the historical overview of OT in mental health services. As a student, I worked with groups of long-term institutionalised patients who had not moved beyond high walls for many years, and with whom I shared their first glimpses of life outside institutions. I recall seeing the joy experienced in realising that a house was a place to live and that bedrooms were small rooms with only one or two beds, with walls that could be painted.

My early knowledge development as an occupational therapist was in an era I now see as straddling the paradigm shift I have outlined above and which formed a major part of the critique I undertook during this study. Many hours of my student years were spent in craft classes, learning the techniques of weaving, pottery and basket-making and memorising the materials required for projects, including costs. We learnt how the characteristics of an activity must be known in order to match that activity with abilities of an individual, or more specifically to treat an illness; and how to be cautious about other factors, such as drug side effects. Later, I became part of the move from institutions to the community and was caught up in the excitement and tension this change generated. Issues included leaving the structured environments, equipped with

activity rooms, kitchens and outdoor recreation areas, for what were meant to be more 'domestic' settings, where teams of staff worked together. Problems concerning the supervision of staff and maintaining professional practice knowledge were raised, with anxiety about the breakdown of strong hierarchies of accountability as teams moved to a multidisciplinary focus.

I learnt as a practitioner that the world was changing and that we must recognise significant shifts in practice during the time of transition from institution to community. Influenced by broader societal changes, we were to realise the adoption of 'consumer oriented', or 'patient centred' approaches, later to become 'person- or client-centred' models of practice. Such changes also brought changes to professional language and the design of intervention programs in mental health services. In an educator's role, my interest moved to the ways in which professional practice knowledge is replenished, and how it is taught to the next generation of occupational therapists. How can we learn from the past? In particular, how can we question professional practice knowledge to learn and improve our practice?

This study is presented primarily from the perspective of practitioners and I acknowledged this as the focus of my thesis. Through my own practice experience, I was able to reflect on my understanding of what participation in a psychosocial rehabilitation program might mean to clients and others involved in mental health services. A practitioner's understanding and experience are one of many factors influencing the critique of OT practice in mental health services presented in this report.

### **1.7.2 Establishing historical and occupational contexts for a critique of practice.**

The framework for my study was guided by the belief that a critique of OT practice should consider contexts of that practice, which are crucial to distilling a view of professional evolution and development. Porter (1994) offered a guide to consideration of historical perspectives of health services by considering the complex mix of biological, cultural and social factors. To apply an occupational lens to my study, I used the Person-Environment-Occupation-Participation (PEOP) model described by Christiansen and Baum (2005), showing interaction

between the person and the activity being undertaken in the context of environment. The four elements of this model are relevant for the study of OT in mental health, with particular reference to those periods being studied during which environments of practice significantly changed. The guiding framework for my study is shaped by historical and occupational perspectives; it is represented at Figure 1.1. In essence, this framework identifies OT professional practice knowledge as being framed by multiple influences, including sociological, historical, personal, client, environmental, policy and procedural factors.



Figure 1-1 Conceptual framework for the study of historical perspectives of OT practice in Victorian mental health services

## 1.8 Overview of the Report

In this chapter, I have introduced the topic and outlined the parameters set for the project. This project emanated from an interest in OT professional practice in mental health services, and specifically through my view that an investigation of historical and current perspectives will add to the development of future professional possibilities.

The following chapters present the work. In Chapter Two I discuss the research approach and detail the process adopted for text construction and interpretation. My personal frame of reference, which shapes the study, emanates from an interpretive paradigm as I seek to understand the transitions that have occurred in the development of professional practice knowledge in OT. I adopted hermeneutics as the framework guiding the work, as my aim was to study and offer interpretations of the way in which knowledge was developed and transmitted across generations of occupational therapists. This involved study of written documents, historical records and transcriptions, and interpretation of critical conversations with occupational therapists.

Chapter Three is a collation and interpretation of historical texts dealing with the historical and developmental scene of mental health practice in Australia. This is intended to explore and interpret the social and philosophical factors influencing the manner in which services developed, in particular within Victoria. While not intended as a formal history of psychiatric services, outlining dates, statistical information and key people involved, it is aimed at presenting a picture of historical contexts of practice, specifically highlighting occupation as part of psychiatric services. The convict era and the nexus between punishment and social views of mental illness shaped the environment into which occupational therapists first entered. Chapter Four builds on the general historical overview, to present the factors leading to the emergence of OT in Victoria.

Chapter Five presents a text constructed and interpreted through the hermeneutic process as I investigated professional practice represented in professional journal records. This chapter traces the development of OT practice in mental health settings from 1960 to 2009. Through construction of this text, I developed a further question-and-answer dialogue to consider OT professional practice knowledge, a critique of transitions in professional practice. These transitions are presented in Chapter Six. In Chapter Seven, I build on the phases of transition of professional practice knowledge to identify six strands of knowledge that emerged through the interpretive process.

The final chapter draws the findings together, with reflections on the research process, the limitations identified, and suggested directions for future research.

### **1.9 Summary: Establishing a Study of OT Practice**

This study investigated OT professional practice knowledge as it was presented in the professional literature and recorded through professional records. My thesis is that OT practice has developed through distinct phases, reflected in the profession's response to implementing its beliefs and theories about therapeutic use of occupation. The eras of professional practice knowledge have historical links to medical practice, social views of mental illness and policies enacted through governmental and non-governmental political action. Through these phases, strands of professional practice knowledge have continued, shaped by the social contexts of practice and informed by experience. These strands reflect the transfer of knowledge between generations of OT practitioners.

The study presented in this report is a formal documentation of the history of the OT profession as interpreted through the hermeneutic interpretation of texts. The aim was to provide historical perspectives of OT in a specific area of practice and across a timespan of significant philosophical change in management of mental illness, with a focus on the evolution of professional practice knowledge.

## **Chapter 2**

### **Research Approach**

#### **2.1 Introduction**

In this chapter I discuss the research framework adopted for my project. The chapter begins with a statement of the research purpose and aims. Ontological and epistemological perspectives are presented, with a justification of the selection of an interpretive approach to underpin the hermeneutics strategy of text construction and interpretation. In explaining the overall research approach, I use a distinction between methodology, methods and processes outlined by Taylor (2006):

- Methodologies set out the underlying philosophical assumptions for the research being undertaken. I state the case for using philosophical hermeneutics as my methodological approach.
- Methods are the actions taken to collect and analyse data. In the context of my project, this constituted a process of text construction and interpretation. I outline strategies used, including identification and study of historical records and interpretation of literature. Text interpretation based on historical and professional literature was followed by a number of interviews. These brought more poignant and complex issues to the fore, and helped me structure subsequent interpretive stages of the research.

Finally, I identify specific processes established to ensure the quality of the work. This includes the ethical and procedural considerations and my personal reflections on the operational and functional aspects of the research undertaken.

#### **2.2 Research Purpose**

##### **2.2.1 Research aims.**

The overall goal of the project was to explore professional practice knowledge of OT mental health practice within the historical context of mental health services in order to understand how this knowledge developed and continues to

evolve. In doing so, I aimed to probe shared understandings of practice that have been and are being created within the OT profession in order to interpret how this professional practice knowledge evolved and was transferred across generations of practice. I propose that such knowledge, generated through a systematic critique of OT practice via historical and philosophical lenses, will contribute to the profession's ongoing development and inform curriculum design of OT education programs relating to mental health. Further, research outcomes will stimulate ongoing reflection, research and discussion within the OT community.

The aim of this research was to understand professional practice knowledge used by occupational therapists within Victorian mental health services. I aimed to

- describe the evolution of OT practice in mental health services in Victoria from its introduction until the present;
- identify factors that influenced the practice of OT in mental health services, including connections and tensions that might exist between philosophical and theoretical perspectives of OT and the services in which occupational therapists practice;
- interpret OT in mental health practices from the perspective of the professional practice knowledge that underpins these practices;
- propose future considerations for education of occupational therapists that build on historical perspectives, with a focus on professional practice knowledge;
- propose future considerations for OT mental health practice with a focus on professional practice knowledge;
- propose key targets for future research in this field.

### **2.2.2 Research questions.**

The overall question guiding the study was:

*What factors shaped OT professional practice knowledge as it evolved in mental health services in Victoria and how is this knowledge emerging to guide current and future OT mental health practice?*

Professional practice knowledge warrants study from diverse perspectives. For this study, I was interested in those historical factors emanating from the early phases of mental health services that impacted on the development of the OT profession, leading to current characteristics of professional practice in mental health services. I sought to investigate the ways in which the OT profession portrayed practice in mental health services since its beginnings in the mid-20<sup>th</sup> century in Victoria.

To illuminate the search for understanding, further questions were developed through the research process I discuss in this chapter. These questions were framed as:

- What were the social influences on, and philosophical drivers of, the historical evolution of OT practice in mental health services in Australia?
- How can the ways in which OT mental health professional practice knowledge evolved and was transferred across generations of practitioners be interpreted?
- What factors (external, e.g. accepted practices and internal, e.g. practice values) within mental health services were viewed by occupational therapists as influencing future professional practice knowledge?
- In what ways has OT professional practice knowledge evolved to fit with changing approaches to mental health services?

Each of these questions was the basis for further process questions and interpretation that emerged through the research process of dialogue of questions and answers. These questions will be discussed in the presentation of text construction and interpretation.

## **2.3 Establishing the Philosophical Research Framework**

### **2.3.1 Ontological and epistemological perspectives.**

Within this study, I sought evidence of professional practice knowledge in the literature and in practice that was varied, influenced by personal experiences and biases, yet at the same time reflective of common, shared beliefs of practice



within a professional group. It is appropriate here to consider how ontological and epistemological considerations came together to shape a research process which reflected my 'world view' and my goal to understand knowledge of the OT mental health practice world.

The first consideration in the design of this study was to situate the work within a research paradigm. Use of the concept of paradigms in the philosophy of science stems from the work of Thomas Kuhn (1970), who described research as organised within frameworks that included concepts, procedures and results which informed subsequent work. Kuhn proposed that within a scientific field, a paradigm emerges as scientists develop explanations for the phenomena they study and over time an organising framework develops to encapsulate the beliefs and assumptions that influenced research methods. Kuhn maintained that these paradigms are not static over time and that scientific development occurs through paradigm shifts, encompassing times of doubt, dispute and uncertainty which require new ideas, discussion and resolution before a new paradigm emerges. Kuhn (1970) further suggested that professions not willing to challenge their ideas and instead held on to previous paradigms to support theory and practice are at risk of missing opportunities for innovation and as a consequence are in danger of becoming ineffective.

Higgs (2001) outlined three key paradigms that provide a framework for research approaches. The empirico-analytical paradigm, coming from a positivist perspective, involves hypothesis generation and testing, primarily using statistical analysis, and pursues objectivity, validity, reliability and rigour, as established within the scientific method model. By comparison, scholars working from an interpretive paradigm aim to understand, interpret and theorise through description and interpretation of experiences seeking to find meaning within lived world situations from the perspective of 'idealism'. This approach is based on the view that reality is constructed and that there can be multiple realities within one situation. A third paradigm is the critical paradigm, arising from a philosophical stance of historical realism and a view that practice is shaped by social and cultural factors. Researchers working within this paradigm aim to create change, often in the form of improvement or reform of a

social situation, or to empower those within the situation. Unlike the previously mentioned paradigms, research in the critical paradigm is commonly collaborative or participatory and often actively involves participants in researching the phenomenon being studied.

### **2.3.2 Paradigms and research purpose.**

Patton (2002) identified different types of research based on the research purpose and underlying assumptions:

- basic research, aiming to address questions deemed important within a discipline or the researcher's intellectual interest and seeking to discover truth or explore knowledge for its inherent value;
- applied research, aiming to 'understand the nature and sources of human and societal problems' (p. 224) and addressing questions deemed important by society; and
- action research, aiming to generate immediate action in response to problems identified in a community or organisation.

My study aimed to understand the historical foundations of professional practice knowledge in OT mental health practice. Through understanding historical foundations, I sought to interpret the features of OT practice related to relationships between occupation and mental health. My aims of *understanding, interpreting and theorising* led to the work being situated within an interpretive paradigm, and considered applied research. Its description as applied is substantiated by its relationship to practice within mental health, an area of health determined to be an important priority within Australian society and by the Australian Government through the National Mental Health Policy (AHMAC, 1992).

As I discussed in Chapter One, historical research in OT practice and in mental health services has included a range of methodological approaches which I considered for my study. Previous historical analyses included 'history of ideas' (Hocking, 2008b; Hocking & Wilcock, 1997; Wilcock, 2001) and content and thematic analysis (Glover, 2009; Moncrieff & Crawford, 2001). Fortune (2002) examined OT practice in the context of deinstitutionalisation and

interprofessional practice, using an ethnographic approach to gain insight into experiences of transition in care models (Fortune, 2002). In-depth understanding of client experiences was sought using narrative and phenomenological approaches by OT researchers in Victoria (Kennedy-Jones, Cooper & Fossey, 2005; Wilding, May & Muir-Cochrane, 2005).

My goals of understanding and interpretation led me to explore hermeneutics as the methodological approach for this study. Hermeneutics has a long tradition in philosophical study, primarily in theology, but has been applied in diverse fields of study including literary criticism (Rees, 2003), organizational management (Prasad, 2002), nursing (Fleming, Gaidys & Robb, 2003; Geanellos, 2000), physiotherapy (Trede, 2006), speech pathology (Reid, 2003) and OT (Paterson, 2003). In particular, use of hermeneutic approaches for research within health professions suggested direction for interpretation of historical and contextual factors relating to evolution of practice knowledge through use of professional literature.

## **2.4 Hermeneutics**

### **2.4.1 Definition.**

Hermeneutics as a term has ancient roots, being found in the works of many Greek philosophers and writers including Aristotle, Plato, Xenophon and Euripides (Palmer, 1969). The word can be traced to the Greek verb *hermēneuin*, interpreting, and the noun *hermēneia*, interpretation. Palmer (1969) noted the link between the term hermeneutics with the winged Greek god Hermes, whom the Greeks credited with discovering language and writing, and who had the 'function of transmuting what is beyond human understanding into a form that human intelligence can grasp' (Palmer, 1969, p. 13).

Friedrich Schleiermacher (1768–1834) is attributed as the first German philosopher to use critical reflection in the translation and interpretation of theological and ancient texts. His use of the 'hermeneutic circle' inspired later philosophers to study more seriously the problems of interpretation and the reliance on interpretation through understanding of 'parts' and 'whole' throughout the interpretation process (Blackburn, 2008). Traditional accounts

of the terminology remain relevant for the use of the word hermeneutics in current research methodology. Three aspects of the use of *hermēneuin* guide the development and use of hermeneutics (Palmer, 1969). Firstly, 'to say', or 'to express'. This relates to the function of Hermes in 'announcing', or proclaiming 'fateful tidings from the divine' (Palmer, 1969, p.14). Secondly, to 'explain'. It is possible to express, to say words, without offering explanations, yet the step of explanation presents the possibility of adding meanings (or hiding meaning). The third implication of the use of *hermēneuin* is 'to translate'. Translation may occur in the context of one language to another, or in the sense of one era to another. Translating text only requires finding the same or similar word in another language; it requires understanding of how words are used and how they form meaning through sentence structure. It is therefore not a mechanical action, but one requiring knowledge of expression and the wider cultural and historical setting. These three ideas encompass hermeneutic interpretation.

Seebohm summarised a similar approach to the use of the Greek roots, but added a further dimension, that of product:

Hermeneia or elocution: the pre-given text.

*Hermeneia or interpretation (translation):* the interpretation or translation of the text.

*Hermeneia or explicatio:* the text of the interpreter as the result of his or her interpretation. (Seebohm, 2004, p 12)

A study of professional practice knowledge using hermeneutics can therefore be expected to have three elements: Firstly, an existing text and / or the construction of a new text is collated within the context of the practice of the profession to establish a basis for further exploration; secondly an interpretive exercise is undertaken to construct a text representing the interpretation of events, actions and knowledge, which in turn forms the basis for the third component, the result of the interpretation, through the work of the interpreter. Hermeneutics is a process whereby a text (meaning, message) is constructed or a set of existing texts is collated (expressed) and the text(s) is / are interpreted, that is, translated into words that are meaningful to the audience and explained as relevant to their socio-historical cultural context. Here I am referring to

hermeneutics as a research strategy rather than as a method or set of rules for interpretation of religious texts, as originally used.

Heidegger (1975) proposed that meaning cannot occur independently of the interpreter and that interpretation of texts is not a linguistic function but has an ontological basis, relating to the study of 'being in the world' – *Dasein* – where the world is not just the physical environment and the 'things' around us and

comes not afterward but beforehand, in the strict sense of the word.

Beforehand: that which is unveiled and understood already in advance in every existent *Dasein* before any apprehending of this or that being. The world as already unveiled in advance is such that we do not in fact specifically occupy ourselves with it, or apprehend it, but instead it is so self-evident, so much a matter of course, that we are completely oblivious to it. (Heidegger, 1975, p.165)

Interpreting the world brings about meaningfulness that occurs through using language, but in a way that is deeper than the 'logical system of language; it is founded on something prior to language and embedded in world – the relational whole' (Palmer, 1969, p. 134). Adopting a hermeneutic approach enabled me to move beyond a translation of 'facts and figures' or of dates and events to consider broader influences of the practice environment. I did not seek to report who said what, but rather to explore how therapists contributed as a group, or as a 'whole', to the 'parts' of practice that related to mental health services at the time of their involvement. Adopting a hermeneutic approach did not mean that I had free reign: understanding hermeneutics required consideration of the ontological and epistemological foundations and influenced how I used the approach as a framework for establishing the parameters that guided each phase of my study.

#### **2.4.2 Philosophical and critical hermeneutics.**

Hans-Georg Gadamer, a student and follower of Heidegger, argued that understanding was not based on rules that govern the process of interpretation but 'rather, it is a very condition of being human ... understanding *is* interpretation' (1970, cited in Schwandt, 2000, p. 194). Gadamer explained

understanding as being at the very core of how life is experienced. Building on the work of Heidegger, he considered the role of hermeneutics 'not as developing a procedure of understanding, but to clarify further the conditions in which understanding itself takes place' (Lavery, 2003, p. 25). In seeking to understand, a process of interpretation is used; it is through this process that understanding can occur. The researcher, or interpreter, comes to the process with prior experiences or prejudices (meaning pre-judgments, not biases) and cannot claim to be totally objective or without preconceived ideas. In my case these pre-understandings centred on my views of OT practice gained through my own experiences. Despite such conditions, through the process of text construction and interpretation, I could create new understandings:

Understanding is always more than merely re-creating someone else's meaning. Questioning opens up possibilities of (new) meaning, and thus what is meaningful passes into one's own thinking on the subject ... To reach an understanding in a dialogue is not merely a matter of putting oneself forward and successfully asserting one's own point of view, but being transformed into a communion in which we do not remain what we were. (Polkinghorne, 1983, p. 375)

Philosophical (Gadamerian) hermeneutics, as this approach is known, can be distinguished from other approaches within the interpretive paradigm by the stance of the interpreter's prior experiences. Gadamer maintained that the sociocultural history of the interpreter is not a factor that can be excluded from the interpretive process. Traditions and experiences of the interpreter are not objective, distant attributes, but are very much part of the interpretive process. Engagement with one's standpoint is a necessary feature of understanding (Schwandt, 2000). Our experiences, traditions, pre-judgements and biases are already present before interpretation begins, and while they might exist out of immediate consciousness, as they 'shape what we are and how we understand the world, the attempt to step outside of the process of tradition would be like trying to step outside of our own skins' (Gallagher, 1992, p. 87). Schwandt (2000) described the process of text compilation as being 'negotiated'. Interpretations may never be considered as finally 'correct', for meaning is not

seen as being 'constructed' (i.e. created, assembled) but as 'negotiated' (i.e. a matter of coming to terms) (Schwandt, 2000, p. 196). In my writing, I considered construction and negotiation as similar characteristics of the process of text construction, as I sought a fusion of my pre-understandings and the new understandings I sought.

Habermas (1968/1972) maintained that Gadamer's hermeneutic approach did not account for the effect of dominant traditions or social influences on the fusion of horizons, resulting in what could be misleading or false understanding. He advocated critical, sceptical perspectives, challenging dominant ideologies and aiming for emancipation from oppression. Critical hermeneutics is the term applied to hermeneutic approaches that are linked to critical theory and where the goal is to discover 'the causes of distorted understanding and communication which operate underneath seemingly normal interaction' (Bleicher, 1980, p. 144). Power structures and dynamics are explicit in interpretation of meaning and cannot be separated from understanding.

In keeping with these characteristics of hermeneutic approaches, my study was informed by philosophical and critical perspectives. As I applied a primarily philosophical hermeneutic approach, particularly within the historical perspective I adopted, I came to realise that professional practice knowledge occurs within the social traditions and power structures which influenced the manner in which OT practice evolved within mental health services. Through the second phase of text construction (outlined at 2.5.3), I recorded a transition in my writing that reflected the incorporation of critical perspectives.

#### **2.4.3 The hermeneutic circle, dialogue of questions and answers and fusion of horizons.**

Drawing on Heidegger's principle that human beings exist in a circular process of understanding, Gadamer (1989) described essential constructs and processes that underpin philosophical hermeneutics. These include the hermeneutic circle, using a dialogue of questions and answers, and the fusion of horizons. The hermeneutic circle is established by recognition that interpretation occurs through a process that involves understanding individual parts of a text with reference to the whole text, and vice versa. Interpretation of one without the

other cannot exist, and interpretation is not static. The process of interpretation therefore continues in a cycle, with the intention of adding new depths and nuances to understanding. Also, because it is a circle, it is never grounded in anything outside itself. In a sense, hermeneutics argues that the end product of interpretation is more interpretation (Shank, 2006).

At the core of Gadamer's notion of fusion of horizons is the belief that observation cannot be entirely neutral. Understanding is influenced by the interpreter's history and life experiences, and by the interpretive process itself. However, the interpreter is not 'limited exclusively to the context or situation he had before approaching the text' (Hoy, 1978, p. 96). The very process of engaging in the interpretive process allows for new understandings that become part of the journey to seek further horizons, thus creating new questions within the circular process.

The interpretive approach fostered by Gadamer (1989) requires its own understanding of the circular nature of the exercise and consideration of 'near and distant' ideas. The notion of 'horizons' is a feature of the interpretive process. Gadamer explained:

The horizon is the range of vision that includes everything that can be seen from a particular vantage point. Applying this to the thinking mind, we speak of narrowness of horizon, of the possible expansion of horizon, of the opening up of new horizons and so forth. (Gadamer 1989, p. 392)

Texts used to inform an interpretive process are viewed in terms of their 'parts' and the 'whole' in a systematic process of interpretation. At each step in the process, understanding is sought through consideration of the detail of sentences and words (parts) in the context of the overall text (whole) and through the lens of the interpreter and participants, thus creating different perspectives (horizons) that in turn inform the next phase of interpretation through questions and further dialogue. This circular process 'could go on indefinitely, because every understanding will change as time goes on. However, a decision, normally based on time or resources, will have to be taken on the number of times the cycle is repeated' (Fleming, Gaidys & Robb, 2003, p. 119).



#### **2.4.4 Historical perspectives of practice.**

Establishing an interpretive process informed by hermeneutics required recognition of historical situations in which OT practice occurred. For my study, history formed an element of the research question. My search for deeper understanding of OT professional practice knowledge necessitated consideration of historical research.

OT professional practice knowledge in mental health services is situated within past and present. Given that current practice is influenced by that which has preceded it, I sought to identify historical *horizons* that would illuminate practices that influenced the manner in which OT occurs today. OT tradition in Australia spans a period of approximately 80 years, and internationally is not yet a century old. In searching for historical perspectives I was guided by a framework suggested by Danto (2008) through which I sought 'two threads' of practice (p. 5). Firstly, I aimed to describe practice that was in response to patient or client needs, as determined within the context of OT knowledge. Secondly, I aimed to identify the broader influences around that practice, incorporating institutional environments, social values and political contexts. Movement within the circular hermeneutic process enabled me to consider written and visual material brought from the past into *dialogue* with recent professional development, recognising that

Interpretation is necessarily a historical process, continuously elaborating on the meanings grasped in an understanding and on the meaning of this understanding itself. In this respect understanding is not a mere repetition of the past but participates in present meaning. (Hoy, 1978, p. 52)

#### **2.4.5 Hermeneutic approaches to visual material and artefacts.**

My search for historical perspectives of OT practice in mental health included visual material that emanated from earlier eras of OT in mental health services. These were either photographs kept as part of public records of practice or crafted objects either kept by practitioners or in museum archives. Photographs and objects are forms of empirical data used in many methodological approaches, traditionally recognised within anthropological research, specifically ethnographic approaches (Flick, 2009). Within interpretive

approaches, visual material is ‘acknowledged not as “objective truth” ... the very act of observing is interpretive, for to observe is to choose a point of view’ (Harper, 2000, p. 721).

As I noted in Chapter One, some of these images and objects symbolise perspectives of professional practice. Hermeneutic researchers have long recognised the opportunities for discerning meaning in human endeavours beyond the written word by conceptualising objects as having potential for interpretation:

from hermeneutic scholars comes the notion that artifacts (by which they meant human creations, such as novels and other writing and by extension, paintings, architecture, etc.) may be ‘read’ to discern the meanings embedded in or projected into them in the process of their creation. (Yanow, 2006, p 43)

More recently, photography and other visual methods have been used broadly for interpretation in hermeneutic approaches within social sciences (Knoblauch, Baer, Laurier, Petschke, & Schnettler, 2008) and specifically within health research, in nursing (Hagedorn, 1996) and in mental health practice (Sitvast, Abma & Widdershoven, 2010). During textual construction and interpretation, I drew on images and objects ‘collected’ as part of my search for historical perspectives of practice, including these as part of dialogue phases, as described in 2.5.6.

## **2.5 Text Construction and Interpretation**

### **2.5.1 Research phases.**

Text construction and interpretation took place during the years 2004–2010, a period reflecting the part-time nature of my studies. The project commenced with the collation and interpretation of literature texts related to psychosocial rehabilitation and OT practice, followed by collation and interpretation of the historical literature. Then followed an interpretative phase, drawing these understandings together and testing them through a presentation of preliminary findings at a professional conference, with the aim of seeking feedback to shape the subsequent focus of the research. In keeping with this

characteristic of a hermeneutic approach, I specifically addressed my pre-judgements, or pre-understandings, which influenced aspects of the study. The third research phase involved construction of texts through engagement with practice via exploration of current practice settings, and identification of participants for ‘critical conversations’. One practice-based text I used for this study was derived from a report on previous work conducted by myself and a colleague investigating a community rehabilitation program. This study sought to understand the experiences of people involved in a Clubhouse psychosocial rehabilitation program. As one of my lenses of interpretation was the experience I have had as an occupational therapist, the study of psychosocial rehabilitation was an important influence on my evolving views of mental health practice. The relevance of the report to my current study lies in the understanding gained of the importance of ‘participation’, which emerged through the interpretation of my work with the rehabilitation program and the subsequent report.

The phases of my study are presented in Figure 2.1. This figure shows the overall approach I adopted within the interpretive paradigm, the processes implemented to progress each phase of the research and the circular hermeneutic steps that were informed by interviews, reading and conversations intended to provide critique and review. A central thread running through the study was the use of reflective journal entries and notes taken after interviews.

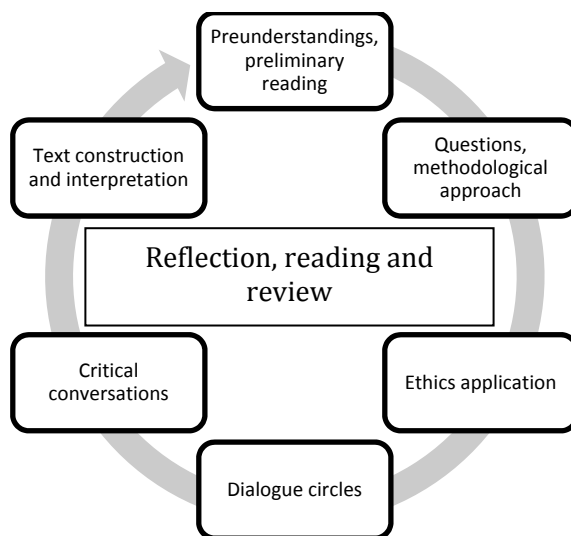


Figure 2-1 Overview of the research process

### **2.5.2 Using the hermeneutic circle.**

In my research an ongoing and circular process was an important part of text construction and interpretation. The starting point was a broad topic and a statement of my interest. In determining each subsequent step, I was influenced by what I had experienced as 'events of learning' in my own practice. To take my first step in the circular process, I reflected on a seminar presentation by Frank Walker (2002) for the Schizophrenia Fellowship of New South Wales that shaped my questions about early development of mental health services and their relationship with legal systems. These questions established my starting point within the convict era of white settlement in Australia and the 19<sup>th</sup>-century context of scientific knowledge development and subsequent social responses to mental illness. From this historical perspective, I explored the emergence of OT in the early 20<sup>th</sup> century, with its eventual 'arrival' in Victorian psychiatric hospitals.

My recording of these historical perspectives up to the commencement of OT in Victoria became the historical horizon I used when considering my dialogue of questions for the text constructed on fifty years of OT practice from 1960–2009. Using this text as a second step into a further circular process, I considered parts of the fifty years, using questions around the contexts I have outlined (see Section 1.7.2) to debate descriptions of practice (the 'parts') within the influences of the broader contexts (the 'whole'). This circle resulted in the second constructed text, which proposes a series of transitions in professional practice knowledge. I considered each of these transitions in turn as 'parts' in relation to the 'whole', which reflected a further horizon: that of linking past with present. Engaging in this round of dialogue led to the emergence of strands of professional practice knowledge. These strands are themes of understanding that form part of the final product, my interpretation of the evolution of OT practice in Victorian mental health services. The text created and interpreted through these circular processes represented my 'whole' product of the study, itself a stepping-off point for future interpretation.

### 2.5.3 Dialogue of question and answers.

As outlined in the previous section, a key step in the circular interpretive process was the use of sets of questions that established 'dialogue' between the parts and wholes of the texts and my interpretive writing. The three phases of my study are illustrated in Figure 2.3. Each phase comprised writing from my interpretive reading of texts which led to a set of process questions, listed in Section 2.2.2. These questions were refined during the process of interpretation, as described in Section 2.5.6.

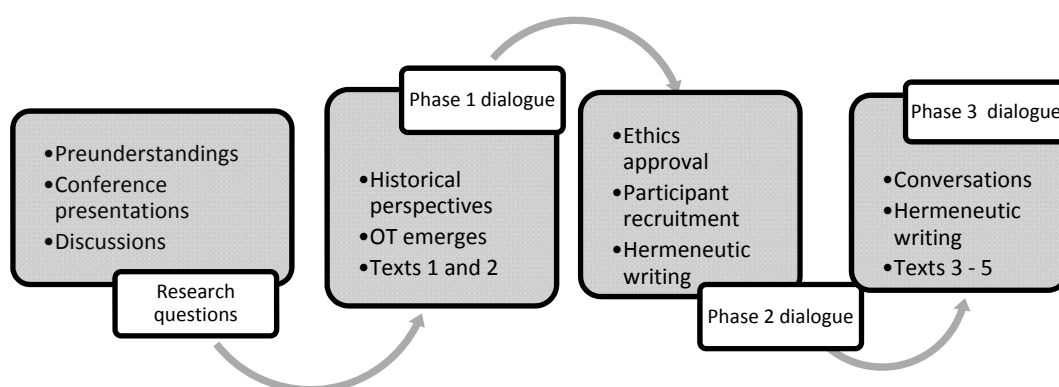


Figure 2-2 Dialogue process

In my study, I sought to understand practice from as many perspectives as I could identify within the overall picture of shared professional practice. The activity of understanding is contained within the concept of fusion. Fusion did not mean blending of views into 'right' or 'wrong', or developing one view of the professional practice knowledge I sought to study. Nor did it mean that I came to the same understanding as those whose texts I used, or who were interviewed during text construction. Rather, I sought to elicit and interact with distant views, re-examine my closest perspectives, and consider future possibilities, another distant view. Svenaeus (2000) describes the interpretive exercise as aiming to enhance that which is already known, to reach a '*different, ideally richer, understanding of the text that the understanding reached by the author and the readers of its time*' (p. 134).

I considered horizons in the context of three main factors. The first was the historical background that influenced professional development, a 'distant view'

that I endeavoured to examine as clearly as possible. This required recognition that, while I could not totally exclude my current perspective, I could aim to view history in a manner that was as close as possible to what might have been practice realities at the time; as an example, this included recognising that language has different meanings over time or that statements that, in today's context, might be viewed as gender biased, were the norm for another period.

The second factor was to recognise that perspectives of practice are experienced by clients as well as practitioners. My intention was not to be a voice for clients, nor to take an advocator's role. I was searching for meanings and deep understanding, but not aiming to provide narratives or stories from a client perspective, as might have been the case had I taken a hermeneutic phenomenological approach. Having taken instead a philosophical hermeneutic approach, I acknowledged that my position and perceived status as a researcher and health professional made it impossible for me to fully integrate and appreciate the client perspective. Instead, I sought to understand a range of views relating to mental health services and to draw on my own practice experience.

The third horizon I sought was that of practitioners who could bring many experiences and views to our discussions. My aim was to reach understanding that could represent many different experiences, even though they might have occurred in what seemed similar practice settings. It is important to note that, as with clients' perspectives, I did not aim to present practitioners' views, nor to re-tell their stories or experiences. These critical conversations were used instead to give me access to horizons that extended and deepened my understanding of the research topic.

#### **2.5.4 Strategies for participant selection.**

The context of this study was OT practice in the Australian health system, specifically in Victorian mental health services. The texts collated for this research and relating to historical practice were set in the context of the development of psychiatry within Australia, with a focus on developments within Victoria. Using purposive sampling, ten participants were recruited for

conversations concerning professional critique. The number of participants was selected to allow me to sample a range of practice areas and experiences within different generations of practice. I wanted to participate in conversations with occupational therapists who had worked in large psychiatric hospitals or community-based settings, or as educators. Participants were identified through professional networks and their employment as mental health practitioners. I sought occupational therapists who were identified by others as experienced: 'experts' within the field. This meant that they had participated in professional forums, or had written about professional issues and were familiar with broad practice issues. This was an important consideration in seeking critiques of both historical and current practice, as their previous engagement with philosophical or theoretical thought would enrich the understanding I was seeking.

Initial contact was made by letter or email, inviting participation (Appendix 1). Ten occupational therapists agreed to participate, and arrangements were made to meet at mutually agreed times and locations. Interviews took place at clinical sites or in meeting rooms at university or professional association offices. Table 2.1 provides a profile of participants. Identifying information was excluded from the profile to ensure anonymity of the participants. In particular, age, gender and actual place of work are not reported. In a small field like OT, reporting gender with years of experience and place of work is likely to enable identification, especially of men working in the field. As gender is a relevant consideration in studying health professions, I identified gender in the context of the historical interpretation, but did not report it in the description of participants in the critiquing conversations. I acknowledge this process decision may contrast with what might be considered appropriate for writing about other practice perspectives: for example stories of *experience* within the mental health system, analysed and reported as narrative or phenomenological accounts. I listed areas of work according to terminology relevant for the time period: for example, 'mental hospital', 'case manager'. These reflect the descriptions given within the public health system at the time when the participant was employed in that role.

Table 2.1 Research participants

<b>Participant (critical conversation)</b>	<b>Years experience as occupational therapist</b>	<b>Roles in mental health practice and areas of practice</b>
<b>CC1</b>	33	Occupational therapist Long-term institutional settings Community-based program Acute general hospital, inpatient program
<b>CC2</b>	30	Occupational therapist Acute hospital Community-based, case management role Private practice/consultancy
<b>CC3</b>	34	Occupational therapist Educator Consultant Long-term institutional setting University
<b>CC4</b>	35	Psychosocial rehabilitation program director Educator Long-term institutional setting Community-based service
<b>CC5</b>	27	Occupational therapist Educator Mental hospital, acute and long-term University
<b>CC6</b>	10	Occupational therapist Manager, OT services Long-term institutional setting
<b>CC7</b>	12	Occupational therapist Case manager Community-based services
<b>CC8</b>	8	Occupational therapist Case manager Community-based services
<b>CC9</b>	30	Occupational therapist Long-term institutional setting Acute mental hospital
<b>CC10</b>	10	Occupational therapist Case manager Community-based services



### **2.5.5 Critique and conversations.**

During each phase of the research, I sought deeper understanding of concepts and issues related to professional practice knowledge through conversations with practitioners. Interviewees participated in one to three conversations, each of one to two hours in length. Interviews were recorded with the permission of the participant (as outlined in the ethics approval) and were later transcribed for interpretation. Interviews for the first phases of the study commenced with introductory remarks explaining the study, then an initial question inviting an account of the experiences of the participant within the mental health services. These interviews were largely unstructured, with few guiding comments or questions needed. Later interviews that focused on texts three and four included questions to guide participants in critique of the earlier phases of interpretation.

Transcripts were read several times to immerse myself in the texts. Notes were taken of general impressions, themes emerging and insights offered relating to professional practice. Minimal notes were taken during the interview, with the aim of creating a professional conversational approach, but field notes were written after each interview, recording features of the interview, first impressions, insights gained and any emerging ideas for writing or for follow-up in subsequent interviews. These notes became part of the reflective journal kept for the project.

### **2.5.6 Constructing the hermeneutic texts.**

Working within the hermeneutic approach I constructed texts that would facilitate deeper understanding of OT professional practice knowledge. Three texts emerged from the first phase of the study, each representing a factor identified in the preliminary conceptual framework (i.e. Section 1.7.2). The construction and interpretation of each text involved similar processes. First, relevant literature and other documents were identified and read, and notes made. The hermeneutic process then required a series of question-and-answer 'dialogues' relating to the reading. This preparation included consideration of the language, the points of view being expressed, and a search for possible meanings within the historical context and in light of other factors that could

influence the setting. A first step in writing was to identify main themes that were seen as 'answers' or factors that shed light on the questions being asked. A second step was to then generate further questions, go back to reading and seek to answer these questions. At this point, I looked further at literature, expanding my search and revising my notes. Next, I continued writing from the new perspective. Interview transcripts were then used to seek further viewpoints, clarify questions and add new insights into the text being constructed.

This process represented the steps towards pursuing a 'fusion of horizons', as outlined previously. In the context of this study, I considered the 'whole' to be a broad focus on the dialogue and questions relating to international and national contexts of mental health. These contexts included the Australian National Mental Health Plan, regional service settings and the OT profession as a whole. I sought to develop diverse views of the horizons, through literature, government documents, examples of OT intervention plans, and conference and workshop presentations. Further views were developed through discussions with participants, and the stories they shared with me during our conversations. A sample of a critique through conversation is in Appendix 2.

Preliminary writing also recorded 'parts' of the topic, reflecting historical, social and personal perspectives. These were collected primarily through interview transcripts in the first phase, and from subsequent discussions and critical conversations. I also drew on my reflective writing, field notes and personal practice experiences. I constructed descriptive texts around images and objects of practice for inclusion in dialogue around the research questions (Appendix 3). A summary of texts is presented in Table 2.2, and further description of each text is provided in the following sections.

Table 2.2 Summary of constructed texts

Text	Title	Sources
One	Historical perspectives: mental health in early Australia	Historical analysis of the convict era Historical accounts of life in early white settlement Mental health service histories
Two	OT emerges	Mental health service histories OT practice literature Historical accounts of OT practice
Three	OT practice in mental health services in Victoria, 1960 - 2009	Written histories of mental health services Written history of the OT profession in Australia Public records (Public Record Office, Victoria) Archival material; photos, stories OT Australia documents, National and Victorian offices OT text books and journals, primarily AOTJ
Four	Transitions in <i>professional practice knowledge</i> in mental health services in Victoria	Victorian Government policy and strategic plan documents AOTJ Critiquing conversations: practitioners
Five	Linking past and future: OT professional practice knowledge and professional identity	Victorian Government policy and strategic plan documents AOTJ Critiquing conversations: practitioners

### 2.5.7 Text 1: Historical perspectives: mental health in early Australia.

I commenced text construction and interpretation within the context of the early settlement of white Australia. Prompted by my interest in the social factors that led to the establishment of lunatic asylums, I addressed the link between the legal and medical systems. Questions guiding this process emerged through text construction and included:

- How was mental health conceptualised in early white settlements of Australia?
- How can 'occupation' be interpreted within the convict era of early white Australia?
- How were mental health services established in the early settlements?

- What local and international influences shaped the early mental health services?

Sources were text-based and primarily historical accounts of early white settlement in Australia. I drew on the work of recognised historians, acknowledging that other accounts might have provided different perspectives. I was seeking accounts that described health issues and ‘everyday’ perspectives of the convict era, in order to interpret an ‘occupational’ view of settlement life.

### **2.5.8 Text 2: Occupational therapy emerges.**

The second text portrayed an interpretation of the emergence of occupational therapy as a health profession in the context of Western society and mental health services of the early to mid-20<sup>th</sup> century. The starting point for text construction and interpretation was the question:

What were the social influences on, and philosophical drivers of, the historical evolution of OT practice in mental health services in Australia?

I refined this question to provide further direction as follows:

- What international developments in OT influenced the emergence of OT as a profession in Australia?
- How were these influences instrumental in the beginnings of OT in Victorian mental health services?
- How did a ‘profession’ related to ‘occupation’ consolidate a role in Victorian mental health services?
- How can the evolution of OT professional practice knowledge be interpreted?

I drew on sources within OT literature and early OT text books to address these questions. Historical accounts of the profession also informed text interpretation. To provide the Australian historical context of OT practice, I drew on the work of Anderson and Bell (1988). This is, to date, the most comprehensive historical account of the OT profession development, encompassing its early beginnings in Australia and its progression through to the 1980s. Of particular relevance is its focus on the two decades of the 1940s

and 1950s, years in which mental health practice was crucial in the development of the profession.

### **2.5.9 Text 3: Occupational Therapy practice in mental health services in Victoria, 1960–2009.**

This text was constructed to address a series of questions as to how OT in mental health services developed in the Australian context. The dialogue of questions and answers within this phase included:

- What were the local and distant influences on the development of OT from the 1960s in Victorian mental health services?
- How did occupational therapists describe their practice?
- What was the organisational framework of Victorian mental health services?
- How was OT practice organised in Victorian mental health services, and in particular in the public sector?
- How were occupational therapists employed within these services?

Sources were text-based and included the following:

- historical documents describing the emergence of mental health services, particularly OT;
- research studies within OT literature;
- professional practice models described in OT texts and reference books;
- Commonwealth documents, including National Mental Health Plans, 1-3;
- State Government mental health strategy and other publications;
- websites of government and non-government organisations; and
- OT professional documents, including minutes, publications and field notes made during visits to national and state professional associations.

In interpreting historical accounts I focused on questions related to professional practice knowledge. In contrast to an approach that documents key people and dates or places, my interpretation was of practice trends, and knowledge generation and dissemination.

#### **2.5.10 Text 4: Transitions in professional practice knowledge in mental health services in Victoria.**

This text was constructed as an interpretation of practice in the institutional and community settings of mental health services. I sought documents that described the organisation of mental health services and in particular of OT. The focus of this search was descriptions of professional practice, roles of occupational therapists and how occupational therapists perceived their practice.

Questions guiding this interpretive phase included:

- What were the influences on changes within OT practice in Victorian mental health services?
- How did occupational therapists respond to changes in practice?

Sources were text-based and included:

- OT professional documents, including minutes, publications and notes from visits to national and state professional associations;
- the text of the study, *A multidimensional evaluative study of Pioneer Clubhouse* (Mullavey O'Byrne & Adamson, 2008);
- transcripts from critical conversations with practitioners; and
- literature that described OT services and the ways in which occupational therapists applied professional practice knowledge to their roles.

#### **2.5.11 Text 5: Linking past and future: occupational therapy professional practice knowledge and professional identity.**

The next interpretive phase involved seeking information that would deepen my understanding of issues around occupation and how this had translated into recent developments in mental health services in Victoria. Questions in this cycle included:

- What features of professional practice connected past and current practice?
- How were these aspects of practice reflected in professional practice knowledge?

- What challenges faced OT in mental health practice in the context of national and international practice?

Sources were text-based and included:

- transcripts from critical conversations with practitioners;
- literature that described OT services and perceptions of occupational therapists about their roles; and
- reviews of mental health services and OT education

## **2.6 Ensuring Quality in the Research Process**

### **2.6.1 Quality framework.**

My journey for this research was prompted by an interest in professional practice and the contribution OT makes to mental health services. Inherent in this process was a belief that my own contribution could, and would, be judged. I was guided by Higgs (2009) who described criteria for judging qualitative research. The credibility of the research findings and their contribution to knowledge will be judged by the combination of contextualisation, congruence and critical rigour. In the following sections I discuss these issues and the ethicality of my work. I return to this framework in the final chapter of the study to discuss the research in relation to these criteria and in light of the credibility of the argument presented and its potential contribution to knowledge.

Working from the premises that meaning is constructed within social settings, and that there can be multiple realities, I set out not to find 'one truth' but to be open to multiple perspectives. My own perspective and practice experience influenced development of the research questions through my aim to critique practice but not necessarily to be critical or to force change. This led to the selection of a philosophical hermeneutic approach to facilitate interpretation of the past and to establish my role as an active part of text construction.

### **2.6.2 Contextualisation of the research.**

The contextualization of the research should be clearly explained. In planning and implementation stages, I aimed to ensure that the research was presented

within a relevant context and embedded in a coherent body of knowledge. The practice context was made up of historical and current practice settings, for which I sourced credible literature and recruited appropriate participants. In writing the process, findings and discussion, I clarified the context of the study to assist readers to ascertain the applicability of this research to their practice or research situations within the field of mental health services.

This research related to OT practice occurring within the mental health services of Victoria. This practice has inevitably been influenced by sociocultural factors, at local, national and international levels. I therefore described and discussed many aspects of practice that are likely to be consistent with practice in other parts of Australia and internationally. Significantly, while the research drew on the influences of historical, social and philosophical factors from previous centuries on current practice, the discussion is primarily in the context of 21st-century practice.

### **2.6.3 Congruence within the methodology.**

I aimed for consistency in my approach, meaning congruence between ontology (the nature of reality), epistemology (ways of knowing) and methods (the process used to generate knowledge). Hermeneutics offered an approach that would link my ontological perspective with my goal to seek knowledge that would give me multiple views of OT history in mental health services. I sought many perspectives and possible answers to the historical questions that guided my search. Adopting a hermeneutic approach drew me into a circular process that opened my thinking to many possibilities.

The congruence of the research strategy was addressed through my design of a process that demonstrated internal consistency. I have explained the ontological and epistemological perspectives that influenced my overall direction and thinking. I used processes for text construction and interpretation that were in keeping with this direction. This included the writing phase and production of a report that was consistent with the research strategy. Within this written product, my goal was to present a coherent argument and to communicate this in a clear and appropriate manner. The language is intended to be appropriate



for the methodology and at the same time respectful of people who participated as well as to the client group represented by this work. As I discussed in Chapter One, the historical span of this study meant that practice language had undergone significant changes. Many terms used previously were now considered highly inappropriate. I endeavoured to be true to the historical context, at the same time ensuring that interpretation was presented in an appropriate manner for today's social and practice context.

#### **2.6.4 Critical rigour.**

Central to my approach was the pursuit of critical rigour. While the research process was essentially circular, I ensured that each step was planned and implemented in a systematic manner, with attention to methodological and ethical conduct. In line with the discussion of congruence, I aimed to ensure quality by developing a process that would be systematic, yet flexible and evolving as each stage within the circle developed and influenced subsequent stages. Strategies to ensure rigour included those adopted for text construction, interpretation and writing. Firstly, multiple sources for text construction were sought with an aim to increase the depth of the texts and to provide as broad a picture of practice as possible, and limit any potential systematic bias as has been described by Ajjawi and Higgs (2007) and Denzin and Lincoln (2000). Secondly, in the interpretive and writing stages I used a reflective diary to document each phase of interpretation and the movement that occurred at each stage of the hermeneutic process. Thirdly, I used a systematic approach to review my own practice as a researcher. By acknowledging the values and perspectives I brought to the work, I recognised that the research occurred within a value-laden environment, and that I was seeking an objective representation of the phenomenon, an approach suggested by Denzin and Lincoln (2000). The reflective diary recorded my thinking as well as reflections gained through the critical professional conversations held during the final phase and writing of the final text.

#### **2.6.5 Ethical considerations.**

Approval for the study was granted by the Human Ethics Committee of the University of Sydney. The main ethical consideration was to ensure anonymity

and confidentiality. Participants were recruited because they were considered within the profession as experts; so they were, to varying extents, well known. Many had written journal articles or books, presented at seminars, workshops or conferences and / or had management roles within practice and education. Some were keynote speakers at national professional conferences. For this reason, I was aware that background details could make them easily identifiable. I avoided all identifiable details and did not report on gender linked to years of experience or area of practice, as outlined previously (within the group of ten, there were nine female participants and one male). I also did not assign pseudonyms as is often the custom in reporting findings, but assigned codes to delineate each participant of critical conversations (i.e. OT:CC1 – 10).

I used direct quotations from these conversations to support the interpretations I made throughout the hermeneutic process. Participants were informed that their transcripts would not be returned for checking, as is the custom for other methodological approaches. Given the philosophical view that there need not be one 'right' view of a situation or conversation, and given that my approach involved my engagement with the texts for interpretation, my commitment was to ensure accuracy of transcription. Some participants expressed interest in knowing more about the research process as it proceeded, and offered further involvement. These participants were subsequently consulted in the later phase of interpretation.

## **2.7 Summary: Identifying the Research Approach**

In this chapter I have presented the methodological framework and strategies used for text construction and interpretation. My work comes from a 'worldview' perspective: that meaning is constructed by individuals and groups within the context of social settings. Historical and philosophical influences, as well as personal views, impact on professional practice. In turn, the knowledge developed and passed on within a profession will be influenced by these factors. A profession is not only a collection of individuals, but reflects common ideologies and perspectives. In order to investigate the common knowledge of a profession, I adopted a systematic approach to text construction and interpretation, using a philosophical hermeneutic approach. This involved a

circular process of interpretation within a methodological framework that ensured rigour, credibility and an ethical approach at all times.

Using the cyclical hermeneutic process, I developed question-and-answer dialogues, commencing with the main question then moving, by way of the generation of a cycle of further questions, to investigate elements of the overall question in more depth. The first of these three dialogue cycles addressed the historical development of the profession; the subsequent cycles addressed professional practice knowledge and resulted in two interpretive texts that sought to understand the evolution of practice knowledge across generations of practitioners.

The research presented in this thesis is situated in a practice environment that continues to evolve. This discussion of knowledge and research paradigms is presented with the assumption that

there is no single “truth” – that all truths are but partial truths; that the slippage between signifier and signified in linguistic and textual terms creates re-presentations that are only and always shadows of the actual people, events, and places. (Lincoln & Guba, 2000, p. 185)

Keeping this in mind, in the following five chapters I present the historical background to and evolution of occupation as therapy in mental health treatment through five interpretive texts that illuminate professional practice knowledge of OT in mental health services. As the beginning of this process, Chapter Three sets occupation and mental health within the context of the early white settlement of Australia.

## Chapter 3

### Text One: Historical Perspectives: Mental Health in Early Australia

This chapter presents an interpretation of the literature (formal and informal texts) that I collated for my first hermeneutic study. The topic dealt with mental health in early Australia and provided a background against which to examine the question, *how did OT develop within Australian mental health services?*

The decision to send the First Fleet to Australia was the result of complex political, social and economic factors occurring in British society. In-depth consideration of these factors was not the focus of my work, so warranted mention only to the extent that they affected the creation of white Australian settlement. I included an interpretative description of the early penal settlement through the occupational lens described in Chapter One, with a focus on *people*, the *environment* and *occupations*. I was interested in the ways in which people *participated* in their occupations and the relationship between participation and mental health in the early settlement. To develop my occupational view, I drew on the work of Manning Clark (*A short history of Australia*, 1995) and for a further critical perspective, the work of Robert Hughes (*The fatal shore*, 1987). To assist me to consider an environment that can only be imagined from this distance, I also drew on the writing of Watkin Tench (1758–1833), a Captain–Lieutenant with the British Marine Corps who arrived at Port Jackson with the First Fleet. Tench published regular accounts of life in the colony, based on his journal records (1793/2000). While OT services appeared long after the convict period, mental health institutions arising from the time of the early settlements were influenced by the living conditions and the social fabric of early Australia. Occupation in the context of institutional environments emerged from these times and served as a precursor to the development of OT.

In writing this interpretation, I am aware that I present a ‘white’ history of Australian health services. I acknowledge that there are other stories, those of the Indigenous people who lived in diverse and well-established nations within the land at the time of the First Fleet’s arrival. While the history documented by

the British newcomers often reads as if an empty land was being settled, I recognise that I am writing about the Port Jackson settlement in the land of the Eora people, and in Victoria, the land of the Kulin nation. While acknowledged as a perspective that would contribute significantly to our understanding of mental health practice, analysis of the concepts of health and mental health within these nations is beyond the scope of this study.

### **3.1 Occupation in Colonial Australia**

#### **3.1.1 The decision to colonise Australia.**

At the beginning of the 18<sup>th</sup> century, Britain was a nation strongly made up of classes, or social layers dominated by a wealthy class of landowners within a predominantly agriculture-based economy (Black, 1996). During the 1700s, the industrial revolution expanded prospects for social wealth and at the same time increased the disparity between classes. There were high levels of poverty, high infant mortality rates and harsh working conditions (Hughes, 1987). Death at an early age was common, primarily from diseases that spread through fever and epidemics. Public health in the form of sanitary conditions and water quality did not exist (Rosen, 1958/1993). Occupational roles were determined by class. Education was available to the wealthy, while the 'lower' classes were occupied by survival and were employed in menial labour, often to support the lifestyle of the ruling classes. Prevailing social views of the time reflected philosophical beliefs that humans were inherently good or bad. Philosophers such as Thomas Hobbes (1588–1679) promoted the need for strict governance with the 'sovereign as ruler' to keep order amongst the population (Blackburn, 2008). Punishment for crime was severe, and the death penalty was used for a range of crimes. Deviance from social norms was often judged as criminal behaviour by those who assumed social decision-making roles, whether or not crime was involved. In many instances, deviance was punishable by death, commonly by hanging. One alternative to the death penalty proposed during this century was a sentence of transportation from Britain. A penal colony was established in Maryland and Virginia in what is now the USA. Here the prisoners became slaves of landholders or cheap labour for the many construction projects underway in the new and expanding colony. This solution was lost to Britain

after the American Revolution (1777–1783). Britain had to look again for solutions to an increasing population of prisoners housed in overcrowded gaols and prison ships anchored offshore. The government of the day turned to the relatively unplanned and chance discovery of a ‘new’ land that had occurred several years earlier (Hughes, 1987).

James Cook’s discovery of a southern continent opened new prospects for commerce and agriculture, and also an opportunity for Britain to thwart attempts by France to colonise the Pacific region (Hughes, 1987). In the ensuing debate about how to best achieve this, political imperatives in favour of commercial propositions for the settlement in the newly discovered region won the day. The British government saw an opportunity to deal with the growing numbers of prisoners and at the same time develop a colony in the newly discovered region. The decision to use prisoner populations rather than free settlers set the scene for a ‘thief society’ that emerged in the newly established colony (Clark, 1995; Hughes, 1987). Sending convicted criminals to the new land was not necessarily considered an opportunity to establish a new growing enterprise, but was a way to rid Britain of unwanted people and problems. Reflection on and any acceptance of responsibility for the social, political and economic problems of the lower classes that contributed to crime and poverty were largely missing from this position. Indeed, ‘the authorities hoped that it would eventually swallow a whole class – the “criminal class”, whose existence was one of the prime sociological beliefs of late Georgian and early Victorian England’ (Hughes, 1987, p. 1).

### **3.1.2 Establishing the new colony.**

When the First Fleet arrived in Port Jackson on 26 January 1788, it brought over 750 convicts. This ‘cargo’ of men, women and children had been rejected from society, deemed to be criminals (Hughes, 1987). In Britain, these members of the ‘criminal class’ had been housed in overcrowded prisons, regardless of age and circumstances, until they were sentenced to join the mass transportation to the new colony. No consideration was given to skills, knowledge or capacity to undertake the task ahead, with the result that these

first white Australian settlers were so conspicuously unfit for survival in the new land that they lived on the edge of starvation in the midst of what seemed natural abundance to the Aborigines. They had practically no idea of what they could eat or how to get it. Most of the First Fleet convicts had not moved ten miles from their place of birth and had never seen the sea before they were clapped in irons and thrust on the transport. (Hughes, 1987, p. 7)

The 'rulers' of the colony (military personnel) were also challenged by the strangeness of the land, the climate and the chronic lack of food. Their duty was to develop a new colony and to explore the land with an unruly workforce which was ill-equipped to carry out the tasks demanded of them. Nor was the military contingent prepared for dealing with the indigenous population. Apart from the officers, many had limited education and were charged with decisions for which they were not qualified. At a distance from familiar structures that provided social control, and with limited medical services, the prevailing conditions meant that 'from the outset, criminality and insanity were closely associated in the Australian colonies' (Lewis, 1988, p.1). Britain's transportation scheme resulted in 825 ships arriving in Australia between 1788 and 1868, carrying an average of 200 convicts per ship, many of whom fared badly in the cramped, dark and humid conditions and were subjected to cruel<sup>2</sup> forms of punishment (e.g. flogging) for any misdeed (Hughes, 1987). By the mid-1800s, settlements had been established in the colonies of New South Wales, Victoria, Queensland, Van Diemen's Land, then South Australia and Western Australia.

### **3.1.3 Illness on transport ships and in the new colony.**

Conditions on board transport ships were cramped, unsanitary and unhealthy. Although the First Fleet had relatively few casualties given the lack of medical knowledge and poor conditions, with forty of the 736 convicts dying during the voyage (Hughes, 1987), subsequent fleets were not as well equipped and not all

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<sup>2</sup> Here I note that my opinion from a 21<sup>st</sup> century perspective judges this punishment as cruel. I acknowledge that at the time, harsh conditions and different perspectives may well have formed different views.

ships carried naval surgeons. Diseases including typhus, scurvy, fevers, and infections caused by days kept in filthy conditions in bilge water when bad weather struck, took their toll. Despite governmental enquiries in Britain and attempts to improve conditions, prisoners faced miserable journeys and harsh treatment with little hope of cure or comfort. Many were shackled together, regardless of the death of another. Journals kept by surgeons and chaplains gave a glimpse of the conditions:

upon their being brought up to the open air some fainted, some died upon deck, and others in the boat before they reached the shore. When come on shore, many were not able to walk, to stand or stir themselves in the least, hence were led by others. Some crept upon their hands and knees, and some were carried on the backs of others. (Johnson, cited in Hughes, 1987, p. 146)

Even when death was inevitable, there was little care for those on shore.

Clothing and food of the dying were stolen:

When any of them were near dying, and had something given to them as bread or lillie-pie (flour and water boiled together) ... the person next to him would catch the bread, &c., out of his hand and, with an oath, say he was going to die, and therefore it would be of no service to him. No sooner would the breath be out of their bodies than others would watch them and strip them entirely naked. Instead of alleviating the distresses of each other, the weakest were sure to go to the wall. (Johnson, cited in Hughes 1987, p. 147)

Surgeons who travelled with the convicts endeavoured to play a role in the health of those suffering on the ships; 'the usual representative of humanity was the surgeon-superintendent, who was not only a healer but the closest thing to an ombudsman the convicts had' (Hughes, 1987, p. 156). Surgeon-superintendent John Smith, who travelled on the ship *Clyde*, in 1839 reported on his role, recording his attempts to treat illness through 'lancing abscesses ... purges, blisters and bleeding' and to prevent illness by keeping conditions clean



against all odds, 'cleaning and scraping, sprinkling chloride of lime by the water-closets, supervising the laundry' (Hughes, 1987, p. 157).

The first medical services after the arrival of the First Fleet at the new settlement were established in a series of tents, under the supervision of a naval surgeon with the help of four assistants (Hughes, 1987). A timber construction with dirt floors later replaced the tents, and in 1790, a wooden prefabricated building was transported from England. A 'tent hospital' was also established in the new outpost of Parramatta in 1789. As the colony expanded, so did the extent of ill-health, and it was not long before facilities were inadequate to the demand placed upon them. The diet of the settlers was limited, food scarce, and sanitation poor. The unskilled workforce was prone to injury and at risk of cruel punishment for any misdemeanour. Hospital records show that many convicts were admitted following repeated floggings or deprivation of food (Bostock, 1968).

Writing in December 1791, Tench described the settlement of Rose Hill, established at a distance from Port Jackson, as the colonists sought land for farming:

A new hospital has been talked of for the last two years, but is not yet begun. Two long sheds, built in the form of a tent and thatched, are however finished, and capable of holding 200 patients. The sick list of today contains 382 names. Rose Hill is less healthy than it used to be. The prevailing disorder is dysentery, which often terminates fatally. There was lately one very violent putrid fever which, by timely removal of the patient, was prevented from spreading. Twenty-five men and two children died here in the month of November. (Tench, 1793/2000, p. 211)

Gradual changes in health care in the new colony were realised as medical services were established. For instance, William Redfern (1774–1833), an ex-convict, tried and transported on charges relating to a mutiny, arrived in the colony in 1801 and, after being assigned as an assistant surgeon in 1803 on Norfolk Island, was granted a free pardon. In addition to being a doctor for wealthy society members in the colony, he treated convicts and fought to

improve the conditions both for them and for those still arriving on transport ships. Redfern arrived at the 'squalid and chaotic hospital' located at Dawes Point in Sydney in 1808, where he soon became well respected, later becoming known as the 'father of Australian medicine' (Hughes, 1987).

#### **3.1.4 Occupational roles in the convict settlement.**

The early years of the new colony can only be described as a period of human struggle against both the social and physical environments, for which the colonists were ill-prepared and under-resourced. Landing in the middle of summer, First Fleet arrivals faced high temperatures and limited water and food. The convicts had been 'classed' by occupation prior to transportation: most convict women of the first fleet were domestic servants or unemployed; they were in demand to keep company with the males, both convicts and military men. Most men were classified as 'labourers'; a smaller group as 'unemployed'. An even smaller number of 'professionals' or tradesmen were included in the convict group. The range of skills represented by the list of occupations of convicts bore little resemblance to the skills required for the new colony:

The colony that would have to raise its own crops in unknown soil had only one professional gardener ... it would need tons of fish, but had only one fisherman ... only two brickmakers, two bricklayers and a mason for all the houses that would need building; no sawyers were aboard, and only six carpenters ... no flax-dressers or linen weavers – proof of the government's indifference to the prospect of a 'strategic' colony. (Hughes, 1987, p. 74)

The primary occupation for all arrivals at the new colony was that of survival: firstly to establish shelter and security against unknown dangers, animal, human and climatic. The lack of capacity to contribute as willing and skilled settlers added to the trauma of relocation from homes and families. As time passed and the basic settlement was established, the early arrivals faced months of limited food as their stocks diminished. Finding the soil and conditions unfamiliar, they failed to grow crops successfully and became weak as their regular rations were restricted. Hours of labour were reduced and productivity

declined, but the imperative of the situation and the lowly role held by convicts meant that work continued. Tench recorded his observations:

I every day see wretches pale with disease and wasted with famine, struggle against the horrors of their situation. How striking is the effect of subordination; how dreadful is the fear of punishment! The allotted task is still performed, even on the present reduced subsistence. The blacksmith sweats at the sultry forge, the sawyer labours pent-up in his pit and the husbandman turns up the sterile glebe ... here I scarcely pass a week in summer without seeing it rise to 100 degrees; sometimes to 105; nay, beyond even that burning altitude. (Tench, 1793/2000, p. 183)

The First Fleet settlers waited many months before subsequent ship arrivals, bringing replacement supplies and increasing the workforce. With successive arrivals, the settlement growth continued, land further from the Jackson's Cove was sought, in the effort to find agricultural land considered more suitable for growing the crops familiar to the new settlers. New buildings were erected, streets created and public amenities installed, first at the Jackson's Cove settlement then at Rose Hill, some distance to the west, with the intention of bringing prosperity to the settlement (Tench, 1793/2000). Work was important, needed not only to develop the colony but to ensure law and order. Leisure time was regulated and idleness seen as undesirable:

The employment of the male convicts here, as at Rose Hill, was the public labour. Of the women, the majority were compelled to make shirts, trousers and other necessary parts of dress for the men, from materials delivered to them from the stores, into which they returned every Saturday night the produce of their labour, a stipulated weekly task being assigned to them. In a more early stage, government sent out all articles of clothing ready made; but, by adopting the present judicious plan, not only a public saving is effected, but employment of a suitable nature created for those who would otherwise consume leisure in idle pursuits only. (Tench, 1793/2000, p. 226)

With the exploration of land to the west of the coast, farms were established, although to varying levels of success. The skills of a farmer were valued and essential to the ongoing replenishment of the colony's food supply. Convicts with expiring sentences and military men were encouraged to continue residence through the grant of land plots without fees and taxes, with convict labour for support, protection by soldiers and medical treatment for periods of at least eighteen months. Tench, reporting on development in farming, was specific in lauding the efforts of 'civil, sober and industrious' men while raising questions about the chances of success for those who were changing occupations, or were without the credibility of a previous occupation that might suggest success for farming:

The Prospect Hill terms of settlement extend to this place. My private remarks were not many. Some spots which I passed over I thought desirable, particularly Ramsay's farm; and he deserves a good spot, for he is a civil, sober, industrious man. Besides his corn land, he has a well laid out little garden, in which I found him and his wife busily at work. He praised her industry to me; and said he did not doubt of succeeding. It is not often seen that sailors make good farmers; but this man I think bids fair to contradict the observation. The gentleman of no trade (his own words to me) will, I apprehend, at the conclusion of the time when victualling from the store is to cease, have the honour of returning to drag a timber or brick cart for his maintenance. The little maize he has planted is done in so slovenly a style as to promise a very poor crop.

He who looks forward to eat grapes from his own vine, and to sit under the shade of his own fig-tree, must labour in every country. He must exert more than ordinary activity. The attorney's clerk I also thought out of his province. I dare believe that he finds cultivating his own land not half so easy a task as he formerly found that of stringing together volumes of tautology to encumber, or convey away, that of his neighbour. (Tench, 1793/2000, p. 219,220)

The penal nature of the colony exerted a significant influence on the occupations of convicts as the military and custodial regime had control over all

aspects of daily life. Hard labour was ordered as much for punishment as for the effort to create a new colony. Any digressions from order brought floggings, solitary confinement and withdrawal of already meagre rations. Some military rulers attempted to change the punishment regime to one of 'therapy and reform'. At the Norfolk Island prison during the 1840s, the prison governor introduced literature, art and music in his efforts to create an environment conducive to turning around convict behaviour:

Music would be the main therapy; the Orphean lyre, once heard on Norfolk Island would charm and soothe the savage beasts of the Old System. Music was an 'eminently social occupation'. It taught collaboration and disciplined obedience. It rested on strict order and subordination, and if 'national and plaintive' in character, kept its hearers affable and patriotic. (Hughes, 1987, p. 507)

Such attempts at humane treatment and 'rehabilitation' of convicts were short-lived; and in general the colony considered its inhabitants beyond redemption, worthy of little pleasure and comfort in life.

### **3.1.5 Mental health and deviance in early settlements.**

Historical accounts of conditions both on transport ships and on land in the new colony included many indicators of mental illness, which, with the benefit of other knowledge, we in a different age would consider likely to have been caused by severe environmental conditions and inhumane treatment. The convict population was transported from a country where conditions were harsh, and many were convicted of crimes they had committed in attempts to relieve the suffering and poverty they endured. The preoccupation of the lower classes in their native land with physical survival meant that behaviour that was likely to be a sign of mental disorder was not identified as such by family or doctors (Jones, 1993). In the new colony, again, survival came first, and often at a high cost. The population had already been classed as 'deviant', explaining and justifying their presence at such an unbearable distance from their homes. For behaviour determined to be deviant even from this standard, punishment and separation were the order of the day. An area along the shore of the Parramatta River was designated for this, called 'Bedlam Point' (Bostock, 1968). The

naming of the area demonstrated the clear association at the time between crime and mental illness by using the name of the mental asylum, Bedlam, the first mental hospital established in London.

However, there was some consideration for humane treatment within the directives for the First Fleet. The commission given to the first Governor, Captain Phillip, included instructions for the care of 'idiots and lunatics' and their estates. Priorities of the time suggested that the first consideration was that possessions, including land, be cared for, before attending to the individual or the protection of others (Bostock, 1968). By 1805, some thirteen years after first arriving, Governor Phillip had also established a mechanism for addressing issues of insanity among free settlers. He set up a jury system to determine the status of 'lunaticks' in terms of whether they could be considered capable of managing themselves, their possessions and any business or land they owned. Five years later, this jury mechanism was replaced by a board comprising three surgeons, reflecting a possible change in views of mental illness (i.e. as a medical not criminal matter) (Bostock, 1968), as will be discussed later in the context of the role of the medical profession.

As the population of the settlement increased by the arrival of more convict transports and a small number of free settlers, expeditions to the west created new settlements. The increase in population also 'created a pool of mental invalids who, if not actually a menace, were a nuisance to the community at large' (Bostock, 1968). The desire for community order meant these individuals were sent to the Town Gaol at Parramatta, before the establishment in 1811 of a Mental Asylum at Castle Hill, some distance from both Parramatta and Sydney Cove (Bostock, 1968). Historical accounts suggest that mental illness also existed within the emerging ruling class of the colony. Two founders of Australian sheep farming, John Macarthur and Alexander Riley, are recorded in history as 'melancholics' prone to 'attacks of extreme anxiety' and 'black fits' respectively (Hughes, 1987, p. 328).

From the date of settlement in 1788, the community was governed as a military autocracy, in which the 'Governor's authority was virtually absolute and it was

the legal foundation on which lunacy administration rested' (Lewis, 1988, p 4). Some semblance of care and concern on the part of the rulers was recorded. When the mental asylum was established at Castle Hill in 1811, the then Governor Macquarie 'intended that the inmates of the Castle Hill Asylum should live under a humane regime' (Lewis 1988, p 5.).

The first purpose built psychiatric facility in Australia, after the early hospital in Castle Hill, was the Tarban Creek Asylum in Sydney, opened in 1838 and serving Sydney and the newer settlement in Melbourne (Bostock, 1968). A lay superintendent was appointed, having arrived from England with experience at St Luke's Hospital, a pioneer hospital for the mentally ill (Bostock, 1968). While such a move was in line with the trend away from punishment and towards care, the model echoed the administrative structures of the penal colony. In 1838 about half of the patient population of fifty males and thirty females were convicts, and the penal influence was evident in the use of handcuffs and leg irons as well as strait waistcoats. Responsibility for the institution involved discipline, restraint, maintaining order and financial management, although there was growing appreciation of the role of a medical perspective and the need for treatment of 'physical and mental ills' (Bostock, 1968).

Early management of mental asylums was the responsibility of the military, then of lay administrators, until the British medical profession claimed 'lunacy' as an area of specific interest and expertise. Late in the 19<sup>th</sup> century alternative approaches to care of the insane were promoted by a 'particular category of medical specialists who claimed the treatment of the insane as their territory', mirroring a broader movement of the medical profession which 'gained hegemonic control over many areas of knowledge and experience which had not previously been defined as issues of illnesses or treatment' (Barnes & Bowl, 2001, p. 9). Australia retained its link with British psychiatry, and Victoria continued the tradition of appointing senior psychiatrists from Britain until the mid-20<sup>th</sup> century (Lewis, 1988).

## **3.2 Influences from the Home Country**

### **3.2.1 Social and scientific views of mental illness.**

The early days of the new colony were heavily influenced by practices that settlers brought with them, for this was by default a British community albeit 'not just a mutant society but another planet – an exiled world' (Hughes, 1987, p. 2). However, in the period that transportation took place from Britain, significant changes were occurring in the views of lunacy, or insanity, across Britain, Europe and USA. Prior to this, the prevailing view was that madness was the result of a range of external causes, such as the influence of demons or Satan, or of natural forces like the moon. Society and, in particular, physicians who sought to act on physical and mental ailments, were also influenced by the philosophies of Descartes (1596–1650) who promoted the view that mind and body were separate entities and that the human mind was somewhere external to the physical body (Lewis 1988).

Traditional philosophies of the material world, thinking and societal organisation were being challenged during a period in Europe that became known as The Enlightenment (1650–1800). Debate by intellectuals promoted the role of experience, reason and logic in thinking and the ideals of freedom for ordinary people. Contrary to traditional notions of authority based on tradition and wealth, views associated with self government, natural rights, and natural laws were promulgated. While there is no single doctrine common to all thinkers of the time that could be said to describe a new vision of human beings, there was 'optimism about their progress through education and science, and a generally utilitarian approach to society and ethics' (Blackburn, 2008, p. 116). Subsequent scientific and medical 'discoveries' merged with this philosophical direction. For example, reason as a basis for scientific enquiry was promoted, leading to discoveries in anatomy, physiology and applied medicine. Links were made between water quality and hygiene, and between food and disease. Surgical techniques were developed and improved. Principles of prevention emerged, replacing superstitions of the past, such as the observation that milkmaids exposed to cowpox were immune from the scourge of the time, smallpox (Lambert, 2009). These changing philosophical and scientific



reasoning perspectives within the social environment set the scene for revisions in thinking and acting in relation to mental health.

### **3.2.2 Providing asylum.**

Within the changing social context of Britain, public asylums were established, firstly in Bethlem (also known as Bedlam), dating from the 13<sup>th</sup> century, then Manchester in 1766 and Liverpool in 1797 (Wilcock, 2001). While they served to isolate those who caused trouble in society, and supposedly provided care, these institutions were also places of cruel conditions and not necessarily of hope. Asylums also offered opportunities for the public to ridicule patients: gazing on inhabitants was a common recreational outing (Digby, 1985; Wilcock, 2001).

By 1845 the provision of county asylums had become mandatory in the United Kingdom (UK) (Smith, 1999).<sup>3</sup> Early asylums took their first patients from other institutions such as prisons and workhouses for the poor (Jones, 1993); the chains and intimidation rife in these locations were transferred to the new environments. The number of private ‘madhouses’ also increased during 19<sup>th</sup>-century Britain. These smaller, ‘better’ facilities were promoted for families who could afford to spare their insane members from public institutions (Jones, 1993; Wilcock, 2001). Conditions in either public or private sectors, neither of which were subject to any policing of standards, were crowded and did not offer any attention to inmates (Wilcock, 2001).

However, despite the harsh conditions and zoo-like characteristics (Digby, 1985), asylums increasingly adopted principles of ‘care,’ often led by physicians and ‘matrons’ driven towards humane treatment, so that

by the beginning of the nineteenth century, the institutions that would provide asylum and be the basis for treatment of the mentally ill for the

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<sup>3</sup> I have used Britain to refer to Great Britain (England, Wales and Scotland), prior to 1800, and United Kingdom for the period following 1801, when the United Kingdom of Great Britain and Ireland was declared.

next 150 years had slowly begun to emerge from the foundation of enlightened thought. (Wilcock, 2001, p. 305)

As social views changed in relation to the plight of the insane, new models of care required different perspectives in the design of buildings and in the lifestyle provided by asylums. One of the first and most well known to move from tradition in the British system was York Retreat. The York Retreat was established by a group of Quakers (Digby, 1985; Tuke 1813/1964) who adopted a 'retreat' approach to distinguish their facility from the large institutions and hospital settings of the time. It was established outside the York city boundaries, close enough to permit regular visitors and contact with the outside world, in particular with family or the Society of Friends. Buildings were surrounded by grounds that offered opportunities for outdoor recreation as part of the treatment: to be outside in a pleasant setting was considered important, both for the effects of the surroundings, the fresh air and the garden, and for the benefits of physical recreation.

The Quaker founders of the Retreat were deliberate in their approach to architecture and set out to create what they considered to be a home-like, domestic environment that would reflect a family lifestyle (Digby, 1985; Tuke, 1813/1964). While other asylums of early 19<sup>th</sup>-century Britain maintained locked buildings, chains for restraint and isolation rooms for the unruly, the York Retreat operated according to a model of 'moral' treatment. The creation of a soothing environment was considered to calm disturbed behaviour and facilitate healing. Part of the approach aimed at appropriate resocialisation of patients, either in the community or within the Retreat.

### **3.2.3 Occupation in asylums: UK and Europe.**

The shift during the 19<sup>th</sup> century across Britain and Europe from punishment to treatment of people considered insane set the scene for the beginning of a profession with occupation as its core area of interest. Earlier in this chapter I outlined the changing philosophical and societal beliefs that saw madness become the management domain of the medical profession. In parallel, institutions of incarceration became places of refuge or asylum. Beatings, chaining and harsh physical conditions were replaced with attempts to create

humane and comfortable environments and daily regimes that were predicated on the belief that there was hope for cure from insanity (Shorter, 1997). From an earlier belief that considered all mental illness as a sign of insanity, physicians began to identify 'conditions' and characteristics that gave rise to differentiated 'treatments'.

Physicians in Europe, Britain and America were also at the forefront of moral treatment developments, challenging social and professional views of previous approaches. Two wrote specifically about the importance of occupation within the asylum environment. William Ellis (1780–1839), self-taught in medicine in addition to completing an apprenticeship to a surgeon, wrote a treatise on the causes, symptoms and treatment of insanity, acknowledging environmental social factors as well as the importance of humane treatment and occupation. He described two main aspects of the asylum routine: attendants and occupation, maintaining that women in particular were suitable to be 'keepers and nurses'; he knew 'no way in which female kindness and ability could be more beneficially employed than in obtaining the requisite information, and then taking charge of the insane' (1838, cited in Hunter & Macalpine, 1982, p. 870). Ellis introduced work on a large scale within the asylums with which he was associated. Men were assigned outdoor or trades work, while women under the supervision of a 'workwoman' were 'employed in making useful and fancy articles for sale' (1838, cited in Hunter & Macalpine, 1982, p. 876). William Browne (1805–1885), a physician in Edinburgh, published a challenging series of lectures titled *What Asylums Were, Are and Ought To Be*. In these lectures, Browne showed that treatment changes were not due to medical developments alone, but reflected broader social changes and social and humanitarian reforms. He was critical of the system that established public asylums to isolate people from society and leave them idle and disheartened. Along with recognising the need for a more humane approach, Browne identified the potential for occupation as an essential part of the reform process, for 'The whole secret of the new system and of that moral treatment by which the number of cures has been doubled may be summed up in two words, kindness and occupation' (Browne, 1837, cited in Hunter & Macalpine, 1982, p. 868).

This occupation, Browne noted, was not prescribed randomly but required skilled and knowledgeable management. Simply replacing the old system of confinement with one that did not have as its goal cure of the insane, and knowledge of how to do this, would be of no benefit to society or inmates. Rather, if groups of inmates could be arranged to regulate behaviour,

the system is at once beautiful and self-operating. There is no need of keepers to direct, and chide, and caution. Their presence is required to regulate the machine, but its motions are spontaneous. The little kindness of co-operation and assistance go forward, the weaver plies his shuttle as vigorously, and the dance and song conclude the day as regularly as if a whip or a comfit were displayed (Browne, 1837, cited in Hunter & Macalpine, 1982, p. 869).

One of the most significant changes in asylum life was the abolition of physical restraint systems. Until the mid-1800s, keepers viewed inmates as vicious, wild animals that required control. John Conolly (1794–1866), who contributed much to the description of signs of mental illness and to education of medical practitioners, is attributed with the demise of mechanical restraint to control asylum inmates across Britain. He campaigned against the ‘old treatment by restraint’, which he described in detail:

Its evils were not imaginary, but real and dreadful ... In the gloomy mansions in which hands and feet were daily bound with straps or chains, and wherein chairs of restraint, and baths of surprise, and even whirling-chairs were tolerated, all was consistently bad. The patients were a defenceless flock, at the mercy of men and women who were habitually severe, often cruel, and sometimes brutal. (1856, cited in Hunter & Macalpine, 1982, p. 1034)

The abolition of routine physical restraint led to efforts to incorporate occupation into asylum life as part of the reform movement. Occupation was not necessarily new to asylum life, but took on new meaning as an adjunct to management of inmates. However, the sheer size of the institutions and the inability to attract the number of attendants with the range of skills and

attitudes to support the principles of moral treatment, meant that the asylums themselves became places of overcrowded squalor. While the use of occupation was ideally prescribed to suit an individual, the reality meant that if people were physically able, they were assigned work in the areas of the asylum necessary to support its running – the kitchens, laundries, farms and gardens, workshops (Jones 1993).

The models of psychiatric care, public and private asylums and retreats and occupation as part of the institutional routine remained in place in the UK until the Mental Health Act of the late 1950s made community care an option. During this time they were an influence on Australian services as is discussed further in this chapter and the next.

#### **3.2.4 Changing views towards leisure pursuits in the colony and 'at home'.**

Recreational pursuits were not a high priority in the new Australian colony, where the struggle for survival took precedence. The view that leisure activities were a sign of idleness reflected the views in the 'home' country. However, of relevance to occupation and health in the NSW colony, it is worth noting that during the 18<sup>th</sup> and 19<sup>th</sup> centuries, many countries' attitudes towards recreation changed along with the scientific developments outlined above. The Enlightenment in Britain saw the development of interests and activities for enjoyment and recreation for individuals and family groups, as well as of the more formal 'arts'. Games, reading and leisure pursuits became accessible to 'ordinary' people, as well as the wealthy in society, although it could be argued that there were differences in scope and availability: only the wealthy people could afford to travel and take up the new trend of visits to the seaside or spas, or indulge in organised recreation in newly formed cricket or horse racing clubs (Lambert, 2009). Not all recreation could be described as enjoyable for all participants. Public hangings were a common form of entertainment for crowds, animals fighting to the death, boxing and even theatre could be cruel (for instance Punch and Judy puppet shows) (Lambert, 2009). Nevertheless, changing views of leisure were later to be relevant to the use of occupation in psychiatric hospitals and the emergence of OT in the 20<sup>th</sup> century, as is discussed in Chapter Four.

### **3.3 Asylums in Victoria**

#### **3.3.1 Early models of care for managing 'madness'.**

The first institution built in Australia to house people considered to be insane was at Tarban Creek, on the outskirts of Sydney. When the population began to increase in the southern part of the colony, Melbourne, the need for a similar establishment was identified. Melbourne had begun with a small number of settlers who crossed from Van Diemen's Land in 1835, searching for grazing land. The first settlers comprised mainly working men, many of whom were convicts or a new generation born to convicts. By the early 1840s the population had increased to more than 10,000 (Annear, 1995). Conditions were rough and the economy was struggling, with only basic levels of housing, sanitation and food available to the majority of the population. Education for children was not readily available. Alcohol was a significant part of everyday life, and domestic violence and public drunkenness were common (Annear, 1995). The city gaol was often full – the fact that police received half of all fines meant that there was some inducement to keep arrests high. In 1842 there were 1500 charges of public drunkenness, out of a population nearing 10,000 (Annear, 1995).

During this period, additional cells were constructed at the gaol for housing those considered mentally disturbed, rather than criminal or disorderly due to drunkenness. Although the government of the time did not accept responsibility for the care of lunatics, authorisation for the additional cells did come from the Governor of New South Wales to the Superintendent of Port Phillip, as the (Melbourne) colony was known (Darebin Historical Encyclopaedia, 2009). In the early 1840s, a period of economic depression, these cells were often full, and their inmates mixed with other prisoners.

#### **3.3.2 Yarra Bend Asylum.**

The colony, led by the developments in England described earlier, was influenced during this time by changing views of lunacy which led to the acceptance of the responsibility of care by governments. Governor Gipps introduced legislation in 1843 to provide for the care of 'lunatics and idiots' (Darebin Historical Encyclopaedia, 2009). In the District of Port Phillip, this

change resulted in the construction of a building, a ward of the Tarban Creek Asylum, on a site of 620 acres on the banks of the Yarra River. It opened in 1848, two years after construction commenced, to house ten people previously kept in the Collins Street gaol (Darebin Library, 2009). It was staffed by a superintendent, his wife who was a matron, four 'keepers' (three male and one female), a cook and a laundress. Medical support was provided by visiting doctors (Darebin Historical Encyclopaedia, 2009).

Within a year of opening, the ward housed more than forty people, prompting more construction. In 1851 it became known as the Yarra Bend Asylum, when the District of Port Phillip separated from the Colony of New South Wales. Numbers continued to increase, and a resident doctor was appointed in 1852, in line with the increasing adoption of a medical role in lunatic asylums. As at Tarban Creek in Sydney, the administrator and doctor clashed over management decisions, and the ensuing arguments led to scrutiny by authorities. A government enquiry was set up to address regular reports received by government of violence towards inmates, corruption and general mismanagement. Findings included:

- evidence of physical and sexual abuse;
- corruption;
- poor treatment of prisoners, including forcing 28 people to share the same bath water;
- illegal use of asylum resources, including using resources supposedly earmarked for patients being funnelled into a private poultry farm run by the superintendent; and
- patients being frequently drunk (Darebin Historical Encyclopaedia, 2009).

The government enquiry led to dismissal of both superintendent and doctor. Overcrowding and generally poor conditions continued, and even though there were calls from society members to close the institution, it remained the main location for lunatic care in Melbourne for many years. Regional institutions were constructed in Ararat, Beechworth and Ballarat to address the growing

numbers of the insane living in other areas, necessitated by the increase in population caused by the gold rush of the 1850s.

### **3.3.3 After the convict era.**

Growing colonial communities were spurred by the gold rush, and exploration of new areas for farming, forestry and associated industries grew along rail lines and roads. With the increasing population came increasing numbers of people identified as having 'psychological' disturbances. Identifying people as disturbed contrasted to the earlier label of social deviance or (criminal) misconduct. In the early 1850s a small percentage (0.95) of the population was labelled as 'lunatic', and by 1880 this figure had risen to 3.4% (Darebin Historical Encyclopaedia, 2009). By 1870, the population of Victoria had risen to 738,200, of which 1 in 397 (1,859) were judged to be insane. By 1888, the number of registered insane persons in Victoria was 3,634 (Coleborne, 2003).

## **3.4 Asylum Environments**

### **3.4.1 Location – influences of UK trends.**

In 18<sup>th</sup>-century Britain there was a 'marked growth in the use of institutional solutions for dealing with people whose madness brought them into conflict with the norms and morés of family and community' (Smith, 1999, p. 13). The growth in the numbers of people deemed to require care reflected the belief that lunacy could be managed, and in some cases cured, through developments in medicine and the use of moral treatments. Economic developments and the increasing impact of the industrial revolution led to the society becoming more urban and less reliant on agriculture and feudal systems where a 'master' cared for his servants or even a family cared for its members. A private sector developed for health care, and this resulted in an increase of private 'madhouses' for all classes. The public sector consisted of workhouses and a growing number of large hospitals that still could not always meet the needs of the lunatic population, especially the poor. A significant third sector emerged, a philanthropic trend permitted by increasing social wealth: charitable organisations. Society's belief in the need to care for the poor and sick led to the establishment of subscription, or voluntary, hospitals located in major cities and provincial towns and managed by those who donated the funds. The buildings



were large and stately and located in prominent positions to reflect the community's progressive ideals in care of the needy (Smith, 1999).

Asylums were built to include many desired attributes such as fresh air, inspiring views and the opportunity to enjoy gardens and peaceful surroundings. Community safety was addressed by providing high walls, locked gates and wide open views. While often linked with a nearby hospital by the attendance of its medical officers, an emerging model of care used specialised medical techniques as curative treatment. The title 'lunatic asylum' was used to distinguish these facilities from hospitals. In some instances, a close link with the town's hospital, which was seen as being for the poor, would 'deter middle-class people from sending their mad relatives to the asylum' (Smith, 1999, p. 15). The notion of 'asylum', a place of protection or safe refuge, also served to add a layer of separation from the community as well as protection to the inmates, who historically were the subject of 'fear, disgust and disgrace' (Smith, 1999, p. 17). A location that set the establishment apart from society offered both refuge and protection to the inmates, and security to the community.

The location of the first asylums in the growing settlement of Victoria in the mid-1800s was specifically influenced by the consideration of environmental factors. The Yarra Bend Asylum was sited outside the town boundary but close enough for easy access by road or river. Within a few years of its opening, overcrowding led to calls for a new, larger establishment. By this time, Victoria had public building programs and associated bureaucracy, and the Public Works Office was delegated the responsibility of finding appropriate sites and constructing the institutions. By the 1850s, by which time Victoria had been established as a state independent of NSW, it had seven lunatic asylums. All were constructed in the style of grand buildings of the time, on large acreages separated from the local community, following the advice of those who planned the Kew Asylum and similar institutions in New South Wales. Similar considerations operated when selecting non-metropolitan locations for the six similar institutions established within a few years at Ararat (1865), Collingwood (1866), Ballarat (1867), Beechworth (1867), Kew (1871) and Sunbury (1879).

### **3.4.2 Asylum environments and living conditions.**

Architecture influences an observer's reaction to a building, as well as affecting the behaviour and experience of those who live within its walls. Architectural design also reflects social views, most often adopting a dominant style or fashion, although sometimes challenging views and expectations. The design of asylums reflected the former standpoint. Early asylums were like prisons, which operated much like policing or prison systems (Monk, 2003; 2008). They were designed to control behaviour and ensure the security of the local community.

The design and use of 19<sup>th</sup>-century buildings also involved gender considerations. Reflecting both social and medical opinions that there could well be male and female mental illnesses, gendered spaces were created within institutions. Male and female wings were included in design, and in the early Victorian asylums men and women were kept separate and prohibited from interaction. Male warders worked only with male lunatics and female warders were employed to work in the female wings of the institution (Monk, 2003; 2008).

In the early settlement of Victoria, the external appearance of public buildings was a reflection of the grandeur of the society that sponsored them. While there was also an intention that they would be domestic and comfortable environments for inmates, it seems that reality was far from this ideal. Accounts of the experience at Yarra Bend, and soon after at Kew Mental Asylum, suggest that the prison-like characteristics created crowding and lack of privacy. The separation of the imposing buildings and grand gardens from the local community behind high walls and imposing gates created an aura of mystery and added to the fear of unknown things occurring within their walls. Those who lived and worked within asylums became objects of curiosity and fear (Coleborne, 2003).

### **3.4.3 Transition from prison to hospital.**

The era during the late 19<sup>th</sup> century that saw construction of large asylum buildings in Victoria was also a time during which social views of insanity continued to change. The community saw a need for asylum that ensured the safe custody of lunatics away from everyday life. However, the growing push for

'treatment' to be offered in addition to custody created the need for different spaces. Within their high walls, the buildings were spaces of restraint and activity. Following developments in Britain, where active employment of asylum inmates had become well established, the institutions in early Victoria also implemented activity.

A key factor in this change of institutional focus was the growing involvement of the medical profession in the administration of asylums and in the treatment of inmates. Physicians took over the running of asylums from administrative managers. Space was then required for treatment, including bath and water treatment rooms, seclusion spaces and, later, surgical theatres. Along with these treatment spaces there were also recreational spaces. The standard design of a mental hospital included dance halls, concert spaces and theatres. Religious observance was also an important part of treatment regimes, with chapels part of traditional asylum design (MacKinnon, 2009).

### **3.5 Occupation in Australian Asylums**

#### **3.5.1 From hard labour to treatment and activity.**

Early Australian asylums retained an overlay of the convict era, that of hard labour. Occupation was used to establish order in the day, and to maintain discipline. Punishments and rewards were part of this routine. The people who instigated this were the administrators, the first of these being military men. Convicts were employed to carry out the construction of buildings in the colony. They were not necessarily motivated to do this, and were often described as lazy and not interested in the community that was being developed. The purpose of 'hard labour' was well established, and carried over to the institutions being built for the insane.

With the introduction of moral treatment within asylums, there was recognition that being occupied could also be a form of treatment. A key part of the treatment approach was the 'organising function' of keeping a regular routine and combining work and leisure activities, building on the experiences of asylums in Britain where 'it had long been established that active diversion of

the thoughts was a key element in the therapy that an asylum could offer' (Smith, 1999, p. 239).

In contrast to the view of leisure as idleness in the early convict settlement, leisure and recreational pursuits were promoted in asylums as alternatives or supplements to work. Supervised exercise became an important part of asylum routine. Physical activities could include indoor games or walking in the gardens, or supervised outdoor games. Recreation and the products of activity later became a sign of the 'normality' of life within the institution and was attributed with the higher functioning of some inmates, as is discussed in 3.5.4.

### **3.5.2 From custody to medical care.**

At Yarra Bend Asylum, the first medical superintendent was appointed in 1852, four years after its opening. Until that time administration was by lay superintendents. The arrival of a medical superintendent is reported as the beginning of more humane conditions for inmates. Motivated by the lack of activity and aimlessness of many of the inmates and a lack of success in obtaining government funds for improvements, the new superintendent set inmates to work for the sake of the institution (Brothers, 1962). By 1856, the work scheme had expanded to involve approximately 50% of inmates, and included farming activities and vegetable growing; an innovation established as a means for the asylum to contribute to its own upkeep and improve the nutrition and general conditions of inmates.

The 'medical' approach signified the introduction of treatment and rehabilitation into Victorian asylums. Patients, as they were then known, were separated into two groups: those who were considered to be 'of criminal nature' and those of whom there was some hope of restoration to society. For example, there was a hope that alcoholism could be cured and the downward path of inebriates arrested before facing total ruin, so they were detained at the institution until symptoms of alcohol abuse disappeared (Brothers, 1962). The need to find employment for those who would leave the institution was recognised, as well, especially for those without family or homes, in order to prevent recurrence and readmission.

### **3.5.3 Gendered occupation: industry, handcraft and domestic duties.**

Organisation of occupation within asylums reflected the gender divide of society in general. Women were allocated tasks in domestic duties, including laundries, sewing room, needlework and mending in wards. Men were assigned to outdoor work including gardening, building, and working in the farms and vegetable gardens that had become part of asylums' endeavours.

Allocation of duties was not only according to physical capacities. Social morés of the time also dictated the importance of occupation to self identity and esteem. For this reason, it was not desirable to set domestic duties for men, more masculine tasks being required. Men occupied the industrial spaces of the institutions: the boiler room, trade areas and external garden spaces. This gender sensitivity also extended to asylum employees. Male warders often refused to participate in activities with female inmates, even if these were part of the overall asylum program such as a dance evening (Coleborne, 2003).

### **3.5.4 Recreation, music and standards of care.**

In addition to the routine work of Victorian asylums, special events were arranged to provide recreation and amusement, including sporting matches, concerts, picnics, theatrical shows and balls. These occasions featured significantly on the calendar of institutions, and served several purposes. They provided amusement to inmates, and in some cases offered opportunities to participate. On another level, they were seen as contributing to treatment and providing 'normal' activities. Appropriate behaviour was expected of patients at social events, and they were only permitted to attend if they were likely to behave according to the social conventions of the time.

Another important function of the activity of the asylum was to demonstrate the standard of care being given by the asylum. Social occasions were public displays of the work of the institution, in which the 'mad' were controlled by staff and encouraged to behave as society would expect (Gilman, 1988; MacKinnon, 2003). Kew Asylum, in the Melbourne suburb, started a cricket team, which participated in the local community competition, as summarised in the Kew Inquiry report:

Text box 3.1 Transcript of Report from the Board appointed to Inquire into Matters Relating to the Kew Lunatic Asylum (1952; cited in Coleborne, 2003, p. 57.)

*A cricket ground has been established at the Kew Asylum, with a club which exchanges amenities with other clubs. In a recent match with a visiting team, four out of the eleven Kew players were patients. Dr Robertson also points out that a game of cricket will give amusement to perhaps two hundred onlookers. At the match just referred to the visitors brought with them a band of music, much to the enjoyment of the patients. By such means the inside and outside world are brought, as it were, together.*

### **3.6 Summary: The Occupational Transition from Convict Era to Asylums**

In this chapter I have provided an interpretation based on a hermeneutic study of selected texts about the evolution of mental health care in early Australia. This interpretation has focused on the circumstances, conditions, influences and environment of psychiatric institutions in Australia, with emphasis on occupation within the institutions.

In the era of convict Australia, the first incarceration of people considered to be mentally ill started with the use of prison cells, hard labour and harsh treatment. The work regime of the early settlement was an integral part of the 'punishment' inflicted through transportation and banishment to the distant colony. Music, recreation, art and drama were offered as 'rewards' for 'good' behaviour in many of the convict communities. Reflecting changes occurring in Britain, Europe and America, recognition of 'lunatic conditions' replaced earlier notions of the criminal, evil or mystical nature of 'strange' behaviours. In efforts to isolate 'mad' people from the community, asylums were constructed, separate and secure. These places, ostensibly of serenity and hope, in reality were usually harsh and overcrowded, not so different from the earlier prison environments.

Occupying asylum inmates was considered important. Initially keeping them busy often merged with the need to maintain buildings, gardens and the general

functioning of the institution in the face of financial constraints. Economic imperatives existed in parallel with humanistic ideals about the care of people with mental illness; of these, two features were particularly identified with occupation. First, the problems of managing large groups of idle people were a challenge to institutions, and addressing idleness became a key tenet in the philosophy of moral treatment. Second, the benefit of being occupied was recognised. Proponents of moral treatment pointed to the 'organising' benefit of daily routine. Those taking part in the routines of the institution, with a role to keep them busy, were seen to be 'healthier' in terms of physical and emotional behaviour.

Against this background I have drawn particularly on the emerging understanding and use of occupation, first as an enforced activity and part of the labour associated with running asylums, and then as part of the treatment and even rehabilitation of asylum inmates. This transition of knowledge and treatment approach is portrayed in Figure 3.1.

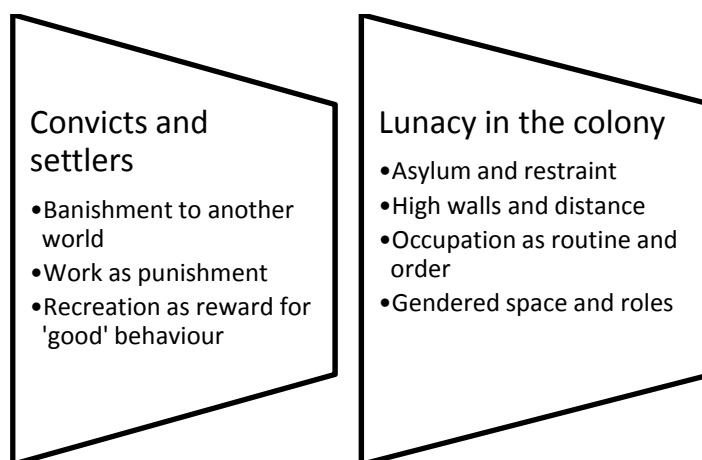


Figure 3-1 Occupational transition: from forced labour to treatment

Institutions were deemed necessary in the expanding Victorian colony to clear overcrowded prisons of 'the mad' in society. There was a strong desire to separate growing numbers of mad and unruly members of the population from their communities. The need for custody and protection of individuals competed with the perceived need for protection from them, keeping the outcasts at a

distance, never to return to their familiar settings in many cases. The forces for incarceration battled the growing belief in many people that there should be more humane forms of custody, as well as the hope that there might be treatment and even cure of mental illness. Notions of using occupation were part of both these directions. Occupation that was meaningful and carefully organised was promoted as an element of humane treatment. At the same time, activity held hope as a treatment 'technique'. I see this evolution as a key step in the emergence of a 'profession' to take responsibility for 'occupation' within psychiatric environments, as discussed in Chapter Four.



## Chapter 4

### Text Two: Occupational Therapy Emerges

In Chapter Three I presented an interpretation resulting from my first hermeneutic study of the development of mental health services in Australia. In this chapter, the second hermeneutic study, the emergence of OT, is portrayed. Key influences on the development of OT practice knowledge were identified through interpretation of the text books and other writings of the early 20<sup>th</sup> century. A key aspect of the debate regarding the effectiveness of the asylum approach to treatment was the issue of how people living in asylums were occupied during their waking hours. Some members of the medical profession, early proponents of the specialty in psychiatry, were interested in taking a scientific approach to the question of occupation. This chapter introduces OT, which grew as a treatment in response to the interest by medical men in the scientific basis of occupation as it could be used in treatment. To address the hermeneutic questions related to the early development of OT in Australia, this interpretive phase returns to the beginning of the 20<sup>th</sup> century, in particular to the USA and the UK. It is generally acknowledged that OT, as a health profession, first emerged in the USA (Gordon, 2009; Paterson, 2008). Early OT developments in Australia were influenced by the emergence of OT in the USA and UK as both psychiatrists and emerging occupational therapists travelled to learn about and teach this new approach to psychiatric treatment.

In this chapter I discuss how OT practice knowledge emerged from the contention that occupation could be used as part of therapeutic processes and that being occupied could be therapeutic. This principle of the emerging 'occupational therapy' was based on the premise that problems in adaptation to environment were a factor in mental illness, and could be addressed within treatment. In Australia, early OT services were based on bringing order and routine into asylum environments so that inmates could be engaged in activity during the day, both to provide a routine and also to bring them in touch with outside realities. Key to the development of the profession and its knowledge base were the physicians, the Women's Auxiliary of mental health services, and the nurses, as well as the women who carried out the work.

## **4.1 Occupation as Therapy**

### **4.1.1 Building on moral treatment approaches: USA.**

While recognition of the benefits of occupation as far back as early Egyptian, Roman and Greek societies is documented (see Wilcock, 2001; Gordon, 2009), it was not until the beginning of the 20<sup>th</sup> century that occupation was adopted as a new scientific endeavour in USA psychiatric institutions (Gordon, 2009). Several factors influenced the way in which occupation was incorporated into the treatment of mental illness. General advances in scientific knowledge during the Enlightenment expanded understanding of the human body and resulted in alternative explanations of health, illness and behaviour. As part of the development of scientific knowledge during this time, views of deviance from social norms also underwent change: behaviour ascribed to mental illness was a graphic example of this. Prior to and during the 19<sup>th</sup> century, 'strange' behaviour was punishable by death or incarceration, or in the case of many, transportation. New understandings of human biology gradually led to a move away from the understanding of mental illness (or 'lunacy') as the result of witchcraft, influences of nature or evil spirits. Large institutions, separate from the community, were seen as providing a more hopeful approach to illness, with cures considered possible (Porter, 1987). In these environments, 'treatment' emerged within a medical framework.

The 'moral treatment' movement of the 19<sup>th</sup> century, discussed in Chapter Three, was promoted as a means to reform lunatic asylums in Europe, Britain and the USA. Reformers of the moral treatment movement sought to overturn the harsh regime and poor living conditions of asylums. These reforms of the institutional environment were promoted as necessary for the sake of the growing number of people in these large communities, for both inmates and their keepers. Early proponents of moral treatment included medical practitioners, who advocated a more humane regime along with a range of 'treatments' for patients (Paterson, 2008). Physical activity and routine became part of the new approach to 'the mad' incarcerated in asylums, intended to 'replace brutality with kindness and idleness with occupation' (Gordon, 2009, p. 203). 'Occupation' was one aspect of the approaches advocated. Having a daily

routine and keeping the body and mind busy in an ordered manner was linked with human function and thus given a role in medical treatment (Gordon, 2009).

In contrast to the philosophical and multidisciplinary nature of moral treatment, a further factor influencing the emergence of OT was the growth of psychiatry as a specialisation of medicine. To be consistent with the scientific approach, the medical profession moved away from the 'unscientific jargon of moral treatment' (Gordon, 2009, p. 204) as it took a more active role in care of people with mental illness. Psychotherapy developed as the core of treatment, with a range of physical and psychological regimes. Included in this range of treatment approaches was the principle that occupation was related to function, although there was not yet any explanation of underlying mechanisms. Some theories proposed that exercise improved bodily function, and mental health; others argued that occupation improved the mental state and the physical, for example by stimulating metabolism and digestion, or encouraging better sleep, and thus more rest and recovery (Gordon, 2009).

Many principles and propositions of moral treatment continued alongside the growth of psychotherapeutic techniques and are directly linked to the emergence of the OT profession. Psychiatrist Adolf Meyer (1866–1950) is credited as a key figure fostering the development of OT. Coming from Switzerland to practise in USA, he held strong beliefs in favour of moral treatment. He promoted a view of human function as related to the integration of several body systems in what he termed biopsychosocial / neurological approaches (Hunter & Macalpine, 1982). In particular, Meyer promoted the principle of holistic<sup>4</sup> function: the importance of balance, both within body functions, and in the routines of life:

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<sup>4</sup> I use the term 'holistic' in the sense that it was a value promoted by OT pioneers who recognised the 'connection between mind and body and seeing the person as connected to the environment through participation in occupations', and in the more recent approach of being able to 'make complex judgements based on the simultaneous consideration of many aspects of the clients and their contexts' (Kielhofner, 2009, pp. 27 & 283).

The whole of human organization has its shape in a kind of rhythm ... night and day, of sleep and waking hours, of hunger and its gratification ... work and plan and rest and sleep, which our organism must be able to balance even under difficulty. The only way to attain balance in all this is actual doing, actual practice, a program of wholesome living as the basis of wholesome feeling and thinking and fancy and interests. (Meyer, 1922/1977, p. 641)

While moral principles were acknowledged by Meyer and his followers as positive, they contended that the use of occupation was a new scientific endeavour (Gordon, 2009).

#### **4.1.2 Forming a profession for the work of occupation: the first occupational therapists.**

Within Western society, the beginning of the OT profession is generally acknowledged as occurring in the USA when a group of individual practitioners from diverse fields shared their views about the importance of occupation as part of treatment (Christensen, 1991). The first meeting of the group of seven, held in 1917 in Clifton Springs, New York, was attended by two architects, a social worker, two nurses, a physician and a stenographer. Inspired by their personal experiences as well as their work, they determined the need for specific practitioners for the new science they saw emerging to meet the growing need of treatment for people in psychiatric or other long-term institutions. They called their new organisation, which aimed to unify their diverse backgrounds, experiences and views, the National Society for the Promotion of Occupational Therapy (NSPOT) (Christensen, 1991).

#### **4.1.3 War and reconstruction.**

The early activities of NSPOT to create a specific profession with occupation as its core occurred in the broader context of World War I, which became a key factor in the development of OT practice. The War, in which American soldiers were involved, heightened awareness in the USA of a link between occupation and health. Many injured soldiers required treatment and recuperation before return to their fighting duties, or to their previous lives if they were sent home from the battlefields. There was concern at home that the number of men

injured in the lengthy war would have disastrous economic effects, given the custom of providing lifetime pensions for wounded soldiers (Christensen, 1991). Treating, then returning soldiers to the front, became known as 'reconstruction', and involved both treatment and a period of recuperation, usually occurring close to the battle.

One of the early promoters of OT, Eleanor Clark Slagle, lobbied the army to recognise the value of therapy, and in particular the use of occupation, as being presented by the NSPOT. Her work resulted in the army appointing six 'reconstruction aides', who were sent to European-based hospitals by the National Committee for Mental Hygiene to work with American personnel. The reported success of this mission led to the establishment of 'emergency war courses' for training reconstruction aides, and a further 460 aides, mostly women, served overseas working with injured American soldiers. Two groups of reconstruction aides were established in what was early delineation of physiotherapy and OT. Physiotherapy aides concentrated on restoration of massage and exercise, while aides assigned to OT had a role 'to furnish forms of occupation to convalescents in long illnesses and to give patients the therapeutic benefit of activity' (Hopkins, 1978, p. 11).

The requirements for appointment as an aide demonstrate the beliefs of the NSPOT as to the practice knowledge needed for the role. Aides were required to be at least twenty five years old, have a qualification in a field such as social work or library science, to be citizens of the USA, and to have a background of 'theoretical knowledge and practical experience in various crafts' (Hopkins, 1978, p. 11). Theoretical knowledge was developed according to guidelines established by NSPOT for the emergency war courses.

Training in reconstruction therapy involved lectures in psychology, anatomy and kinesiology, ethics and hospital administration. The training courses, ranging from six to twelve weeks, also included instruction in applying specific crafts for remedial purposes, along with practical experience in local hospitals. The work done by reconstruction aides with thousands of soldiers led to an increasing acceptance of the possibilities of OT for both psychological and

physical illnesses. After the war, the demand for therapy based on occupation extended beyond military hospitals, and services expanded into civilian hospitals, both general and children's. The wartime training courses became schools of OT in an attempt to meet the growing demand for therapists.

#### **4.1.4 Naming the profession to reflect its practice and knowledge base.**

The term 'Occupational Therapy' is attributed to George Barton, an architect who was one of the founding members of the NSPOT. Barton became interested in the value of being occupied following his own illness, tuberculosis, which led to a period of incapacity. After experiencing what he saw as the benefits of being engaged in directed occupation, he founded Consolation House, an institute and residence for people with physical disabilities, and became the first president of the NSPOT (Christensen, 1991). Barton was instrumental in deciding the name of the profession that would take on the role of being practitioners using occupation. While the term 'occupation work' had been used, Barton maintained the need for a title that would emphasise the therapeutic nature of occupation and the place of the practitioners within broader medical practice:

one thing I cannot and will not stand for is the use of "occupational workers". It means nothing ... it does not even suggest the hospital to the casual reader and it is bad English. We cannot, I think, lose a single opportunity to run in the word 'therapeutics'. I shall insist always that this be the matter of prime importance, both from my interest in the development of a new line of medicine, and from my horrid vision as a sociologist of what may occur if therapeutics is forgotten. (Barton, 1916, cited in Christensen, 1991, p. 8)

Barton believed that as occupation could cause illness, so could it also be used to treat illness. He maintained that activities could be prescribed as treatment in a similar manner in which medication was prescribed to treat specific conditions (Christensen, 1991). For each malady, or illness, Barton proposed there could be a corresponding occupation or task that would provide cure or amelioration (Christensen, 1991).

With the expansion of 'occupational practitioners' internationally, the term occupation therapy, or occupational therapy was adopted for use by medical services in English speaking countries. However, the name was not without some controversy. After the establishment of an international association, the World Federation of Occupational Therapists (WFOT) in 1953, the two words 'occupation' and 'therapy' were consolidated in the profession's title. Within the first few years, however, the title was questioned (Mendez, 1986). Translation into other languages was not straightforward, as in many languages there was no word to correlate with the concept of 'being occupied'; some countries used 'ergo therapy' as an alternative. In addition, the connotations of occupation raised serious concerns as for many member countries of WFOT 'occupation' was linked to oppression and war. Even in English speaking countries, confusion was caused by the common meaning of occupation as a job, type of work or career. In 1960, the issue of naming was raised at the international council of the World Federation (Mendez, 1986, p. 23). While the debate about name change continued, the international group remained the World Federation of Occupational Therapists and 'occupational therapy' remained the most common descriptor for the profession.

## **4.2 Beginnings of Occupational Therapy in Britain**

### **4.2.1 Adaptation and occupation.**

Newly forming practice knowledge in OT was the impetus for the emergence of occupational therapists in Britain during the first half of the twentieth century. Scottish psychiatrist Professor Sir David Henderson (1908-1965), who worked with psychiatrist Adolf Meyer in New York and Baltimore before returning to the Gartnavel Royal Hospital in Glasgow, was particularly interested in the concept of adaptation. He considered that mental disorders resulted in social failure brought about by an inability of people to adapt to their environment, regardless of the underlying cause for the condition. This social failure led to a state of hopelessness and idleness, an apathetic state that could be addressed, and even reversed, through occupation. Henderson maintained that well planned activity and a balanced routine in the hospital environment would address this hopelessness and create feelings of success:

there is nothing which will sooner and more satisfactorily increase a person's self-esteem than his ability to accomplish something ... It is therefore our duty to attempt to establish well coordinated, purposeful ways of doing things, instead of idleness, apathy, or inadequate reaction. We must plan and organise our patient's day, so that adequate time is provided for work and rest and play, so that interests are stimulated and to borrow a word from Meyer – exteriorized. Even although the patient has been a failure in the world at large, we must attempt to make him a success in the hospital environment. (Henderson, 1925, cited in Paterson, 2008, p. 9)

In 1922, Henderson employed the first instructress in OT at Gartnavel Royal Hospital in Scotland. The role of the instructress, who was a university graduate but with no OT training, was to set up craft activities for the many patients who were physically unable to undertake work already available in the hospital such as farming and gardening for men and domestic work for women. The benefits of work in the asylum were well recognised, as discussed in Chapter Three. Patients who required constant supervision as they suffered from conditions such as epilepsy or were not physically strong were not suited to work undertaken under the supervision of non-medical staff. Patients allocated to alternative activities, such as making toys, rugs and baskets under supervision of an instructress, were observed to improve (Paterson, 2008).

The success of the Gartnavel Royal program, one of the first in the UK, led to the proposal to erect a special building for craft activities, signalling the forerunner of the 'OT department', discussed further in Chapter Five. Henderson continued to support the introduction of the OT profession, but was unable to find funds to employ qualified occupational therapists. The first qualified British occupational therapist, Margaret Barr Fulton, became interested in OT during a holiday in the USA. After returning from training in Philadelphia, she was employed at the Royal Aberdeen Mental Hospital, where the use of occupation was being promoted after it was reported that many long-term patients had emerged from demented or depressed states shortly after commencing OT (Paterson, 2008).



An army hut in the grounds of the hospital was used for the program, another early space that became an OT department.

During the 1930s, increasing numbers of craft instructresses and qualified occupational therapists were employed in the UK, and two professional associations were formed: the Scottish Association of Occupational Therapy in 1932 and then the Association of Occupational Therapists in 1935, which represented occupational therapists across other regions of the UK (Paterson, 2008). A training course was established in London at the Maudsley Hospital, for nurses to learn about the use of occupation; formal schools of OT opened in London and Edinburgh in 1937. These developments, along with those already mentioned in the USA, were key influences on the development of OT in Australia.

### **4.3 Occupational Therapy in Australia**

#### **4.3.1 Organising occupation in the asylums.**

Three independent but related factors influenced the establishment of OT within the mental hospitals of Australia, and in particular, within the Department of Mental Hygiene in Victoria. The first of these was an ongoing change in attitudes towards insanity, which meant that alternatives to incarceration and punishment were sought to manage people who displayed behaviour considered unmanageable in society. Rather than being considered 'animal-like' or criminal in nature and needing incarceration and total separation from community, the 'mad' people began to be seen in medical terms. Emerging from the era of 'asylums', where conditions were reminiscent of prisons and strict control of behaviour, mental hospitals were seen as being places of treatment as well as containment. Approaches to treatment reflected the medical profession's developing explanations of the causes of mental illness and the physicians' search for cure, or at least containment, of symptoms. Society was happy to see people housed safely and treated humanely, although at a 'safe' distance. The philosophy of 'pleasant environments' of the asylum era continued in the establishment of mental hospitals, with sites located in large areas to accommodate park-like surroundings, farming and recreational

pursuits. However, even with an increased number of mental hospitals in Australia, patient numbers continued to rise. Hospitals housed both those remaining from the 'asylum era' and those newly admitted, often on a voluntary basis. The hospital population continued to increase so significantly that, as each new facility was built, issues of over crowding and lack of staffing soon emerged. Even construction of large residential buildings such as Mont Park, in a northern suburb of Melbourne did not meet demand: by the early 1930s, Mont Park housed far more patients than the facilities could manage. Overcrowding was reported, along with shortage of basic supplies like bed linen (Bircanin & Short, 1995). Concerns were expressed about how to manage the number of patients and deal with their daily routines. A consequence of this overcrowding and lack of staff and facilities was that hundreds of people remained largely inactive. Administrators saw the direct effect of minimal meaningful activity in the daily routine of the hospital as patient management became an ongoing issue (Bircanin & Short, 1995).

The second factor impacting on the development of OT services was the influence of the local community on the administration of mental hospitals. While communities appeared to be satisfied for hospitals to be at a distance, as were asylums, it seems that they also were prepared to take more notice of what occurred behind the high walls. For Mont Park hospital, community interest was represented by the Women's Auxiliary, an organisation of local women who took on benevolent roles within their community. Mont Park Mental Hospital had an active Women's Auxiliary group, interested in the welfare of patients as well as in the broader social implications of mental illness. When, in the 1930s, official visitors were appointed through the provisions of the Lunacy Act, Mrs Edith Pardy, who was also President of the Central Council of Mental Hospitals' Auxiliaries, became one such official visitor. She agitated not only for better conditions in light of society's more enlightened attitudes towards the 'mentally afflicted' (Pardy, 1937) but for more 'sympathetic' approaches and more diversity in the craft programs offered. Pardy lobbied the Victorian Government to make more funding available to provide resources for occupation, and in particular to train nurses to take on the craft and activity

programs (Pardy, 1937). In 1934, the Women's Auxiliary funded the salary for the first six months of an 'organising therapist' position, until it became an official appointment of the hospital (Bircanin & Short, 1995; Cameron, n.d.).

The third factor affecting the emergence of OT in Victoria was knowledge developing within psychiatric medicine. This growing specialty saw increasing numbers of psychiatrists practising in Melbourne during the 1930s. Although a growing number of doctors were qualifying in Australia, many travelled to Britain to undertake advanced training or to gain clinical experience at British universities or hospitals. In particular, many had a link with the Maudsley Hospital in London, known for its promotion of the use of activity as part of treatment regimes. Psychiatrists returning to Melbourne from the UK, especially those from Maudsley, promoted the use of occupation in their practices and incorporated the work of the first Melbourne-based occupational therapists in their treatment (Anderson & Bell, 1988). However, progress in establishing the therapy was slow. By early 1940 there were three occupational therapists holding overseas diplomas working in Australia (Cameron, n.d.).

#### **4.3.2 From organising therapist to occupational therapist.**

The occupational therapist of the 1930s and 1940s in Australia was a young woman in her late 20s or early 30s, single and from a middle class family, with independent financial means. They were few in number. Each one travelled to the USA or the UK in their pursuit of knowledge about OT. The first person designated a specific role related to the use of occupation was Lucy Symes. She had nursing training, but did not hold a formal OT qualification. The premise of her work was built on emerging principles of care of the insane in public institutions. Occupation was seen as having curative value, through the mechanism of 'occupying the mind'. In 1934 she was employed at Mont Park Hospital; her role was to organise the activities prescribed for patients and the title of her position, 'organising therapist', reflected this (Bircanin & Short 1995). Symes introduced activities that reflected the normal routines of life outside the hospital environment. At Symes' instigation, a hairdressing salon adjacent to the female wards was established in 1938 for women patients. It

became such a success at lifting morale that hairdressing salons were recommended as permanent feature in all large asylums in Victoria.

Symes was the first therapist to publish an account of her work. In an article in *The Hospital Magazine*<sup>5</sup> of 1937, she wrote:

In the treatment of the mentally afflicted, after the acute phases of their illness have passed, there is no more powerfully beneficial agency at our disposal than occupational treatment, which frequently produces an improvement in patients who, from the nature of their diseases, cannot be cured. (Symes, 1937, p. 15)

The key aspect of practice knowledge and rationale underpinning OT treatment, identified by Symes for those patients spending lengths of time away from their usual routine, was 'to induce them to do something to occupy their minds' (Symes, 1937, p. 15). Over time, inactivity could lead to listlessness and loss of self-confidence. Introducing indoor activities and outdoor occupations (gardening being the most effective) was a means to counteract any 'disinclination for effort' (p. 15). Symes made a clear distinction between work and recreation as reflections of the normal social routine. She asserted the importance of this distinction even within the hospital setting, as 'games have a considerable treatment value, but they should, as in the outside world, be used as a means of recreation, rather than as a substitute for work' (Symes, 1937, p. 16). She also ascribed a power to occupation that motivated and encouraged treatment or cure when patients found they had a skill, which had been previously unknown to them:

One of the greatest privileges that every now and again falls to the lot of an occupational teacher is to assist in bringing to light a patient's latent talent. By this I mean a talent that previously the patient has had no opportunity in expressing or developing, because of lack of leisure or lack of help and encouragement. Usually it is a talent for some form of art – for example

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<sup>5</sup> The Hospital Magazine was a publication of the Charities Board of Victoria, representing public hospitals and charitable organisations.

drawing, painting, or fancy needlework. Often the creative urge has had to be completely suppressed through force of circumstances, but has nevertheless persisted in the patient's unconscious mind, finding from time to time unrecognised symbolic expression. When such a talent can be developed under guidance and find full and satisfying expression, it is astonishing to observe the accompanying change in the patient, who often becomes a different being with a richer and more mature personality. One feels that such a patient, when discharged from hospital, will carry on the art as an engrossing hobby, which will be of the utmost value when once more the difficulties and stresses of life have to be met. (Symes, 1937, p. 16)

The first Australian occupational therapists to gain formal qualifications studied in the USA and UK, primarily at the OT Schools of Philadelphia, Dorset House, Maudsley Hospital and London. By 1939, there were four qualified occupational therapists working in Australia, two of whom had worked with psychiatrists in Melbourne. Most occupational therapy programs in Victorian psychiatric hospitals were carried out by nursing staff and 'artisan' staff working in the workshops and farming endeavours of the institutions (Bircanin & Short, 1995). While psychiatrists and community auxiliaries promoted the use of occupation, institutions were slow to respond, drawing on limited resources and reluctance to introduce change, thus accounting for the slow introduction of formal OT programs and the small number of qualified staff.

During the early years of practice, Australian pioneer occupational therapists took the responsibility of sharing their practice knowledge seriously. They became leaders in the emerging profession, first as proponents of OT during the war years, then as foundation members of the Occupational Therapists' Club that formed in Sydney in 1944. The Club was instrumental in promoting expansion of OT, as had NSPOT some years earlier in the USA.

#### **4.3.3 World War II: the need for rehabilitation and OT education.**

Australia's involvement in the Second World War was a significant factor in the growth of OT as a profession. Significant numbers of injured soldiers returned to hospitals in Australia, creating demand for new approaches to treatment. A growing number of people, predominantly men, faced the challenge of returning

to civilian life with disabilities both physical and psychological. Medical professions responded with developments in technology, techniques of treatment and a search for more participants in the medical process. The concept of rehabilitation for returned soldiers was developed, and expansion of the rehabilitation workforce became urgent.

The Australian Army considered occupational therapists to be one health group that could meet the demand to treat soldiers, whether physically wounded or suffering a range of conditions not previously treated (Anderson & Bell, 1988; Cameron, n.d.). At the war's beginning, only nurses and physiotherapists could be mobilised, as the Australian Army had not previously employed occupational therapists. The Army subsequently made a decision to employ only qualified therapists, and to assign them to the medical service with officer ranking (Anderson & Bell, 1988). The decision to employ only qualified therapists was made despite the fact that there were no courses to train occupational therapists in Australia, thus limiting eligibility to a few therapists who had trained overseas and returned home. In the meantime, the Army decision created the need for an 'emergency training course'.

The first Australian educational course in OT was initiated by the New South Wales Hospital Commission soon after the commencement of World War II in 1939. A group of doctors and other medical service personnel commenced arrangements for a course through the University of Sydney, although it was shortly afterwards transferred to the Australian Physiotherapy Association (APA) when the organising committee realised the scope of what would be required for such training. The APA undertook the training as they already had responsibility for training (in physiotherapy). The course, 'organised and controlled' by the APA, was designed to meet 'war emergency needs' (Anderson & Bell, 1988, p. 22); however, despite their willingness to undertake the training, the APA soon realised the requirements were beyond their resources, and instead an OT Training Centre in Sydney was established in 1942. This was subsequently recorded as marking the commencement of the OT profession in Australia.

The small group of Australian occupational therapists drew on their overseas experiences to advise on the range of knowledge and skills to be taught in the early training programs. The first course at the Training Centre comprised fifteen months of full time study, although this was varied to six or twelve months for students with other qualifications, such as members of the Australian Physiotherapy Association or graduates of an approved Art School. Such recognition of prior training in physiotherapy or art reflected the diverse nature of the perceived skills and role of occupational therapists. Other prerequisites for admission included leadership skills, administrative ability and being 'capable of ready social adaptability' (Anderson & Bell, 1988, p. 22).

Theoretical learning in the course was undertaken through lectures in anatomy, physiology, pathology, muscle movements, psychology and psychiatry. These subjects were considered the medical underpinnings of OT treatment, and were supplemented by studies in administration, supplies, recreation, games, child guidance, social service, and analysis of occupations and their application. The use of occupation was underlined, with training in crafts including weaving, carpentry, leatherwork, book-binding, fabric painting, lino cuts, basketry, macramé, chair seating, pottery, toy making, needlecraft and marionettes. Practice experience was gained through hospital affiliations, including two mental hospitals, where students were under the supervision of nurses (Anderson & Bell, 1988).

Early OT pioneers took a pragmatic approach to both practice and education. The war years meant limited supplies and facilities. Classes were conducted at night under curfew conditions, and materials were gathered from low-cost sources (Anderson & Bell, 1988). Workers and patients alike faced challenges of separation from family, limited finances and food, loss of loved ones, and the prospect of 'a bleak new future – career hopes shattered, spouse killed in action, or, as can happen, a wife leaving home for another partner' (Sloane, 1976, p. 7). In this social context, purposeful activity was considered a means for shaping positive futures (Sloane, 1976).

#### **4.3.4 Practice post World War II: establishing a profession.**

Orientation of medical services towards physical disabilities influenced the development of OT immediately following World War II. Aiming to extend the successful rehabilitation services introduced for injured soldiers, the Department of Social Security established a government funded organisation, the Commonwealth Rehabilitation Service (CRS) (Tipping, 1992). Civilian rehabilitation programs included treatment for work and transport accidents as well as injuries or illnesses, including those incurred by men who might have been suffering from the effects of war, but whose injuries were not recognised as war-related (Tipping, 1992). In the early years of CRS, 'nervous disorders' categorised the largest group of clients within the scheme. Rehabilitation had a specific focus on return to paid work. Craft activities, under the guidance of occupational therapists, were the starting point for many patients who progressed to heavier manual tasks and trades. Some crafts, such as leatherwork, led to employment within that trade; craft was therefore positioned not only as a leisure activity but as an activity related to employment.

The first step towards establishment of a professional group to represent occupational therapists occurred in 1944, when a group of women employed as occupational therapists met to form the Occupational Therapists' Club. This club was intended as a way to develop and share practice knowledge, with the aim of 'furtherance of the knowledge of OT and social contact between Occupational Therapists; to arrange lectures by medical men; to circulate articles and recommend books, to arrange for lectures and demonstrations' (Occupational Therapists' Club, 1945, p. 3). Monthly meetings were held, and a year later thirty one members belonged to the group, primarily from New South Wales; a Victorian division of the Club was formed in 1947. This group of practitioners was instrumental in lobbying for further development, and by the early 1950s there were growing numbers of practitioners and schools of OT in New South Wales and Victoria. Early practitioners and educators described OT as a profession based on training that consisted of 'extensive training in handcrafts and recreation combined with the study of anatomy, physiology, psychology, orthopaedics, general medicine and psychiatry' (Philcox, 1951, p11). This



training prepared therapists to 'administer and adapt these activities to aid the recovery of the sick or disabled' (Philcox, 1951, p. 10). Along with practice knowledge gained through study, desirable attributes for potential occupational therapists were considered to be caring and interest in the 'human condition'. As had been the case during the world wars that had created the impetus for rehabilitation and therapy involving activity, women were considered 'right' for the role, for 'the girl who hopes to make OT her life career must possess the gift of human understanding, with all that goes with it of empathy, tact and persuasion' (Philcox, 1951, p. 10).

The emerging professional association exerted a significant influence on the structure of training for occupational therapists. The Occupational Therapists' Club supported the transition of graduates into military and civilian positions, initially in psychiatric and general wards and rehabilitation centres. The Club also assumed responsibility for professional regulation, and promotion of OT to government and the medical profession. Regular meetings of the Club were held, and the first official publication for occupational therapists appeared in 1945, including Club news, records of lectures given at meetings, notification of new equipment that had become available and employment opportunities (Anderson & Bell, 1988). The Club adopted the role of knowledge generation and sharing, monitoring curriculum development, reporting research from overseas and promoting the need for research in Australia.

#### **4.3.5 The international occupational therapy scene.**

The group of occupational therapists promoting professional development in Australia were also interested in the formation of international links. A group of occupational therapists met in Stockholm in 1951 and decided to establish an international group to foster links between countries where OT was being practised. The first meeting of this group, named the World Federation of Occupational Therapists (WFOT), in 1954 was attended by ten countries, recorded as founding members: Australia, Canada, USA, UK, South Africa, New Zealand, India, Israel, Norway and Sweden (Mendez, 1986). The first meeting of delegates, known as the Council, was immediately followed by the first congress, attended by over 400 delegates from both member and other

countries. Included were fifteen doctors from Egypt, Germany Norway, UK and USA (Paterson, 1994). Work was presented by occupational therapists from various practice areas including psychiatry, but predominantly from those that reflected the growing areas of medicine of the post-war years, including tuberculosis, poliomyelitis, cerebral palsy, rehabilitation and home resettlement after hospitalisation. The generation and sharing of knowledge contained an international focus despite the problems of distance and slowness of communication. International committees were established by WFOT to develop educational standards, including a monitoring and accreditation system, promotion of the profession, research, and communication of latest trends and information (Mendez, 1986).

#### **4.4 Relationships with other Professions**

##### **4.4.1 Medical profession.**

A supportive medical profession was identified as crucial to the development of OT. From the beginning, doctors were instrumental in promoting the theories that occupation was related to health and that 'practitioners' were required to carry out specific occupational treatments. The first practice area for occupational therapists emerged as a consequence of the medical specialisation in psychiatry emerging in the early 19<sup>th</sup> century in UK and USA. Early OT practice in psychiatry was centred in large institutions in which doctors were the medical superintendents, 'overlords of vast establishments filled with chronically incapacitated patients' (Bynum, Porter, & Shepherd, 1985, p. 90). Early OT practice knowledge emerged as the medical profession prescribed treatment. Medical practitioners of the early 20<sup>th</sup> century set the theoretical perspectives for the new area of OT and wrote the first text books to guide practice. Originally directed at nurses providing activities in psychiatric institutions (see 4.4.2), these texts presented the theoretical background to practice as well as detailed descriptions of activities to be undertaken. The first specific text available for occupational therapists working in psychiatry was written by an American occupational therapist and her physician husband (Fidler & Fidler, 1954). Early texts used to inform training and practice in Australia are listed in Table 4.1.

Table 4.1 Early OT text books written by doctors

Publication details	Chapter/s related to psychiatric treatment
Dunton, Jr., W.R. (1915). <i>Occupation therapy: a manual for nurses</i> . Philadelphia, PA: W.B. Saunders.	Psychology of occupation
Haworth, N.A. & Macdonald, E.M. (1940). <i>Theory of occupational therapy for students and nurses</i> . London: Bailliere, Tindall & Cox.	Occupational therapy in the treatment of mental disorders Occupational therapy in mental nursing
Dunton, Jr., W.R. (1945). <i>Prescribing occupational therapy</i> (2nd Ed). Springfield, Ill.: Charles C. Thomas	Mental disorders
Fidler, G.S. & Fidler, J.W. (1954). <i>Introduction to psychiatric occupational therapy</i> . New York, NY: Macmillan.	Psychodynamic approaches and use of projective techniques in activity groups
Dunton, Jr., W.R. & Licht, S. (1957). <i>Occupational therapy: principles and practice</i> (2nd Ed). Springfield. Ill.: Charles C. Thomas.	Bibliotherapy in psychiatry Occupational therapy for psychiatric disorders
Fidler, G. S. & Fidler, J.W. (1963). <i>Occupational Therapy: a communication process in psychiatry</i> . New York, NY: Macmillan.	Past and current trends in psychiatry, meaning of activities and implementation of individual and group approaches

Doctors also participated in the establishment of the professional association in Australia:

The influence of medical men in the early development of the profession was epitomised by the requirement that the President of the newly formed Association of Occupational Therapists should be a member of the British Medical Association (Anderson & Bell, 1988, p. 213)

The pioneers of the OT profession were influenced by the leadership of doctors, many of whom were pioneers in their own areas of specialty within medicine. The first qualified occupational therapists in Australia 'felt they were pioneers of a new profession, and were dedicated to making it one acceptable to the medical profession' (Sims, 1967, p. 29). While some doctors were promoting the therapeutic value of occupation, many had not heard of OT or its proponents. Others were ambivalent at best, dismissive at worst. Occupational therapists

tolerated the obvious lack of respect at times, convinced that what they had to 'contribute to rehabilitation of patients was necessary and worthwhile' (Sims, 1967, p. 29). Committed to their quest of establishing OT within all hospitals, occupational therapists acknowledged their 'lower' position in the medical hierarchy, for 'There was a mystique about medicine and so powerful was it that we were prepared to accept a good deal of neglect and lack of communication even from the brand new resident [doctor] in return for complete loyalty and willingness to serve' (Philcox, 1951, p. 12).

#### **4.4.2 Nursing.**

Early historical accounts identified the relationship between OT and nursing as one of connection and interaction. In many institutions, nurses were the first group of workers interested in how inmates, or patients, spent their time. In Victoria, the need to organise occupation was acted on by nurses. Lucy Symes, the first 'organising therapist', was a nurse at Mont Park Mental Hospital. Her special interest in 'occupational treatment' took her out of the ward role and into the role of coordinating 'congenial tasks' directed at diverting patients' interest away from themselves and their illness and to raise 'their self-esteem enormously' (Symes, 1937, p. 15). In calling for the development of OT services at Mont Park where Symes worked, Mrs Pardy from the Mont Park Auxiliary demanded funding of more nurse positions to support those who wanted to move into the new field of occupation (Pardy, 1937).

The new field was initially part of the domain of nurses already working within the hospital environments. Early text books were directed at nurses who were interested in using activities in the hospital routine. One of the earliest text books used in Australia, *Theory of Occupational Therapy for Students and Nurses* (1940) by Haworth (a physician) and Macdonald (an occupational therapist) includes a chapter titled 'Mental Health Nursing' in which activities are described for use with different types of mental illness (Table 4.2).

Table 4.2 Activities for nurses to carry out in wards

Text	Activities
Haworth & Macdonald (1940)	Essential crafts Needlework of all kinds Knitting and crochet Rug-making Weaving – hand and foot loom Basketry, raffia and cane work Leatherwork Block-printing Painting (for Christmas cards, calendars) Joinery Brush-making Coir mat making Dyeing Use of waste materials Country dancing Community singing Simple physical exercises

## 4.5 Education for Occupational Therapy in Victoria

### 4.5.1 Establishing a training program.

Formal education for occupational therapists commenced in Victoria in 1948 with the enrolment of thirty students at the Occupational Therapy School of Victoria (Cameron, n.d.). The development of the two and a half year program was facilitated by the Department of Post-War Reconstruction. A director was recruited from the UK and premises were rented from the Try Boys Association for classes during the day (the teaching space being used for Association activities in the evening). Some classes that required more space, such as recreational exercises and dancing, were held in a local church hall.

The commencement of the OT course in Victoria signalled recognition that the role being developed extended beyond nursing provision of activity programs. It demonstrated that the new discipline required an understanding of the structure and function of the human body and knowledge of medical conditions. In addition to this 'basic' knowledge, comprehensive knowledge of and practical skills in a range of exercises, primarily craft but also physical activities, were required. The course was designed to address both physical and psychological functions, equipping graduates to work across the range of fields in which OT

positions were being created. Limited practical work (such as clinical education) was available for students until OT departments were established in public hospitals including The Royal Melbourne Hospital, Alfred Hospital, Children's Hospital, Children's Welfare Department, Heidelberg General Repatriation Hospital, and Bundoora Mental Hospital (Cameron, n.d.); the School redressed this deficiency.

Eligibility to study as an occupational therapist included being over eighteen years of age, and having a school matriculation certificate or being considered suitable 'in all other respects' (Occupational Therapy School of Victoria, 1949, p. 3). Applicants were also required to be in 'sound health and good physique' and to appear before the Selection Committee with a certificate of physical and dental fitness, and to be prepared to undergo a vocational guidance test and X-ray examination. Further, as 'a proportion of practical work is undertaken in tuberculosis or mental institutions, candidates under twenty one years of age [were] required to submit a statement signed by a parent or guardian that they [were] permitted to enter upon the course' (Occupational Therapy School of Victoria, 1949, p. 3). The selection process included an interview for all prospective students with the school director.

#### **4.5.2 The early Victorian curriculum.**

The course comprised a minimum of 114 weeks (in blocks of forty, forty eight and twenty six respectively), with a curriculum modelled on those developed in the USA and UK, as well as on the existing course in Sydney. Science subjects related to medicine were considered background knowledge, and lectures in these were held at the University of Melbourne, courtesy of the medical school. These subjects included anatomy, physiology, psychology, medicine and surgery, orthopaedics and psychiatry. There were two theoretical units relating directly to OT, *Occupational Therapy Part 1 and Part 2*, and two subjects dealing with rhythmic activities (as described below).

Craft lessons made up most of the course, in terms of hours. The curriculum required development of knowledge that would link specific activities with medical conditions likely to be encountered in practice. It was considered

important to learn a range of crafts in order to have a wide selection with which to match patient needs although it was also felt that a set of core crafts would 'provide all that is necessary, and provided that the knowledge is thorough, they will give scope for almost unlimited variety and will meet the needs of every type of patient that [a therapist] is likely to be asked to treat' (Haworth & Macdonald, 1940, p. 7).

Students of OT in the first few years of the new course in Victoria were expected to develop an understanding of

Abnormal psychology and the aetiology, signs, symptoms, prognosis and outline of treatment of all mental illness. The use of mental testing and treatment of behaviour problems, and the psychological factors influencing mental outlook. General knowledge of the laws and rules surrounding the treatment of mental patients. Knowledge of principles of modern treatment. (Occupational Therapy School of Victoria, 1949, p. 14)

In related OT subject students learnt 'to cover the application of OT to all diseased conditions, the grading and analysing of activities and the co-ordination of the same with other treatment' (Occupational Therapy School of Victoria, 1949, p.15).

In the study of Rhythmic Activities, the syllabus was designed to

foster an appreciation of movement and the development of motor skill and good posture habit and ... use of recreations in the promotion of bodily health and mental alertness. Instruction will be covered in games, dancing and rhythmic activities and also in methods of teaching. Emphasis will be laid on the importance of relaxation and rhythm and on the use of music, and ... special emphasis will be laid on the application of these activities, the possible dangers encountered and the precautions required. The importance of correct posture, especially in the treatment of mental illness, will be stressed and practical application of muscle anatomy and kinesiology will be included. (Occupational Therapy School of Victoria, 1949, p. 16)

The use of crafts by occupational therapists was specifically recognised by psychiatrists as an adjunct to physical therapies. Wechsler (1951) argued that 'OT in psychiatry is a particularly fine art ... emphasis should be placed on constructive projects to awaken new interest and skills, and these must be adapted to the patient's individual needs (p. 7)'.

Tension is a sign of unreleased energy. In the properly selected work and recreations, the psychiatric finds an opportunity to release his unreleased tension, and this is the task of the psychiatric occupational therapist. It goes back to 1913 when the American Psychiatric Association adopted a resolution namely that 'OT marks the standing of a psychiatric organisation and neglected or omitted the patients are not receiving the adequate care and treatment to which they are entitled'. After all, OT is applied physical treatment. (Wechsler, 1951, p. 7)

In addition to the text books described in 4.4.1 and 4.4.2, the primary OT text used in Australia was *Occupational Therapy*, written by two American occupational therapists, Helen Willard and Clare Spackman.<sup>6</sup> This text was prescribed reading in all early OT training programs, along with the UK text written by Haworth and Macdonald. The range of activities suggested for occupational therapists working in psychiatric hospitals now extended beyond the crafts and simple physical exercises described in the earlier work by nurses (Table 4.2). Table 4.3 presents 'modalities' of treatment and associated activities characterised by Wade, author of the 'Mental Illness' chapter in the Willard and Spackman textbook. Willard and Spackman continued to edit this text, which remained prescribed learning in all Australian programs and continued to be a significant influence on practice knowledge<sup>7</sup>.

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<sup>6</sup> Willard, H.S. & Spackman, C.S. (eds). (1947). *Principles of occupational therapy*. Philadelphia, PA: J.B. Lippincott. Chapter on psychiatry: Occupational therapy for patients with mental disease.

<sup>7</sup> With changing editors during the years following the retirement of Willard and Spackman after the 7<sup>th</sup> edition in 1971, the text remained prescribed reading across many generations of OT students.



Table 4.3: OT activities for psychiatry (Adapted from Wade, 1947, p. 86).

Occupational therapy department			
LIBRARY	RECREATION	INDUSTRIAL THERAPY	HANDICRAFTS
Reading service	Dramatics	Placement bureau	Arts
Study groups	Music	Maintenance work	Crafts
Newspaper	Games	Housekeeping assignments	
	Parties		
	Sports		
	Holiday festivities		
	Gardening		

Students attended lectures given by psychiatrists for instruction in common psychiatric conditions and associated behaviour likely to be met in clinical visits. Instruction included clinical signs, commonly applied treatments and advice for occupational therapists, and emphasised the therapeutic nature of the interaction between therapist and patient. Students were to develop knowledge adaptation of activities according to the individual patient, understand group processes and be aware of the impact of their emotional reactions on patients and their work. Text Box 4.1 is a transcription of student notes from 1957 that illustrates the lecturer’s message about therapeutic approaches as well as the positive impact expected of OT in the treatment of patients with schizophrenia. The characteristics of art are also mentioned highlighting the part art played in psychiatric treatment of that time. Consideration of art as a component of OT practice knowledge is discussed further in Chapter Five.

*Depressed patients often have underlying aggressiveness – good for cutting down trees, other gardening. Beware of too much competition ... O.T. can be pre-vocational ...*

*Never like or dislike a patient, the group will soon pick up who is the favourite ...*

*Mutual help – help them to become one of a group ...*

*Never fit patient to work, always work to patient*

*Never laugh at a patient, but laugh with them ...*

*OT's need never be frightened of mental patients. Dangerous mental patients are very rare.*

*One of the biggest jobs in O.T. is in the schizophrenic field, because they are in hospital for such a length of time, and often O.T. is the only way of trying to prevent slow deterioration.*

*Try to get them out of that dreadful state of apathy. Schizophrenics tend to surrealism in art, some are very artistic ...*

#### **4.6 Changing Times**

In 1952, the Victorian Government appointed Dr Eric Cunningham Dax, a psychiatrist from the UK, Chairman of the Mental Hygiene Authority. At the time of the Dax appointment, there were five occupational therapists, none with formal OT qualifications, employed in public mental health services (Dax, 1961). Not long after his appointment, Dax met with the Victorian Branch of AAOT to discuss his intention for OT to be expanded within mental health services. Two years later seventeen occupational therapists, and nine years later a total of forty three occupational therapists, were employed, all with qualifications (Dax, 1961). Large psychiatric hospitals often had more than one department. Dax not only influenced the expansion of OT service, but also had a significant influence on the way in which they practised. One aspect of changing practice involved the development of more employment options for patients within long-term care, with the introduction of 'industrial therapy'. The use of crafts within the routine work of the institution were considered to limit the benefit of being occupied, and a view emerged that payment was also part of the therapeutic aspect of work.

Against a background of competing areas of practice and mixed support from the medical profession and employing organisations, the 1950s did bring a realisation that OT could be a more significant part of future developments in mental health services. Figure 4.1 presents the occupational timeline to this point.

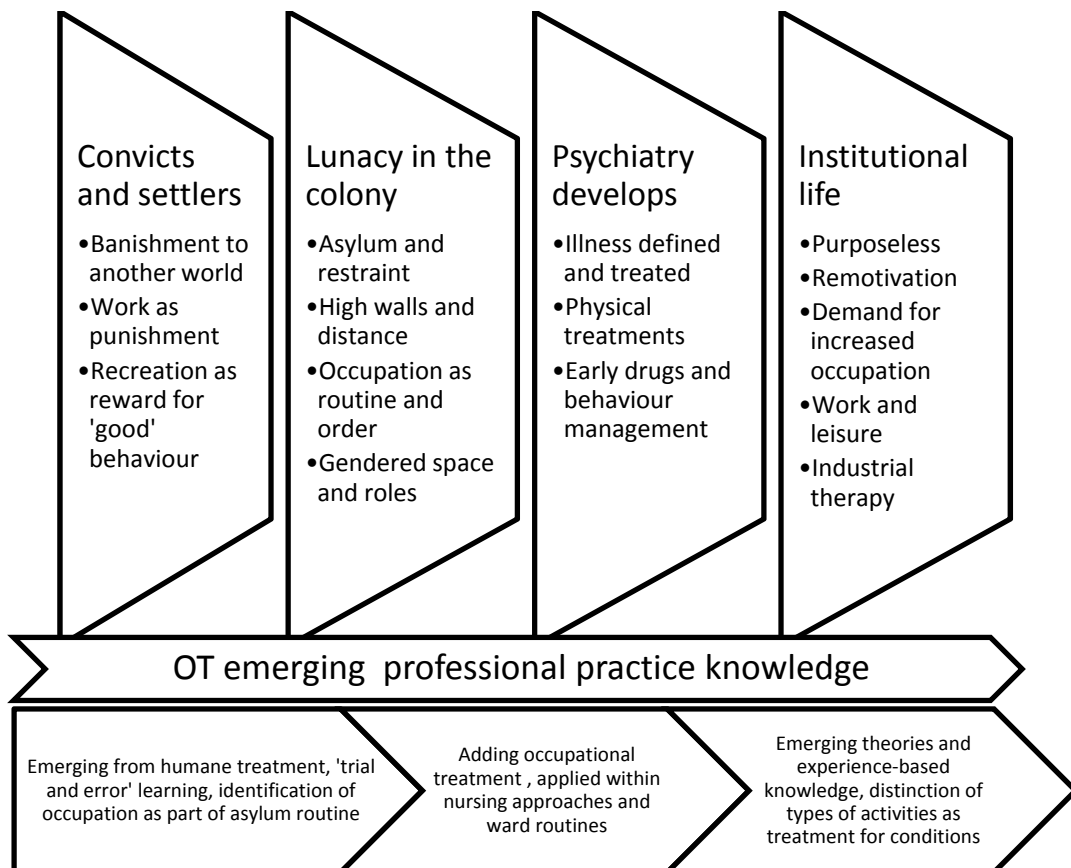


Figure 4-1 Occupational transitions to the 1950s

#### 4.7 Summary of Chapter and Reflections on Practice Knowledge

In this chapter I have described early development of OT as a health profession involved in mental health services in Australia. The creation of OT positions in mental health services occurred as part of the paradigm shift from punishment to treatment. The institutions were transformed, from places of incarceration to places of asylum for safety, retreat and care. Asylums later became hospitals with growing focus on treatment and even cure. As mental health physicians developed their own roles in mental asylums, they began to incorporate

occupation into their treatment regimes. The need for an 'occupation' profession became apparent as physicians continued to prescribe 'activities' as treatment in psychiatry, and the role of 'occupation therapist' grew beyond what could be reasonably incorporated within the roles of existing staff, primarily nurses. Theories of the therapeutic value of activities emerging during this time were based on the success of activity programs within medical institutions. Introducing activity and organised daily schedules created quieter and less chaotic hospitals. The notion of distraction or diversion away from personal troubles was considered an important result of the successful use of activities. The 'new professionals' moved quickly to describe their practice and record their knowledge base, drawing on scientific principles borrowed from medicine, nursing and the developing field of psychology. Influenced by their practice successes, they lobbied for education programs and sought new areas of practice.

Growing demand for OT in mental health services during the 1950s was initially resisted by some medical personnel and administrators who were not convinced that the need existed for this type of therapy. However, the physical and psychological injuries suffered by soldiers during World War II created a significant demand for the new medical field of rehabilitation. By the end of the 1950s, demand for occupational therapists in mental health services increased as psychiatric hospitals moved from the asylum era to one in which rehabilitation became the aim of treatment programs. The emerging theory and identity of occupation within mental health services were supported by administrative changes within the State mental health system. Rapidly advancing experience-based knowledge was greatly facilitated by the external influences of the changing health care environment, the growing number of mental health patients and greater opportunities for employment in OT that were linked to social change and support for treatment for mental illness sufferers. By the end of the 1950s, OT was an established field within mental health services and the stage was set for opportunities to expand practice and develop OT practice knowledge within the scope of medical treatment for psychiatric illness.

## Chapter 5

### Text 3: OT Practice in Public Mental Health Services in Victoria 1960–2009

#### 5.1 Introduction

OT was recognised within Australia as a ‘paramedical profession’ by the end of the 1950s. During its beginning phase in the 1940s the Australian Association of Occupational Therapists (AAOT) was formed, and in 1954 AAOT was a founding member of the international professional association, the World Federation of Occupational Therapists (WFOT). By the end of the 1950s Australia had developed internationally accredited OT education programs, including the course at Victorian School of Occupational Therapy. The increasing supply of occupational therapists provided by the schools, as well as the increasing demand for their work in Victorian public psychiatric hospitals, created opportunities for the profession to expand its role in mental health services.

This chapter portrays my third hermeneutic study, with a focus on OT practice in Victorian mental health services during the five decades from 1960 to 2009. Sources for the construction of the text were primarily the *Australian Occupational Therapy Journal*, records of the professional association in Victoria and historical accounts of Victorian OT practice and mental health services. I also drew on critical conversations I undertook with occupational therapists who worked during these fifty years of practice. I sought information on administrative arrangements for mental health services, education programs, changing practice settings of occupational therapists and the manner in which OT was practised. I organised these according to historical decades. For each decade, I included a typical practice scenario (presented in text boxes). My interpretation of the historical documentation of OT practice during these fifty years provided the basis for my reflections on factors that affected OT professional practice knowledge into the 21<sup>st</sup> century.

## **5.2 OT Practice in Mental Health Services in Victoria, 1960s**

### **5.2.1 From asylums to psychiatric hospitals.**

By the early 1960s there were ten state-run psychiatric institutions in Victoria. Five of these were in metropolitan Melbourne or on its outskirts, with country counterparts in Ararat, Ballarat, Beechworth, Sunbury and Warrnambool. The Mental Health Act (1959) was the legislative framework that established the levels of care required to be provided by hospitals, and identified conditions for voluntary and involuntary admissions. 'Receiving houses' identified under the Act were hospitals that provided a shorter-term assessment function that operated as a screening mechanism to determine longer term care options. The Victorian Mental Hygiene Authority was replaced by the Victorian Mental Health Authority in 1962, responsible for overseeing management of State mental health institutions. These were administered at a local level by a medical superintendent in charge of clinical management and a hospital secretary responsible for day-to-day operations.

The medical specialty of psychiatry continued to develop, with significant changes occurring in the treatments offered. Physical treatments, to which OT practices of the previous decade had been linked, were declining in use and many, such as the full coma treatment, were discontinued because of a lack of evidence of their effectiveness but ample evidence of the frequency of negative outcomes. Other treatments such as leucotomies, once considered to provide hope for schizophrenic and depressive illnesses, were also being questioned, given their dubious levels of effectiveness and safety (Bircanin & Short, 1995). Pharmacological developments in the 1960s were responsible for significant changes in psychiatric treatment. Main diagnostic categories including manic depressive illness and anxiety were treated with new classes of drugs, leading to major changes in the management of patients. Significantly, the introduction of benzodiazepines such as Librium and Valium during the 1960s meant many patients could live in the community and have medication managed by psychiatrists who were either in private practices or based at hospitals (Cade, 1979). Recognition of diagnostic differences and a move towards 'specialisation'

led to separation of facilities for people with mental retardation, the aged, those suffering brain injury and those with drug- and alcohol-related conditions.

Patient numbers in psychiatric hospitals, however, remained high. The large institutions of the 1950s continued to exist, often with more than 1,000 people resident, the majority for lengths of time often in excess of ten years. Within these large, sexually segregated buildings, each ward could house more than 100 people. The age range of patients housed together could be from twenty to seventy five years (Lindsay & Honey, 1960). Nursing personnel made up the majority of staff, followed by 'artisan' staff practising various trades that supported the supply of food, laundry and equipment for each institution. From 1960 increasing numbers of allied health staff were employed, although numbers remained small in comparison to other groups (Bircanin & Short, 1995).

'Reactivation' of long-term patients continued to be a focus of treatment regimes in psychiatric hospitals. OT became a recognised part of reactivation programs and subsequently of the 'rehabilitation' approach. Occupational therapists and assistants were employed to implement these programs. A hierarchy of staff was created, with a Chief Occupational Therapist responsible for a number of Grade 1 and Grade 2 therapists and handcraft assistants. These were considered state public servant positions, established through the Public Service Board of Victoria.

### **5.2.2 Education: science, practice and clinical training.**

The Occupational Therapy School of Victoria had been in operation for twelve years by the start of the 1960s. The curriculum continued to evolve in response to changing practice, including content described as scientific, and examinable subjects in general science and kinesiology (Rayne, 1960). Science subjects, including anatomy and physiology, were undertaken at the University of Melbourne, under arrangements made during the 1940s. Practical elements of the curriculum made up the majority of the course, providing training required in therapeutic media, industrial skills and group work. Clinical training, the third aspect of the course, was carried out in conjunction with eighteen

hospitals and other organisations (Rayne, 1960). The School emphasised the role of occupational therapists as part of hospital teams within a medical model and curriculum development followed developments within hospital services. In response to promotion of a team approach to patient care, the curriculum of the early 1960s included a subject addressing elementary nursing, to extend students' 'understanding of hospital routine and increase their confidence in dealing both with their patients and with other members of the therapeutic team' (Rayne, 1960, p. 7).

The subsequent years of the decade brought significant change to the delivery of the OT training program. After its beginnings in the Try Boys club premises, the School moved to a Toorak mansion owned by the state government in 1953. This was an era when OT was seen as an educational program primarily for young women wanting to take on a caring role, and leadership, as in many other professions, came from overseas professionals. The early 1960s saw more change with the first Australian-educated occupational therapist appointed director of the Occupational Therapy School of Victoria in 1960. The first male student of OT in Victoria commenced study in 1962 (Cameron, n.d.).

The 1960s saw the OT course becoming part of a broader 'paramedical' health professional scene. Other professions, primarily physiotherapy and speech therapy, were also developing alongside the medical field of rehabilitation; they sought links with OT to consolidate educational resources. In 1966 the OT School moved to Lincoln House, a former factory in Carlton, shared with the Schools of Physiotherapy and Speech Therapy, which came from separate locations. The move was followed by affiliation with the Victorian Institute of Colleges in 1967. Consolidation between what were separate schools meant that the capacity for growth of each school could increase. Each program had access to lecture theatres, tutorial rooms and enhanced library facilities and, while each remained separate, it was hoped students would form a community within Lincoln House. For OT this move occurred after almost 20 years of development, and



it was indeed a short span of time for such spectacular change. Twenty brief years almost to the month since two or three people seriously considered the worth to medicine, and therefore to the community, of setting up a second School for the therapy of occupation in Australia (Cameron, n.d., p. 84).

During the decade of the 1960s interest in research and evaluation increased. Practitioners and educators agreed on the need to establish the worth of OT as an effective treatment. Staff at the Victorian School of OT carried out research projects under the supervision of the Psychology Department at the University of Melbourne, and the School hosted its first visiting scholar, who came to the School from the USA under a Fulbright Scholarship (Cameron, n.d.). The recording of formal evaluation projects commenced in the *Australian Occupational Therapy Journal*. OT authors acknowledged the importance of program evaluation in the ongoing efforts to prove the value of OT (Bilney, Shillinglaw, Holt & Hordern, 1962; Lindsay & Honey, 1960; Nicholson, 1965). Reports of Victorian OT in mental health services also reached international journals. Recorded as a 'first' for Australian OT, Lindsay and Honey's (1960) evaluation of OT program outcomes appeared in the *American Journal of Occupational Therapy* and was subsequently reprinted in the *Australian Occupational Therapy Journal*.

### **5.2.3 Occupational routines of the mental hospital.**

#### **5.2.3.1 Occupation for therapy.**

The occupational routines of the lunatic asylums of previous decades continued into the large psychiatric hospitals of the early 1960s. Occupation was a focus of institutional daily life for patients identified as being physically capable. Work on the farms, in gardens and in trades such as carpentry, shoemaking and painting was allocated to men who could work independently or with supervision by artisan staff. A small payment was often made to those who performed work for the institution. Women were directed to work in laundries or in needlework and sewing repairs. Patients were also given unstructured 'free' time within enclosed 'airing' courts and gardens. Within the wards, 'helpers' were enlisted from amongst patient groups to assist with meals,

cleaning, rubbish collection or 'running messages' for the staff (Bircanin & Short, 1995, p. 37). Personal hygiene was an organised part of the ward routine. Bathing or showering occurred once a week for most patients, and men were shaved on alternate days (Bircanin & Short, 1995). Recreation was also organised, in the form of card and board games. From the 1960s, evening television viewing became possible after the purchase of televisions by the Hospital Auxiliary. Many institutions, such as Mont Park Hospital, arranged film nights and regular social dances, complete with small orchestra and light supper, bringing the male and female inhabitants into organised contact (Bircanin & Short, 1995).

With the introduction of OT, it was possible to extend and vary the occupational routine of the institution. Recognition was given to patients who were not able to take part in the organised work of the institution but were deemed capable of some activity beyond the regulated ward environment. Selected patients commenced attendance at OT for woodwork or craft activities as a precursor to extending contact with the 'outside world' (Lindsay & Honey, 1960).

#### ***5.2.3.2 The OT department: a sign of progress.***

When occupational therapists first commenced employment in psychiatric hospitals, they were allocated spaces to be used for craft and group activities. These were seen as the 'light' activities of the institution. Other spaces run by men, often artisan staff, were for the heavier occupations and routines of the organisation. As described previously, psychiatric hospitals had a range of environments and facilities for occupation. These included farming sheds, vegetable gardens, orchards, printing shops, carpenters' workshops and spaces for other trades such as tailoring, shoe- and soap-making (Bircanin & Short, 1995). Occupational therapists sought to extend these occupational spaces to create 'therapy' environments that were linked to the everyday occupations of patients. OT of the 1960s was influenced by the prevalent social attitude that having a purpose in life was important and that involvement in relevant activities would reflect a productive role in society. 'Ordinary' routines were introduced into psychiatric hospitals, but still reflecting the gendered nature of earlier asylum life. Occupational therapists continued to direct men towards

carpentry and light trades, while women undertook hairdressing and sewing (Bircanin & Short, 1995).

While the rhetoric of the institution, fostered by the administration of the Mental Hygiene Authority, may have taken a positive view of the introduction of OT, there were often limited facilities or equipment to provide adequate OT service. Many OT services started in a shed, outbuilding or other dilapidated space that had once been used for other purposes. Occupational therapists had to find materials, second hand equipment, or offcuts of materials. The need for thrift impacted on the range of activities and equipment available and curtailed the development of a professional identity. In this post-war era, occupational therapists had to 'make do', and they took pride in their ability to create occupation for therapy with almost no resources (Sloane, 1976). Unfortunately, such resourcefulness contributed to lasting images of occupational therapists as capable of 'making do' and therefore not requiring finances for resources. I return to this factor of professional identity in the interpretation of transitions and 'strands' of practice presented in Chapters Six and Seven.

Within the large psychiatric institutions of the 1960s, new 'OT departments' were created to house therapy organised around specifically prescribed activities. Construction and fit-out of spaces for occupational therapists were symbols of the expansion of OT and the development of practice knowledge. The external environment around these buildings also became OT 'space'. While vegetable growing and other farming activities were part of institutional routines, many patients were excluded from these activities due to their physical or psychological states. Vegetable gardens were introduced at most psychiatric hospitals as part of OT programs. Gardening as part of OT was different to that carried out by patients not receiving therapy: in the OT garden, supervision was required and gardening activities were part of 'prescribed' activities for treatment, unlike the less supervised environment of farming activities.

Initially, OT departments were based close to the ward buildings and were segregated (as were the wards) for male and female patients. However, the

large expanse of grounds of the hospitals meant that OT could expand. By 1961, at Mont Park Hospital there were

five widely separated Departments ... two departments treat female patients, one male patients, and a screen-printing unit and a pottery workshop are attended by male and female patients. A male carpentry workshop, run by two skilled tradesmen, functions in close co-operation with the Occupational Therapy Department, and a new industrial workshop is being equipped for a mixed group of male and female patients. (VAOT, 1961, p. 13)

Across these five departments, approximately 300 patients attended the various programs per day, with a further 250 people seen by occupational therapists in weekly groups held in wards. Work was under way to increase capacity with the addition of a further OT area for another 100 patients. Progression from a ward group to attendance at one of the department-based activities such as pottery, printing or the industrial unit, was considered a sign of improvement in function, part of the reactivation process for patients who had been in long-term institutional care (VAOT, 1961). Having space for occupation also allowed 'escape' from the ward environment for patients who had previously been confined indoors for most of their days.

Introducing OT into long-term psychiatric institutional environments also highlighted the negative effects of the previously overcrowded and meagre facilities of hospitals. Moving to the OT space, a 'new and modern building' was 'an environmental change from the rather gloomy ward' (Lindsay & Honey, 1960, p.11). These new spaces for occupation were designed to create environments more like home than regimented, drab living spaces. The OT department was an active place, away from the boredom and control of the hospital ward. Rather than creating formal structured space, therapeutic 'results' were sought from

an informal and homely approach ... the centre was always open, as were many of the cupboards ... most work was done spontaneously ... the

therapy centre became part of the ward all day and every day, not just during the therapist's hours of duty. (Lindsay & Honey, 1960, p.12)

The OT treatment environment had more than physical characteristics. Occupational therapists believed they could create spaces that would influence behaviour and provide support for a return to a non-hospital environment: that is, community living. The department was structured not only to be a friendly environment but to create a therapeutic environment designed to

- establish an accepting, reassuring and quietly stimulating atmosphere;
- interrupt delusional and hypochondriacal thoughts and other pre-occupations and to provide realistic substitutes;
- restore self confidence and re-establish work habits; and
- observe and assess the patient's progress. (Bilney et al., 1962, p. 4)

Department spaces also offered the capacity to structure activity as 'group therapy'. Occupational therapists sought to engender a sense of belonging to this new space, and 'for motivation it was decided to aim at a community spirit' (Lindsay & Honey, 1960, p.12). Use of group programs was underpinned by a core of OT practice knowledge, extending individual relationships with patients to relationships that fostered interpersonal communication and interaction between patients.

#### Text Box 5.1 Royal Park Hospital

*Bilney et al. (1962) described the OT program for women at Royal Park Psychiatric Hospital, an acute treatment centre. The hospital was staffed by 14 physicians and 90 nurses, with 1500 women admitted annually, of which one-quarter presented with depressive illness. The OT department was 'a large aluminium prefabricated building staffed by 5 occupational therapists who normally supervise some 120 patients daily, of which 90 are women. All the usual types of occupational therapy are available to patients' ( p. 4). The OT program consisted primarily of group activities, with two-thirds of time spent in the department as well as individual projects for the remaining time. The department offered activities that were part of treatment regimes, prescribed by the medical staff for individual patients.*

#### **5.2.4 Therapeutic activities.**

##### **5.2.4.1 Practical activities and crafts.**

During the 1960s occupational therapists extended the range of activities they had initiated during the previous two decades. Patients were encouraged to undertake projects such as pottery, basketry, or making cane and seagrass furniture, rugs, mats and toys (Bircanin & Short, 1995). Activities were used as an assessment technique as therapists observed their new patients 'to ascertain what skills and social graces remained. Creative painting and games were the two activities used and they revealed much' (Lindsay & Honey, 1960, p. 11). This initial assessment of function through activity guided the choice of subsequent techniques. Activities were selected to appeal to the interests of the individual and were important for developing acceptable social behaviour.

Other activities were gradually introduced and included sports like golf and croquet outside, table tennis, darts or deck tennis inside, music, play reading, singing, cooking groups, quiz sessions, afternoons of cards, chess and other board games (Woods, 1962, p. 14). Gardening was extended to include lessons in horticulture; these were all attempts to make stronger links with the outside world that would encourage patients to continue with these interests upon discharge.

By 1967 the emphasis of mental hospitals such as Mont Park in Melbourne was on 'rehabilitation, occupational therapy, socialisation and work for the patients' (Bircanin & Short, 1995, p. 34). OT services expanded to provide therapeutic programs aimed at developing socialisation, work and community living skills.

##### **5.2.4.2 Industrial therapy.**

As outlined in Chapter Four, industrial therapy was introduced into psychiatric institutions under the jurisdiction of the Mental Hygiene Authority in Victoria. Industrial therapy had been used in the UK and Europe for some time during the 1950s. Workshops were established within hospital precincts to encourage patients to undertake 'real' work at a pace and skill level they were able to manage. Work was primarily 'process work' sourced on a contract basis from outside industry.

By the early 1960s industrial therapy was established at several Victorian psychiatric hospitals, and occupational therapists added this to their treatment programs. At the Mont Park/Larundel complex, there were more than 260 patients within twenty four groups carrying out work in OT departments, eighteen groups in wards, and others working in two day centres where industrial work had been set up (Nicholson, 1965). The perceived benefits of industrial work were that it offered a 'realistic day to day situation, around which a balanced programme of social, recreational and homemaking activities [could] be built' (VAOT, 1961, p. 14).

The concept of 'normality' and the link with the outside world was a strong part of the OT contribution to knowledge within mental health services at this time. In particular, occupational therapists became interested in ways to measure performance objectively, and to extend the performance of patients undertaking work in the workshops. To do this, they set out to examine both work layout and patient training. They sought to apply methods used generally in industry to measure work performance in workshops, to identify links between performance and diagnostic groups and to devise modifications to job structure and patient training as a means of pursuing 'improved treatment of patients and greater ease in obtaining and handling contracts' (Nicholson, 1965, p. 19).

In their efforts to quantify the impact of occupation, occupational therapists sought ways to compare patient work rates to rates reported in outside industry. Using industry systems such as Methods Time Measurement (MTM), occupational therapists began to assess patient performance. Comparison with 'normal' rates was seen as an indication of the worth of industrial therapy as a means to increase patient motivation and create training opportunities towards work outside the institution. However, very low rates of performance made outcomes difficult to ascertain, and occupational therapists realised that patient improvement could not be measured by increases in work rate alone. Further, work rate was not the only parameter to indicate a desire to return to life in society. Another identified effect of the workshop environment was the creation of interpersonal relationships, mostly established within the framework of the training and interaction required for carrying out work roles within the

workshop. Improved personal relationships were considered to create in the patients

- an improved satisfaction in seeing a heap of assembled parts rapidly growing in front of them;
- improved ability to do more interesting tasks; and, eventually,
- ability to accept a more responsible role in the workshop. (Nicholson, 1965, p. 19)

In addition to the social graces gained in OT departments and the interpersonal relationships inherent in workshops, industrial therapy provided opportunities to encourage integration into the world beyond the institution. A combination of a graded approach to create satisfaction in work and an improved ability to take on a range of tasks and responsibilities could result in more income, which could

for many patients, be worthwhile; not for its own sake, but for the reinstating of motivation towards the normal capitalistic society from which they are withdrawn ... financial motivation will be minimal, but improved interpersonal relations, improved activity level and work satisfaction will be paramount. (Nicholson, 1965, p. 19)

### **5.2.5 OT as psychotherapy.**

#### **5.2.5.1 Art therapy.**

'Psychiatric art' was a significant area for some occupational therapists. It was based on the premise that some patients created art and modelling that was different in nature when they were 'sick' than that created when they were well (Meares, 1961). Proponents of art therapy maintained that it was possible to delineate painting and modelling for different purposes, and to design treatment based on the relationship between the pathology and the work produced. While there was a

great gulf between Art proper and the work produced in the studio of the mental hospital ... it has been observed on many occasions that archaic residues continually appear in the painting of the mentally ill, and further



that the two factors of regression and withdrawal are an integral part of the symptomatology of the psychoses. (Gooday, 1961a, p. 11)

Art therapy was recognised as a form of non-verbal communication that could take the place of other therapeutic approaches:

We are all aware of the time-wasting processes involved in psychotherapy, the devious, complicated procedures by which the analyst works to achieve his ends, but it has been found that with the advent of art therapy this has been largely obviated where medical officers have availed themselves of its service. (Gooday, 1961b, p. 9)

Occupational therapists used art therapy as 'another occupational feature with instruction and direction' (Gooday, 1961b, p. 10). However, they were cautioned by physicians that their involvement was to be specific for certain psychotherapeutic techniques and they had to understand the various uses, some of which were under their direction and others that were to be prescribed and supervised by psychiatrists. When used as a projective technique by the psychiatrist, occupational therapists were cautioned against active participation. If used as part of psychotherapy, directed by a psychiatrist, the occupational therapist was admonished to 'never comment about the patient's work or ask the patient any questions at all' (Meares, 1961, p. 4): the painting or clay model was a focal point of discussion with the psychiatrist in effort to gain understanding of the symbolism and meaning of the work, or knowledge of unconscious thoughts and material drawn from associations described by the patient. Occupational therapists might supervise the production of art work in the OT department, but they were to be aware of the importance of their silence. Occupational therapists also witnessed production of art used for diagnostic and treatment within the psychoanalytical processes, for facilitating abreaction, or in hypnotherapy or hypnoplasty.<sup>8</sup> Clear distinctions were made between

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<sup>8</sup> Psychoanalytic techniques involving hypnosis: abreaction: emotional release brought about by mentally reliving repressed or painful experiences (Harris et al., 2006); hypnotherapy: inducement by the physician of a trancelike state in the patient (Harris et al., 2006); hypnoplasty: encouraging the patient to create objects, often of clay, while in a trancelike state (Raginsky, 1962).

'occupational' therapeutic art and art not considered to be of direct concern to occupational therapists (Meares, 1961, p. 4).

Occupational therapists were, however, able to use psychiatric art under medical direction as recreation, an OT treatment, an integrating experience or a creative activity. While recreational art was directed at relieving boredom caused by long periods of hospitalisation and was intended to be fun and a pleasant experience, as OT it still involved a 'number of psychological factors' (Meares, 1961, p. 3). The two-way process of doing an active and specific task with the patient facilitated a process more powerful than might a conversation or therapeutic discussion:

it gives the occupational therapist something definite to do and something to say, and it provides a ready means for non-verbal communication which has greater effect on the patient than the expression of the same idea in words. (Meares, 1961, p. 4)

Two further purposes of art and clay modelling required the active participation of occupational therapists. When used with patients recovering from an acute episode of schizophrenia, art was an 'integrative therapy which aim[ed] to help in the resynthesis of the personality following the disruption of the schizophrenic process' (p. 40). An occupational therapist was

all the time encouraging [the patient] to do better quality work, to make it just a little neater, a little clearer, and very important, improve the relationships of the various objects in the painting with one another, and thus integrate the work as a whole. (Meares, 1961, p. 4)

In addition, the occupational therapist was instrumental in facilitating painting and modelling as creative activity to tap into what was considered to be an inherent need for individuals to be creative. Aimed at assisting both 'sensitive individuals of introvert personality' to express feelings and extraverts to develop 'new values and greater sensitivity', an occupational therapist using art 'does all she can to encourage the patient in the creative and artistic aspects of his work, and craftsmanship is only stressed as it relates to the artistic quality of the final product' (Meares, 1961, p. 5).

#### ***5.2.5.2 The occupational therapist and 'symbolic love'.***

The most significant of the psychological mechanisms identified in psychiatric art involving occupational therapists was that of 'symbolic love' between patient and therapist. The therapist became part of an emotional relationship, after establishing a rapport that allowed the therapist to assist the patient with his work, thereby 'giving affection or symbolic love' (Meares, 1961, p. 4). For this relationship to occur, the occupational therapist would demonstrate the task first. This demonstration was an essential element in the process of the art. If the 'patient [was] simply left to his own devices to cope as best as he can, then the procedure [was] no longer occupational therapy, but should properly be classed as recreational therapy' (Meares, 1961, p. 3). The role of the occupational therapist in the art process was one of 'symbolic love' and was particularly important given the isolation of the patient from usual personal relationships:

She must explain it to the patient; but before she can explain it, she must have some degree of emotional contact with him ... she must first establish rapport. It is this emotional relationship with the occupational therapist which is the main therapeutic mechanism which helps the patient to recover in true occupational therapy. This is something very important. It becomes more obvious if we consider the basic psychological situation of any patient in hospital. He is more or less isolated from his family and from those from whom he normally receives emotional support. His dependent needs are thus not fully satisfied. In addition to this there is an element of guilt, a feeling of having let the others down. This often provokes the patient to wonder, 'Why should this happen to me?' This may bring him to dwell unduly on various short-comings of his past life. The emotional contact with the occupational therapist represents symbolic love, and in these circumstances, it is the effective psychological mechanism in helping the patient. (Meares, 1961, p. 3)

The psychiatrist using art allocated the occupational therapist a powerful role in this psychodynamic process. He (i.e. generally a male psychiatrist) expected the occupational therapist to have knowledge of the importance of the relationship,

and, more particularly, to be able to incorporate the activity into their interpretation of the prescription for OT in the individual's case. Using an activity provided a more powerful mechanism than words alone:

One might ask, 'if symbolic love is the effective psychological mechanism, why worry about painting or modelling? Why not just have the occupational therapist talk with the patient?' The answer is simple. The painting or modelling merely provides a situation which gives a background that allows the easy operation of this mechanism. The fact of doing something with the patient greatly facilitates matters ... helping the patient with his work is a form of giving, of giving affection or symbolic love. (Meares, 1961, p. 4)

#### **5.2.5.3 'Specific' OT.**

In addition to the art therapy directed by psychiatrists, occupational therapists used other activities as part of treatment for patients referred for specific therapy to treat conditions. 'Systematic desensitisation' programs were designed by psychiatrists for implementation by occupational therapists to treat phobias or obsessive conditions. Using an 'anxiety hierarchy', the occupational therapist encouraged the patient to start with the least stressful part of a routine task before graduating, step by step, to the desired outcome. For example, to resume shopping using public transport, the first steps might be to walk along a short section of road accompanied, before attempting to walk along and then cross the road alone. Shopping might start with purchases at the hospital kiosk, then move to using public transport to visit a larger shopping centre, first accompanied, then later alone. The patient would not progress to the next step until the previous one was completed with comfort (Woods, 1962).

OT also involved other psychological techniques directed by psychiatrists, including 'conditioned inhibition' and 'conditioned avoidance', in which undesired physical movements or spasms produced by the patient were 'inhibited' by use of electrodes and a low voltage electric shock (Woods, 1962). Occupational therapists explained this as OT by the use of activities, such as writing, that related to the behaviour being encouraged or inhibited.

#### **5.2.5.4 *The therapeutic process linked to OT.***

Despite the importance of the activity as the central component of OT, emerging practice of this decade acknowledged the *therapeutic process* as being more than the activity itself:

occupation is not the key word, but attention must be paid to 'modified and properly presented' ... we believe that a properly presented program of occupational therapy will effect improvement in chronic mental hospital patients. (Lindsay & Honey, 1960, p. 17)

OT was seen to promote more meaningful lives by reinforcing healthy thoughts and behaviour, creating a sense of belonging, increasing self esteem and developing connections with the world outside the institution. Initially this work began within the walls of the institution, although occupational therapists found ways to bring the 'outside' in. Relatives were encouraged to visit, to see the products of OT; and often items made within OT departments were offered for sale, partly to fund materials for more activities, partly to display the skills of the patients (Lindsay & Honey, 1960).

#### **5.2.6 Looking beyond the walls.**

##### **5.2.6.1 *Stepping into the community.***

With their deliberate distance from local communities, asylums were often set apart from their suburbs, or towns. The size and grandeur of buildings and high walls created a sense of awe and mystery, yet institutional administrators were keen to make links with the outside community. Many asylums held social events, some of which included invitations to community members. In earlier years, there had been dances and regular sporting events involving patients in teams playing against 'outside' groups (Bircanin & Short, 1995). Hospital auxiliaries, established in earlier decades, also brought the larger world into the institution, raising money for the purchase of amenities and visiting patients. The sixties brought a greater realisation to asylum staff that many people were deeply affected by the many years of institutional care and that significant numbers of people had no substantial contact with the outside world, 'normal' daily routines or everyday activities. Occupational therapists took an active role to 'bridge the gap between the hospital and the community' (VAOT, 1961, p. 14).

For many patients, this could not occur until they had taken part in 'small reactivation groups', often involving several months of activity to 'stimulate motivation and socialization as the first step in rehabilitation' (VAOT, 1961, p. 14). Most groups were held in ward settings until participants could cope with attendance at one of the OT departments, before being included in outings and shopping trips. Later in this decade, early steps were taken to allow patients to spend daytime hours in the community then return to the institution for meals and sleep. This extended the previous practice of patients having a 'working day' within the institution, and was known as 'extra-mural' occupation (Govan, 1969).

#### Text Box 5.2 Work beyond the walls

*At Lakeside Hospital in Ballarat, a new program focussed on 'extra-mural occupation'. During what were weekly meetings to discuss 'means of occupation and problems therewith', an idea arose of work that would foster links with the community. This proposal was primarily as a step to further rehabilitation into the community, while still maintaining a supportive link with the hospital. Working in the community could also mean that 'the community too could profit, gaining a better knowledge of patients from the hospital, and at the same time receiving benefit of some useful service'. The program required support of the Trades Hall Council to ensure that encouraging patients to work would not 'interfere with the labour market' and also drew on support from the Apex Club of Ballarat and the Association of Civilian Widows, who were the first group to benefit from assistance provided by patients. The program subsequently spread to other groups within the community. Patients used public transport (trams) to go to work carried out within the program and some later progressed to outside employment. (Govan, 1969, p. 26)*

#### **5.2.6.2 Day hospitals.**

As an addition to facilities for the residents of long-term psychiatric hospitals, day hospitals were a new development for mental health services during the 1960s. A structured treatment environment was considered necessary for people leaving institutions but for whom twenty four-hour care was considered neither necessary nor desirable. Support and contact with the service provided a range of therapies for those needing such services but not considered ill

enough for hospital care. The structure of day hospital programs varied depending on the approach adopted by the service. Some day programs were attached to long-term institutions, while others were established within hospitals linked to inpatient wards as part of the move of acute services to general hospitals. Occupational therapists shaped their interventions accordingly:

The occupational therapy programme, in keeping with the approach of the department of Psychiatry, emphasizes a passive technique ... there is no rigid programme with activities strictly time tabled for various days, or compulsory attendance or enforced participation of all patients. (Woods, 1962, p. 13)

Day hospital programs signalled a shift in OT approaches to treatment, and were the start of programs that emphasised patient interest and the beginnings of client-centred practice that emerged in subsequent decades. Occupational therapists began to shape their knowledge around community-based everyday living situations and the skills required by patients for living in the community.

#### **5.2.7 Review of 1960s: growth in professional practice knowledge.**

The 1960s were a time of expanding OT practice in mental health services and the emergence of practice knowledge that centred on the 'therapeutic relationship' established with patients. As occupational therapists looked beyond the confines of wards and high external walls, they sought greater depth and breadth to their practice knowledge. Crafts and other activities were extended to become a prescribed element of psychotherapy treatment. Occupational therapists were given responsibility to provide this treatment under the direction of psychiatrists. Psychoanalytical approaches to the treatment of mental illness created a specific area of knowledge for occupational therapists to develop. Art was used for a range of projective approaches, and occupational therapists were called on to assist in art-based therapy. In addition to activities, occupational therapists became co-directors or facilitators of psychodrama techniques, extending their knowledge base to include psychotherapeutic techniques. Some occupational therapists began use of techniques such as electrical stimulation as part of conditioning programs.

While described as a treatment, minimal written critique of the techniques appeared and no evaluation of effectiveness or otherwise was reported.

During this decade of practice OT departments became a focus of practice. Specific space for OT was an important symbol for emerging practice knowledge. OT departments were the centre of occupation within the institution: the physical space where occupation occurred. The daily program with the OT department established routine, set expectations for behaviour of patients and generated the range of activities to be undertaken. In addition, these departments offered support and supervision for staff through administrative and mentoring arrangements. The core of OT practice knowledge, therapeutic activity, was demonstrated through the tangible output of the department.

Tangible outputs included the products of 'industrial therapy', already by the 1960s a traditional area of OT practice, following developments in UK and Europe. Industrial therapy offered opportunities to expand productive occupations and recognised the contribution of psychiatric patients to the community work ethos. Occupational therapists sought to expand their knowledge and scientific applications to industrial therapy with measurement of performance and evaluation of patient characteristics in the work environment, mostly with the aim of extending productivity.

The developments and changes of the 1960s had significant ramifications for the knowledge base of OT. Occupational therapists started the decade looking out from inside the walls of psychiatric hospitals, but rapidly took their work *beyond the institutional walls*. Discussion groups, shopping, cooking and a broader range of recreation were introduced to the OT activities repertoire. Traditional craft activities were supplemented with a range of techniques including relaxation, social outings and films. Throughout this decade, occupational therapists were constantly required to extend their knowledge; but the traditional use of crafts and activities for treatment remained firmly in place. Students were required to demonstrate competence in a range of crafts and be familiar with their application to diagnostic groups. However, changes in



psychiatric care, including new drug regimes and the growing acceptance that effects of institutionalisation were detrimental, led occupational therapists to rethink how people developed the capacity to function; and they came to realise that people had the potential for more independent, 'normal' lives despite illness or disability. Reactivation approaches developed into rehabilitation, creating opportunities for occupational therapists to extend their practice yet again and seek new possibilities. Therapy extended beyond the notion of crafts being used for the development of individual routines, for relief of boredom or for reactivation from an inactive existence within the hospital environment. Occupational therapists became promoters of independence, increasing living skills, developing scientific measurement and becoming active participants in psychotherapy treatment programs. The training program now incorporated a 'scientific' component of activity as the core of treatment and consolidated OT within a medical model of practice.

### **5.3 Occupational Therapy Practice in Mental Health Services in Victoria, 1970s**

#### **5.3.1 Changing administration of public mental health services during the 1970s.**

During the 1970s the administration of public mental health services in Victoria was influenced by changes occurring at both state and federal government levels. In Victoria a new agency took over administration of mental health services. State legislation enacted in 1977 (the Health Commission Act 1977, No. 9023) led to the Victorian Health Commission being established in 1978. The Commission assumed administration of all services previously the responsibility of Department of Health, the Mental Health Authority, the Commission of Public Health and the Hospitals and Charities Commission.

Funding to mental health services also came from Commonwealth programs, established in 1973 to foster the development of community health centres. The Community Health Program aimed to create locally managed, multidisciplinary health centres that would respond to a range of health problems, as part of a coordinated national network of services for primary health care. Allied health positions were created in greater numbers for community services, so

occupational therapists could take on new positions, particularly in community-based teams. The major public employer of occupational therapists working in mental health remained the ten psychiatric hospitals located in Melbourne and across three regional areas, as described in Chapter Five. OT departments established during the 1960s continued to be the professional base for practice, with management by Chief Occupational Therapists.

The decade also saw the beginnings of diversification in the management of OT practice. Further positions were created within acute services established in general hospitals. While these positions were administered through the OT departments of the general hospitals, occupational therapists also became part of multidisciplinary teams. Community health centres funded by the Community Health Program created opportunities for the expansion of OT practice and the creation of positions not directly within the structure of an OT department.

### **5.3.2 Occupational therapy education and research in Victoria during the 1970s.**

Significant educational developments in the tertiary sector occurred during the 1970s in Victoria. In 1972 approval was given by the Victorian Institute of Colleges for the commencement of the Bachelor of Applied Science (Occupational Therapy), phasing out the original Diploma awarded by the School (Cameron, n.d.). The development of a bachelor degree program created two levels of qualification within the profession. The School developed a 'conversion' program to degree status for diploma graduates prior to 1973 who chose to complete study on subject matter not previously covered in OT studies in Victoria.

In 1975, the three separate schools of OT, physiotherapy and speech therapy, were administratively 'dissolved' and re-established as the Lincoln Institute of Health Sciences, offering bachelor degree programs in these areas (Mocellin, 1978). Towards the end of the decade, diploma courses in prosthetics and orthotics, medial record administration, orthoptics and chiropody were added. Lincoln Institute and the College of Nursing amalgamated. A postgraduate

course in rehabilitation studies commenced in 1978, and work began to develop masters level programs for practitioners, including OT.<sup>9</sup>

In comparison to earlier times in which the majority of the students were female, and fee-paying, the 1970s brought significant changes in the makeup of student cohort, influenced by introduction of free tertiary education. Higher numbers of mature-aged students enrolled in university courses, some of whom had not completed formal secondary education, changing the mix of student groups. OT programs also recorded an increase in the number of male students, although not enough to significantly change the make-up of the profession. Lincoln Institute increased staff numbers in each school and student numbers through larger annual intakes. Continuing workforce shortages in all paramedical areas, including psychiatric services, influenced the growing demand for increasing course intakes. This was rapid change, with the intake increasing from sixty in 1975 to 110 in 1977; fifteen of these were male (Mocellin, 1978).

The move to Lincoln Institute signalled identification of OT as a 'health science', although the course was keen to maintain a 'vocational' focus in that it aimed to produce graduates with a range of practical skills ready for immediate application to their work (Mocellin, 1978). Introducing a bachelor degree program in OT required increased study in behavioural sciences, added research methodology and changed the nature of students' assessable tasks (Mocellin, 1978). Many previous educational approaches in the OT program were retained in the degree program: for example, in the first year of study students were introduced to a range of practice areas, including visits to psychiatric hospitals. During these visits of up to half a day, students were to observe OT practice, meet patients and learn about the importance of communication between the professionals who made up the clinical team in psychiatric practice (School of Occupational Therapy, 1979).

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<sup>9</sup> These postgraduate courses were for ongoing education; graduate-level entry programs emerged in later decades.

Mental health components of the course included lectures, predominantly delivered by psychiatrists, building on early learning in psychology subjects. In line with the overall curriculum approach of early and increasing exposure to clinical areas, fieldwork in mental health commenced early in the course with first-year students allocated to one of the large psychiatric hospitals to be part of activity groups:

Each week for part of the term we were responsible for choosing a group activity and in groups of four, we went to the locked ward to run the group. We arrived, walked what seemed like miles across the grounds to enter the old building with its lino floors, high ceilings and drab, plain walls. We tried games, painting and play reading ... a little daunting at first, but we felt safe, it was fun. (OT: CC 9)

### **5.3.3 Occupational therapy practice settings during the 1970s.**

#### **5.3.3.1 Institutional settings.**

OT departments in psychiatric hospitals continued to deliver programs based on prescribed activities and group interaction. Rehabilitation units became a stronger focus of long-term psychiatric institutions as ongoing developments in medication created opportunities for patients to move beyond custodial environments. Even if the institution remained their residential base, patients were permitted to leave the environs on a daily basis, for either work or organised programs.

Larundel Hospital's rehabilitation unit, in existence since 1958, catered for long-stay patients, the majority ranging in age from 18–65 and with diagnoses of chronic schizophrenia. The focus of rehabilitation in the early years of the 1970s was to 'reactivate' patients who had been hospitalised for many years but had not participated in rehabilitation during the 1960s. If they had been part of earlier rehabilitation programs, they had not yet reached the level of function to permit a degree of independence. This group of patients was considered a challenge: needs were higher and the effects of institutionalisation more noticeable.

In addition to the general program, a 'total push' program was introduced, 'geared to activate patients to the maximum degree and to force patients into shared activities, with an accent on group participation' (Graves, Kahans & McGrath, 1970, p. 8). 'Total push' programs, based on work in the USA, were not a new concept, having been used in long-term psychiatric institutions since the 1930s (see Tallman, 1954; Tillotson, 1939). They were used in Victorian psychiatric hospitals as a means to reactivate long-term patients as policy directions continued the move towards less restrictive environments of care, either living in the community or with more freedom to be active within an institutional setting.

The rehabilitation unit became a focus for day programs for patients coming from several wards (often called the 'back wards', reflecting the distance between buildings and the forgotten nature of people living for many years in psychiatric hospitals). Programs offered in the rehabilitation unit were geared to provide a high level of activation and to stimulate new learning. Requiring patients to participate in group activities was considered a strategy that could create greater personal awareness at an individual level and foster traits such as cooperation and social skills. All activities of the day were incorporated within the program; so, for example, morning and afternoon teas became structured opportunities for socialisation (Graves et al., 1970).

#### ***5.3.3.2 General hospitals: acute services.***

Extending hospital-based services, OT practice settings expanded early in the 1970s as the trend for psychiatric practice moved 'away from the traditional "mental hospital" and towards community-oriented treatment such as day centres and psychiatric service in general hospitals' (Bailey, 1971, p. 13). At the Austin Hospital in Melbourne, a psychiatric unit commenced with a focus on crisis intervention, aiming to provide treatment close to the community setting of patients. Advantages perceived in this approach included linking other medical care to psychiatric intervention where required by patients, removing the perceived stigma that admission to a mental hospital brought to the individual, and allowing easier transition back into family and community life. The occupational therapist was a member of a multidisciplinary team in an

environment based on 'therapeutic community' principles, meaning that ward activities and group processes were used to assist patients to gain an understanding of their emotional problems. The therapeutic community approach aimed to facilitate communication, creating therapeutic relationships between patients and staff. Hospital-based services brought different patient groups under the aegis of mental health services with an increase in diagnostic groups, including 'middle aged housewives, prone to overdoses when crises occurred' (Bailey, 1971, p. 15).

Regional psychiatric services were developed to provide care close to home communities rather than hospitalisation at a distance. Outpatient, crisis intervention and consultative services were established early in the 1970s, usually linked to acute hospitals which offered inpatient and outpatient services to the region. These services were generally implemented by new teams of staff coming together from diverse areas of practice. Working in the new care environment presented challenges as the staff members learned to work together in new ways, adapting to the changing approaches to care (Bomford, 1976). Crisis intervention in particular was an area identified as requiring new skills amongst the staff team, including support staff and hospital administrative staff. This was a new area of practice for occupational therapists, but one in which they saw the profession having 'a major role to plan, most effectively applied in group psychiatry' (Bailey, 1971, p. 17).

#### ***5.3.3.3 Community health approaches.***

By the mid-1970s major changes had occurred with the siting of services within communities not directly linked with hospital-based services. Many were shop-front services, or were located in houses located near other community facilities. The Melville Clinic in Brunswick, opened in 1975 and administered by the Victorian Mental Health Authority, was based in an inner urban area; the team of eighteen professional staff, including three occupational therapists, was responsible for the initial assessments of referrals or people presenting directly to the clinic, as well as for ongoing management. The approach represented 'a departure not only from the traditional medical model but from specialist roles

and the mystification that often accompanies specialization' (Kewish, 1979, p. 133).

#### **5.3.4 Occupational therapy intervention.**

##### ***5.3.4.1 Occupational therapy as part of rehabilitation.***

Within the OT departments of the large institutions, activities continued as the main focus of OT intervention. OT was part of the program for chronic patients and included industrial work and craft activities (Graves et al., 1970). Within the total push or reactivation programs, occupational therapists devised weekly programs, with a core of industrial work around which other sessions were arranged. Industrial work was chosen as the main activity as it 'provided for the repetition of a well-known and simple activity ... and also for the learning of a series of new and more complex industrial tasks' (Graves et. al., 1970, p. 8). Broadening of industrial work changed earlier approaches that had meant many patients were assigned a single repetitive task that might be undertaken day after day. Recognising the value of variety, and of building and extending skills and patient responsibility, were slowly incorporated into work programs.

Other activities were designed to meet aims within the treatment process. Carpentry, while requiring physical and cognitive skills, was also used as a means to produce a personal item that could be kept: a new concept for many residents of institutions. For many years patients had been clothed in basic uniform-type clothing provided by the hospital; they shared basic personal items such as toothbrushes and had no personal private possessions. An early OT task was to encourage new, less institutional clothing and individual personal care items (OT:CC1). Cookery programs set up by occupational therapists provided opportunities for 'individual and group achievement in addition to opportunities for socialisation' (Graves et al., 1970, p. 9). Daily routines were also extended, and a range of new activities introduced. Sporting groups and expressive movement sessions were aimed at increasing mobility and group shopping trips took patients beyond the hospital environment, for those who had not previously had access to these activities due to their level of disability. Group discussions and play reading in the wards where people previously considered not suitable for rehabilitation, were instituted as a way

for 'arousing patients to a higher level of social participation' (Graves et al., 1970, p. 9).

In acute settings, occupational therapists were required to have competent knowledge of and skills with crafts and to know how to include these for use in psychotherapy treatment; and to make distinctions between the ways in which they used activity, as was discussed in the previous section. In group settings, art became a medium specifically used to provide a forum for discussion of feelings, as an aid to diagnosis and to record patient progress. Other activities were also used to create group dynamics, again to foster discussion and interaction. For these aims, the occupational therapist's choice of activity was important. Activities that required 'no instruction, previous learning or skill and little concentration' (Bailey, 1971, p. 15) were chosen so that patients, while seemingly engaged in the activity, were free to concentrate on discussion of the issues or circumstances that brought them to the hospital ward. These activities, while perhaps seeming unimportant, were in fact vital to contributing to the mood of the ward, promoting a 'relaxed informal atmosphere and something to do with acting out' (Bailey, 1971, p. 14).

#### ***5.3.4.2 Activities of daily living and community life.***

The decade of the 1970s continued the move away from craft-based approaches to OT intervention and towards activity-based approaches. Occupational therapists sought new ways to address rehabilitation aims as well as to foster community spirit, a sense of belonging, and a capacity to interact with others, as was necessary in the effort to create more community-based care. Two new approaches were introduced in these long-term settings, moving away from the traditional activity regime. First, building on previous approaches for a balance in daily routine, occupational therapists extended their use of activities beyond craft to the knowledge and skills required for living in community settings. Activities of daily living were a new venture, and proved to be one of the most meaningful to patients. Sessions included not only activities intended to help the patients achieve independence in personal hygiene and improvement in personal appearance; but to help the patient to establish an identity as a citizen by providing instruction in the use of money and holding discussion sessions on



current affairs (Graves et al., 1970, p. 9). Second, recognition was given to broader personal activities, using group discussion methods rather than one-to-one therapist instruction:

A further session devoted to discussion centred around pre-selected topics such as films seen, T.V. programmes viewed, outings preferred and selected hobbies, and also included topics of a more personal nature, such as “making friends”. A session was devoted to recreational activities [and] interior decoration and music sessions provided opportunities for creative expression. (Graves et al., 1970, p. 9)

#### ***5.3.4.3 Occupational therapy as part of therapeutic communities.***

In community-based settings, OT practice knowledge was influenced by the constraints of the new environment and the treatment approaches adopted within them. Occupational therapists found different ways to use activity in settings that did not have the environment of an OT department. In the ‘therapeutic community’ approach adopted by inpatient services, patients were usually expected to dress in street clothing each day, to participate in general ward duties and to use free time to ‘leave the hospital to make arrangements about accommodation, employment or to do shopping’ (Bailey, 1971, p. 15). The structured ward treatment program included activity-focused groups arranged by the occupational therapist, and involved creative activities to encourage verbal interaction and non-verbal expression as part of the psychotherapeutic approach. Art groups were used as a regular part of the program, with patients encouraged to use their work to ‘free associate about their own paintings and to make interpretations about other patients’ work’ (Bailey, 1971, p. 16). Work produced formed part of a patient’s record for use in diagnosis and record of progress. In therapeutic community approaches OT practice knowledge evolved to focus on interaction with patients, communication methods and reinforcement of patient responsibility and participation in treatment.

#### **5.3.5 Occupational therapy treatment approaches.**

##### ***5.3.5.1 Behavioural therapy.***

Behavioural therapy techniques were also used by the occupational therapist, in both group and individual work, to encourage modification of behaviour in

everyday life situations. Activities used as part of this process included relaxation techniques and graded outings, using desensitisation approaches to situations that were problematic for the patient (Bailey, 1971). Using these techniques continued the trend of the previous decade for occupational therapists to align their interventions with psychological, psychodynamic and other therapeutic treatments, reinforcing the link with medicine.

#### ***5.3.5.2 Multidisciplinary approaches.***

By the end of the 1970s significant changes had occurred in the approach to OT activities for therapists working in early intervention programs based in community settings rather than in hospital-based services. Occupational therapists became part of the 'front line of assessment of new cases and usually in their continuing management, arranging for the involvement of other team members as needed' (Kewish, 1979). This team approach to care resulted in a 'blurring of professional roles [and] a high degree of cooperation among staff' (Kewish, 1979, p. 133). Occupational therapists were required to take part in initial assessments and a range of group programs, with the aim of sharing skills across staff within the team. The use of activities in treatment was not seen as the sole domain of the occupational therapists, nor were other clinical approaches located within specific disciplines. All team members were encouraged to contribute to activity groups with the help of the occupational therapist, who in turn was involved in such previously untouched areas as assertiveness training and psychotherapy groups (Kewish, 1979).

#### **5.3.6 Review of 1970s: 'scientific' practice knowledge for activities of daily living.**

The 1970s started with echoes of the 'institutional era' of mental hospitals. Thousands of people resided in long-term institutions, and occupational therapists continued reactivation, industrial therapy and activity programs. Community-based services continued to emerge during the decade, in the early phases of what would subsequently become major deinstitutionalisation programs. Occupational therapists sought close links with psychiatric medicine, continuing their involvement in psychotherapy and seeking 'scientific' approaches to OT intervention. Towards the later part of the decade, occupational therapists saw their practice as aiming towards promoting the

development of independent living skills while continuing as an adjunct to psychological therapies.

Moving patients out of psychiatric institutions created greater diversity in mental health practice, and OT roles in turn became more diverse. Living skills became a focus of therapy, and activities of daily living became a dominant theme for assessment and intervention. These living skills were those deemed necessary for life in the community for people who had not previously had to shop, work, keep house and make decisions about a daily routine. Occupational therapists expressed their belief in the balance between self-care, work and leisure, and incorporated this concept in emerging models of practice.

Community practice created opportunities to extend OT practice, and many therapists realised a knowledge base built predominantly on activity did not give them the knowledge and skills required to move into the community. The newly created 'unlimited scope' of community practice created both strengths and weaknesses for OT. While new areas of intervention were opened and occupational therapists were part of many innovative initiatives in mental health services, some practitioners saw the expansion as creating vague notions of what constituted professional practice, challenging the traditional core of knowledge required and used by occupational therapists in their mental health roles.

## **5.4 Occupational Therapy Practice in Mental Health Services in Victoria, 1980s**

### **5.4.1 Administration of Victorian public mental health services during the 1980s.**

At the beginning of the decade the Victorian Health Commission continued to administer mental health services through the Mental Health Division. The Commission commenced the process of regionalisation of health services with the 'Policy of Health Regionalisation for Victoria', setting the stage for the establishment of regional offices and District Health Councils to encourage community participation in the design and delivery of health services (Health Commission, 1980). Further governmental reorganisation of health services

occurred throughout the decade. In 1985, the Department of Health II was created, becoming known as the Health Department. Mental health service administration was transferred to the Office of Psychiatric Services within the newly formed Department.

Legislative changes occurred following enactment of the Mental Health Act 1986. The Act determined procedures for both voluntary admission to services and involuntary treatment within a community service framework, using a process by which *involuntary treatment orders* were independently reviewed by a *Mental Health Review Board*. Pre-empting the attention given to human rights issues in subsequent decades, the Act emphasised that

treatment should be provided in the least possible restrictive environment and in the least possible intrusive manner [and that] interference with the rights, privacy, dignity and self-respect of people with mental illness must be kept to the minimum necessary in the circumstances. (Mental Health Act, 1986)

OT services were administered through the Mental Health Division of the Victorian Health Commission, and subsequently through the Office of Psychiatric Services of the Health Department. Throughout these changes, the position of Occupational Therapy Advisor remained as coordinator and supervisor of OT services within hospital- and community-based services.

On a national level, ten per cent of occupational therapists practising in 1981 identified their work area as psychiatric hospitals, and a further ten per cent worked in health centres or community services (Taylor, 1983). Occupational therapists working in psychiatric institutions reported small increases in the number of occupational therapists employed in the period 1980–1981; occupational therapists in charge of departments reported inadequate levels of staffing (Taylor, 1983).

OT departments established in earlier decades continued as the main sites for OT programs at the beginning of this decade. These departments had a structure, determined by the Public Service Board of Victoria, of 'graded' OT

positions, representing levels of professional seniority. However, as the decade progressed many occupational therapists, previously working in departments, moved to 'multidisciplinary' teams within the community. An occupational therapist could be responsible to a team leader or coordinator from any of the disciplines represented, and often was the only occupational therapist on the team. The line of responsibility was to the team coordinator, with a discipline-specific structure for professional supervision. The senior occupational therapist within the Mental Health Division, subsequently the Office of Psychiatric Services, had responsibility for overall professional supervision and development of occupational therapists.

The professional association, the Victorian Association of Occupational Therapists, initiated a network of professional support groups within various OT practice areas. A 'special interest group' was initiated for psychiatric OT, to bring therapists together for professional development, the sharing of experiences and development of resource information, particularly for those therapists working as sole practitioners (VAOT, 1988).

#### **5.4.2 Occupational Therapy education in Victoria during the 1980s.**

##### ***5.4.2.1 Administration of tertiary education.***

At a national level, the delivery of tertiary education was reviewed during the 1980s. Parameters for review included the length of courses and the number of organisations within the sector. Proposals were made to amalgamate smaller education organisations within states, in particular amongst the colleges of higher education (Gamage, 1992). The Board and management of Lincoln Institute, adamant that the 'health science' nature of Lincoln Institute should be retained, rejected several proposals for mergers with other colleges of advanced education, primarily teacher education colleges. After discussions with the two major universities Melbourne and Monash, talks commenced in 1985 with the third largest university in the state, La Trobe, based at Bundoora. La Trobe University was sited on land originally owned, and mostly farmed, by the mental health hospitals of the Larundel and Mont Park precincts (Bircanin & Short, 1995). Agreement for a merger was made later in the decade, with the amalgamation of Lincoln Institute and La Trobe University taking place on 1

January, 1988. The Occupational Therapy School became the Department of Occupational Therapy, part of the new Lincoln School of Health Sciences, La Trobe University. Despite construction of new facilities on the Bundoora campus commencing soon after the amalgamation, the actual move of the Institute did not occur until well into the next decade.

While there was a growing demand for allied health education, and for OT, difficulties arose in recruiting qualified senior academics for the course. During the 1980s, the Institute, then the School, were initially unable to recruit to the position of head of school, nor to a professorial position that was created later (VAOT, 1989).

#### ***5.4.2.2 Undergraduate occupational therapy education.***

The 1980s heralded a further period of change for the undergraduate OT program at Lincoln Institute of Health Sciences. Student numbers continued to mount in response to calls for growth in health professions to address increasing need for staff within health care services. Eighty students commenced the undergraduate course in 1980; 139 in 1989 (VAOT, 1989). Similar growth in other courses housed in the Institute meant that facilities, particularly teaching spaces, were put under pressure. Arrangements were made to use space at a former convent in Abbotsford, requiring students to travel between campuses. Clinical placements continued to be a component of the undergraduate program, although given the increasing number of students the School reported difficulty in finding adequate short-term placements in mental health services suitable for introducing students to mental health early in their studies (Mocellin, 1984).

#### ***5.4.2.3 Curriculum design.***

The 1980s was a time of curriculum review and change. The first major area under scrutiny was the teaching of activity skills. Questions were raised as to whether teaching reflected the types of activities being used within practice. Changes were made to reduce the range of crafts taught and less emphasis on production of craft items by students. Instead, the focus was on activity analysis and the therapeutic process. Amalgamation with the University created a different impetus for change so that curriculum delivery would fit the semester

system. By the end of the decade the undergraduate curriculum was taught across four years, each with two semesters of thirteen weeks, and with a ten per cent reduction in contact hours for students (VAOT, 1988).

Until this decade, postgraduate courses were offered in the form of continuing education or short courses. During the 1980s, courses relating to mental health practice included movement, dance and dance therapy. Interest in the craft-related courses offered previously by the School began to wane, to the extent that continuing education courses did not always proceed due to lack of numbers when the topic was related to handcrafts like, for example, using natural dyes for colouring weaving materials (VAOT, 1988). In place of these short courses, the School proposed more formal postgraduate qualifications, starting with a Postgraduate Diploma in Occupational Therapy, accredited in 1983 by the Victorian Institute of Colleges. This course, however, did not proceed due to insufficient enrolments. Other postgraduate education options such as gerontology and family therapy were available to occupational therapists through other Institute courses. Later in the decade, preliminary planning commenced on the development of Honours and Masters programs in OT (VAOT, 1989).

The limited range of postgraduate education available to occupational therapists was seen as a restriction to the ongoing development of the profession, and specifically of the development of research that would inform new practice-related knowledge:

Occupational Therapy has been greatly disadvantaged in this country by the slowness of the controlling educational bodies to develop appropriate post-graduate courses. This has meant that therapists have had neither the skills nor opportunity in terms of time to carry out anything but very rudimentary research. (Farquhar, 1980, p. 22)

#### ***5.4.2.4 Student voices influencing education practice.***

At Lincoln Institute, students during the 1980s became more active in reviewing and influencing their education. OT students expressed their views on fieldwork placements in mental health settings through student membership of the

Victorian Association of Occupational Therapists. Regular surveys collected data on student experiences for the 105 OT students placed at Larundel Hospital in the final year fieldwork placements between 1979 and 1983. This group represented approximately one third of the OT cohort at the time. Between four and nine students were at the hospital at any one time, and worked across all areas where occupational therapists were employed (Mocellin, 1984). Students suggested that positive attitudes towards mental health practice were more likely to develop if students were given previous clinical experience in psychiatry through shorter introductory placements. They expressed a need for professional role models and adequate teaching of skills before being expected to take on clinical roles (Mocellin, 1984).

### **5.4.3 Practice environments: hospital and community.**

#### **5.4.3.1 Hospitals.**

During the 1980s significant numbers of people remained in psychiatric institutional care and continued to be a major client group for occupational therapists who worked with 'large groups of chronic, socially unskilled patients' (Mocellin, 1982). As already noted, large institutions remained the major employer of occupational therapists early in the decade, with a smaller number of therapists developing new programs in community-based practices. The 1980s demonstrated increasing diversity in OT practice settings in community-based mental health services.

As the decade progressed, the large psychiatric hospitals continued to close beds, although many still had significant patient numbers. Larundel Hospital, proclaimed a mental hospital in 1953 with 387 patients, had 640 patients in 1957 and over 700 patients by the 1970s (Bircanin & Short, 1995). By 1984, bed numbers had decreased to 550. The process of deinstitutionalisation accelerated later in the decade, resulting in large numbers of 'ex-patients' living in a variety of community-based accommodations. Acute psychiatric services remained within the larger institutions, although many were being established as specialised wards within general hospitals, with OT positions being created in some, but not all, of these settings.



#### ***5.4.3.2 Community settings.***

The early 1980s saw the continuing establishment of community-based programs for people with mental illness. A significant number of clients were ex-patients of hospital wards, relocated under deinstitutionalisation programs. Towards the middle of the decade, OT positions were well established both in community-based mental health services and in the general community health centres which were being established under the community health program funded by the Commonwealth Government.

In hospitals where regional services were being established, many staff moved from institutions that had struggled financially through the deinstitutionalisation phase. New facilities set up around the acute wards of general hospitals, involving outpatient clinics, day hospitals and community based residential and rehabilitation programs, were seen by occupational therapists as a positive move (OT:CC3).

#### ***5.4.3.3 Occupational therapy in the criminal justice system.***

During the 1980s a new area of practice was developed by occupational therapists with establishment of an OT service in the Victorian prison system. Two occupational therapists had been appointed at Pentridge Prison in Melbourne, as part of a psychiatric clinical services team in the late 1970s (Farnworth, Morgan & Fernando, 1987). OT was identified as having the potential to contribute to the rehabilitation of prisoners, as part of a team-based service that would support the work of psychiatrists (Bartholomew, 1976). In particular, occupational therapists were given the task of developing a focus on meaningful use of time for prisoners within rehabilitation programs. Prisoners in the psychiatric division of Melbourne gaol had been diagnosed with a range of mental illnesses or related characteristics, and the new program was to deliver a multidisciplinary approach of education, OT, psychology and nursing, on the recommendation of, and under the supervision of, a psychiatrist. Regardless of diagnosis, the majority of prisoners in the program were assessed as having 'a limited repertoire of coping behaviours and [showed] few basic life skills [including] deficits in areas of self-awareness, interpersonal communication, management of affect and major life roles' (Farnworth et al., 1987, p. 44).

Occupational therapists approached their role with the aim of developing competency in life skills among prisoners. Programs were designed around activities chosen according to individual needs and skills, selected to

help prisoners perceive a connection between their actions and the experience that may result from these actions. The therapist's role is to provide an environment where prisoners achieve success from their activities and to build on these successes to promote competent behaviour (Farnworth et al., 1987, p. 44).

#### **5.4.4 Activities and living skills.**

##### ***5.4.4.1 Extending tradition: therapeutic activities.***

Within institutional settings, many therapeutic activities of the 1970s were continued into the 1980s and remained as the main approach to OT intervention. Despite significant numbers of people leaving psychiatric institutions, many others remained within long-term hospital environments. Patients in long-term care required a different approach to intervention than those moving into community settings. They were generally lower functioning in terms of living skills, less able to cope socially and with limited financial resources. While they might have fitted with the previous routines of long-term programs, they were challenged by the new expectations of independent living (OT:CC1). With the move of significant resources to the community, occupational therapists within hospital departments were faced with keeping the institutional programs running as well as taking on community caseloads, often over large distances within a hospital's catchment area (OT:CC1).

Without the facilities and equipment of OT departments, newer services often had to modify techniques to supply traditional OT activities. For instance, rather than using traditional pottery techniques that required long production times and continuous management of resources, occupational therapists working with prisoners used pre-prepared moulds and slip-casting so that less skill was required to achieve a more immediate result (Farnworth et al., 1987). The diversity of ethnic groups and proportion of lower functioning patients within the prison population also required activities that did not demand a high level of

verbal skill: discussion groups were based around sport, music, films and newspapers with the aim of developing social skills. Occupational therapists also used 'techniques from psycho-drama, simulated games, problem solving and group interaction' to foster development of insight into behaviour (Farnworth et al., 1987, p. 45).

#### **5.4.4.2 Multidisciplinary practice.**

Early moves into the community meant that staff in multidisciplinary teams had to learn ways to work together. The core change occurring with community-based services was the introduction of 'case management' as the framework for the organisation of team functions. Occupational therapists joining multidisciplinary teams were appointed to case management roles involving initial assessment and organisation of treatment programs.

Text Box 5.3 In the community: a new work role

*I immediately went into a role of case manager, we used to call ourselves community worker then, and part of that was around what we did and part of it was around not particularly identifying with our profession it was that basically it was all hands on deck. We shared the duty intake so you'd be rostered on a day a week where you would be the first point of contact for screening the referrals. Work became quite generic what I could call welfare ... not necessarily due to social disadvantage, sometimes it was about difficult family situations. We interacted with everyone - GPs, police ... we were often the first point of call (OT: CC2).*

Along with the increasing diversity of practice settings, OT 'treatment' techniques continued to diversify during the 1980s. Occupational therapists were challenged by the changing client groups. In contrast to patients arriving at the department doors each morning from their hospital ward, with needs assessed, clients from the community arrived with many unique factors impacting on their lives and health. Many of those who had been 'decanted' from hospitals were living in sub-standard accommodation, and occupational therapists saw the effects of the poor housing, limited money to spend on food and clothing and limited personal resources to arrange necessary aspects of

community living. The one occupational therapist in a multidisciplinary team added to his or her role by addressing a range of such issues, either as a single practitioner or in conjunction with other team members:

I did basic counselling, sorting out issues with social security employment services ... I did individual relaxation therapy, a particular interest of mine and a couple of drop-in groups for men and women who lived in special houses ... one of the nurses and I did a basic craft time to socialise people ... I visited people at home, living skills ... it was very eclectic, I did a bit of everything. (OT: CC2)

#### **5.4.5 Review of 1980s: expanded and diversified practice knowledge.**

The 1980s was a time of continued diversification of OT practice in mental health services. Community-based practice was extended to roles within multidisciplinary teams and shop-front community health services aimed to bring services closer to communities, in contrast to the isolated hospitals of the past. As in the 1970s, occupational therapists were challenged to adopt new approaches to practice, often in contrast to traditional discipline and department-based services. Deinstitutionalisation and community-based services created significant changes in social responses to mental illness and occupational therapists began to draw on other fields of knowledge, moving beyond the familiar biological and psychological knowledge bases. Education programs reflected broader social sciences in curricula as undergraduate programs moved into 'health science' institutions.

New areas of specialty practice emerged during the 1980s, one of them forensic services, creating new institutional settings in contrast to the move to the community by other services. The expansion of mental health practice within prisons resulted in OT positions at Melbourne's major prison, providing scope for occupational therapists to work in this very traditional institutional setting. Occupational therapists drew on emerging practice models to develop and evaluate programs, establishing the use of theoretical principles applied to service design. So, while they were in the institutional setting, links with community were important, as described in later sections.

Within community mental health programs, occupational therapists continued to use activities, and extended the notion of 'activity' to include a range of exercises, group discussions and tasks designed to meet the characteristic needs of a specific patient group. Living skills were translated, from a focus on institutional living to survival in community settings. Occupational therapists saw their role for each client as being to contribute to self esteem, provide a sense of worth, and encourage worthwhile contribution to a larger social group through assisting clients to make connections with existing community activities or services.

By the end of the decade occupational therapists were in a position of some uncertainty. Economic restraints were threatening many Victorian mental health services, and occupational therapists still faced many challenges in their move to community-based services. They worked to strengthen OT theoretical perspectives and the rationale for practice, yet were unsure about the credibility of their knowledge base. Many sought further qualifications in specialist areas including family therapy, Gestalt therapy or psychoanalysis to enable a 'more credible' role as practitioners with a specific focus. Challenging work environments threatened professional numbers and strength in most community-based and remaining institutional mental health services.

## **5.5 Occupational Therapy Practice in Mental Health Services in Victoria, 1990s**

### **5.5.1 New directions for Victorian public mental health services.**

A significant change in the national agenda shaped Victorian mental health services during the 1990s. Ministers of health at state, territory and federal levels agreed on the adoption of a National Mental Health Policy (Australian Health Ministers' Council, 1992). The accompanying National Mental Health Plan (Australian Health Ministers' Council, 1992) established a national approach with the aim for States and Territories to implement consistent approaches to mental health services across a five-year period. The Plan required reform of existing services based in psychiatric hospitals and continued growth of community-based services. At a national level there was

recognition by the government that 'people with mental illness have traditionally been one of the most disadvantaged client populations in Australia' (Department of Human Services and Health, 1993). Attention was to be given to early intervention, promotion of mental health and involvement of consumers in the services they used. A second National Plan was released in 1998 for the following five-year period (Australian Health Ministers' Council, 1998). Consultation phases brought many perspectives into planning processes through involvement of consumer groups, people who experienced mental illness, carer groups and health professionals, including occupational therapists.

In Victoria, the Office of Psychiatric Services continued the deinstitutionalisation program, moving patients from major psychiatric hospitals to community-based residential services. The 1990s was a time of major reorganisation across the public sector, with government policy geared towards cutting many services across health, education and privatisation of transport and other utilities. The Victorian Department of Health and Community Services set its agenda for reform in *Victoria's Mental Health Service: The Framework for Service Delivery*. The main elements of the second stage reforms, implemented in the mid to late 1990s, were:

- Decommissioning of all remaining psychiatric institutions.
- Replacing these services with a system of 'mainstreamed' inpatient mental health services (collocated with general hospitals or general aged care services) and community-based assessment, treatment and support services.
- Grouping of services into area mental health services (AMHS) across Victoria, each of which provides a range of services – covering both inpatient and community clinical treatment, and disability support – to a defined geographic catchment.
- Prioritising services for people with 'serious mental illness' and/or significant psychiatric disability. (Department of Human Services, 2002, p. 5).

Reinforced by the National Mental Health Plan, psychiatric services in Victoria continued the process of change during the 1990s, developing new services in community settings. The primary aim of regionalisation was to establish specialist psychiatric services within mainstream health facilities and to surround acute hospital services with an integrated system of crisis, assessment and treatment teams providing 'mobile' support near where patients lived (Bircanin & Short, 1995). Many of the large psychiatric institutions of the previous decades continued to reduce inpatient capacity, although still retaining services for those assessed as not yet ready for community living. OT departments closed as part of the deinstitutionalisation process, and occupational therapists moved to community settings.

Community-based services established from previous hospital services kept links with those hospitals, with the OT department seen as a 'parent service' for those in the community (OT: CC2). The senior occupational therapist at the OT department was a supervisory or support link, through which ongoing educational and support opportunities could be accessed. Other, new, services were established within general health services, with no supervisory or support structures. Occupational therapists reported to 'team leaders' who could be of any profession represented in the team, or worked in 'generic roles', taking on the newly emerging case management function that shaped the community approach to mental health care. In the process many positions were abolished, and a drop in the number of occupational therapists working in public mental health services was reported. Other services were also under pressure to justify positions in the face of general budget cuts (Clarey & Felstead, 1990).

## **5.5.2 Occupational therapy education in Victoria during the 1990s.**

### ***5.5.2.1 Expanding undergraduate educational programs.***

With the formal merger of Lincoln Institute of Health Sciences with La Trobe University in 1988, the major program for undergraduate OT continued in the newly formed Lincoln School of Health Sciences, the tenth school to be created at La Trobe. The OT course was still located at the Carlton premises, with some teaching occurring at Bundoora and the Abbotsford site while planning was

under way for buildings to accommodate a final move to the Bundoora campus (Gamage, 1992).

A second undergraduate program commenced in 1994 at Charles Sturt University (CSU) in Albury (Fortune & Adamson, 1998). Although gazetted as a university in New South Wales, the CSU program attracted a significant number of students from Victoria, and drew on clinical organisations in that state for fieldwork placements. Mental health was reported by students as well covered in the curriculum, especially during the final two years of the course. Despite recognising mental health as a possible area for practice, few students expressed this as a preference for the first position for which they would apply (Eldridge & Manderson, 1998).

#### ***5.5.2.2 National planning for education of practitioners.***

While postgraduate education remained a priority for development within the profession, limited opportunities existed beyond in-service and continuing education programs. No formal postgraduate qualifications were available in mental health for occupational therapists, although some therapists continued postgraduate education in specialist areas of psychiatry.

The issue of further education of mental health practitioners was raised at the national strategic planning of mental health services. The Commonwealth Department of Health and Ageing, in conjunction with the Australian Health Ministers Advisory Council National Mental Health Working Group (AHMAC NMHWG), sponsored a national study to investigate the educational needs of those disciplines making up mental health services. The resulting report, *Learning Together: Education and Training Partnerships in Mental Health* (Deakin Human Services Australia, 1999), identified OT as one of the five main disciplines by size of workforce within direct care services and operating within mental health services. OT was the smallest of the five, which included registered nurses, psychologists, social workers and consultant psychiatrists. The OT profession through its professional organisation, OT Australia participated in the consultative processes of this study, identifying attitudes, knowledge and skills relevant to OT practice in mental health services and using



them as a basis for development of competencies for practice in mental health in the following decade (Ciolek, 1999). Short courses and in-service training remained the common forms of continuing education for occupational therapists.

### **5.5.3 Practice settings for occupational therapy.**

#### ***5.5.3.1 Hospitals and centres.***

OT departments remained in institutional settings during the decanting of patients into community-based residences or smaller institutional settings. Specialised services that had emerged during the 1970s, such as drug and alcohol addiction services, continued to operate with inpatient and outpatient services. Pleasant View Centre, a service for drug and alcohol addiction, moved away from the 'hospital' name, adopting 'Centre' instead to fit a broader range of services and using a 'psychosocial' model for service. OT programs at the Centre also adopted a psychosocial frame of reference to shape programs, to 'use activity therapeutically' (Clarey & Felstead, 1990, p. 87). In this addiction service there were three full time OT positions, with forty six inpatient beds, outpatient programs in a therapy centre and a drug program offering day and evening sessions. Occupational therapists worked within a multidisciplinary team but retained the space of an OT department for individual and group activity programs.

#### ***5.5.3.2 Community and non-government organisations.***

The growth of community mental health services, which commenced in the 1980s, continued through the subsequent decade. OT positions were transferred from hospital settings to the newly established area-based community services. In Victoria, the newly adopted structure for mental health services created distinct programs, dividing funding between 'clinical services' and 'psychiatric disability rehabilitation and support services' (PDRSS). The community health sector also expanded to include non-government organisations supported by a mix of State and Commonwealth funding to establish a range of services including residential support, employment skills training and support for job finding, recreation, respite for carers and education programs for clients, carers and the community. In Victoria, these community

based services were linked through a peak body, the Psychiatric Disabilities Services of Victoria (VICSERV) which acted as a coordinating, lobbying and support group representing the non-government sector.

#### **5.5.4 Occupational therapy intervention.**

##### **5.5.4.1 Activities and groups.**

Crafts used in institutional programs of previous years were transferred into some community settings. These craft activities tended to be 'lighter', not requiring investment in machinery and equipment, and included art, pottery, screen printing, woodwork, sewing, jewellery making and leatherwork. Activities were used individually, but more specifically in groups in order to facilitate social interaction and to use group dynamics to support therapeutic goals:

The occupational therapist has training and expertise in both activity based groups and other problem solving groups. Activities may be usefully employed in discussion groups as a 'warm up' or as a means of expressing feelings ... For the less verbally skilled client, activity can be an important medium for the expression of thoughts, feelings and behaviours. (Clarey & Felstead, 1990, p. 88)

OT programs continued their emphasis on learning to return to pre-treatment living arrangements, and activities assessed cognitive and perceptual skills in order to 'promote return of cognitive competence, concentration and eye hand coordination' (Clarey & Felstead, 1990, p. 87). Using activities, occupational therapists were able to test performance in areas such as concentration, reality testing, organisation skills, accepting and following directions, initiative and problem solving, manual skills, self esteem and frustration tolerance. Activities were categorised according to the characteristics likely to provide the desired skill being tested.

##### **5.5.4.2 Living skills.**

By the 1990s living skills were established as an important part of psychosocial OT programs. Occupational therapists divided tasks into discrete areas according to the nature and purpose of the required skills. For example, 'self

care' included tasks needed for personal hygiene and grooming, while other daily living requirements included meal planning, shopping and cooking. Other skills related to personal interaction, communication and social skills (Clarey & Felstead, 1990). Developing a balance of both work and leisure also became a focus of OT programs, and included job retraining and developing leisure interests and skills. OT intervention in these areas aimed to develop aspects of daily living for the individual that might not previously have been part of life because of a mental health condition such as addiction (Clarey & Felstead, 1990).

#### **5.5.5 Review of 1990s: practice knowledge challenged by change.**

The 1990s for mental health services was primarily a time of continuing deinstitutionalisation and the development of community-based services. The national policy agenda drove change at state levels through the Commonwealth-State agreements established through AHMAC. While the national activity around mental health drew occupational therapists together at a national level, professional identity was challenged through the changes occurring at the service level. Many services faced economic restraints that impacted on the transfer of OT positions from hospitals into community-based teams; many occupational therapists became disillusioned with changing practices and moved away from mental health services. For those who did remain, or who joined mental health services during this time, practice settings became diverse and multidisciplinary in nature. Occupational therapists continued to augment their knowledge from other areas of psychotherapy and to develop specialist interests to extend the activity base of occupational therapy practice. Responding to deinstitutionalisation, they consolidated 'living skills' as a core area of practice knowledge. Conceptual models were developed around components of the 'activities of daily living'. As part of the direction to formalise knowledge, occupational therapists developed assessment processes to evaluate patient performance and to standardise reporting of OT intervention. Development of language to describe parameters of human activity and to delineate occupational therapy principles were an important part of the efforts to consolidate professional identity in the context of changing services and the loss of discipline roles in mental health settings.

## **5.6 Occupational Therapy Practice in Mental Health Services in Victoria, 2000s**

### **5.6.1 Administration of Victorian public mental health services during the 2000s.**

At the national level, national strategic planning moved into a new phase with the release of the Third National Mental Health Plan 2003–2008 and adoption by Commonwealth, State and Territory governments of the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (Commonwealth Department of Health and Aged Care, 2000). In Victoria, mental health services continued under the legislative framework of the Victorian Mental Health Act 1986 and mental health regulations (1998). A review of the Mental Health Act 1986 commenced in 2008, with a series of community consultations and a submission process. Victorian mental health services were situated within the Department of Human Services, until restructure of the department was announced in 2009.

Government policy was communicated through a series of plans to direct development and reform within services. The first of these documents, *New Directions for Victoria's Mental Health Services: The Next Five Years* (Department of Human Services, 2002) outlined restructure arrangements and strategies to extend community based services. Government policy was shaped by ongoing gaps identified in meeting demand for mental health services in the State:

Currently one in five people experience a mental health problem, with depression predicted to rise from the fourth to the second most common cause of global disease over the next twenty years. Growing service demand by consumers with more serious forms of mental illness, combined with increasingly complex consumer presentations, clearly indicate the need for a new stage in reform of the specialist mental health system. (Department of Human Services, 2002, p.1)

Two specific aspects of the policy are of interest in the broader contextual consideration of professional practice knowledge. First, the policy identified a need to increase consumer and carer involvement in services. For occupational

therapists, client centred approaches were a core tenet of practice. Second, strategies within the policy were intended to address workforce shortages, with the underlying belief that there were difficulties in attracting practitioners, including occupational therapists, due to an apparent 'image problem'. Specific steps were proposed to develop a 'campaign to raise awareness and improve the image of mental health careers in the general community and amongst nurses, social workers, doctors, psychologists, occupational therapists and other allied health workers' (Department of Human Services, 2002, p. 36).

Mental health services in Victoria continued to be divided into the two broad areas developed during the 1990s. Clinical services encompassed child and adolescent, adult, aged persons, and state-wide and specialist services. Within each of these divisions a range of inpatient and community-based services existed across regional areas. The second broad area was that of Psychiatric Disability Rehabilitation and Support Services (PDRSS) (Department of Human Services, 2006). With the restructure of 2009, mental health services moved to a re-formed Department of Health, in a division titled Mental Health, Drugs and Regions. The second report of the decade, *Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009–2019*, was released in 2009.

*Because Mental Health Matters* defined the state of mental health services at the conclusion of the decade for my study of OT mental health practice. Public mental health services aimed to provide a range of acute psychiatric services, psychosocial rehabilitation and support services under a design that was described as a recovery model. The government report; however, included a statement that mental health services continued to fall short of meeting the needs of the Victorian population, and that reform and development remained foci of mental health service administration. The closing context of OT practice for this decade, therefore, was within a model of psychosocial rehabilitation and recovery. OT mental health practitioners worked within a system that was failing to meet the goal of participation for clients:

A significant gap in access to mental health care currently exists in Victoria. In any 12-month period an estimated 44 per cent of Victorians with a

severe mental illness, and 54 per cent of people with a moderate mental illness, do not receive a service from either the public or private mental health system ... the failure to systematically intervene early in the illness pathway results in relapse that could have been prevented in many cases, and subsequently propels people to crisis and the need for costly interventions which often involve police, ambulance services and hospitalisation. Repeated relapse over time may lead to enduring psychiatric disability and significantly reduces the individual's capacity for social and economic participation (Department of Human Services, 2009, p. 93).

Practice environments for Victorian occupational therapists working in mental health services in the 21<sup>st</sup> century reflected directions set by the state government in response to ongoing implementation of national strategies. Occupational therapists could potentially be employed within any of the four subdivisions of Victorian mental health services, as outlined above and in Appendix 4, in either discipline-specific or generic positions. However, while multidisciplinary teams were well established in community mental health services, it seems that the early 2000s were still a time of transition following the major changes during the 1990s when services moved from psychiatric hospitals or centres to community-based services.

Services that were based within a region could have multiple teams spread across clinical areas encompassing acute, residential and community services and across broad geographic locations (Fortune, Maguire & Carr, 2007). Occupational therapists could be employed in any of the typical service structures, including continuing care services, crisis assessment and treatment services (CATS), mobile support and treatment services (MSTS), community care units (CCU), acute inpatient units and adult mental health rehabilitation units. Wages and conditions for occupational therapists were governed by enterprise agreements negotiated between the Government and the Health Services Union, and set out in agreements, such as the Victorian Psychiatric Services Agreement, 2000–2004, later reissued as the 2004–2007 and 2009 Extended and Varied Version agreements.

## **5.6.2 Occupational therapy education in Victoria during the 2000s.**

### **5.6.2.1 Entry level education.**

A second Victorian undergraduate program in OT was introduced at Deakin University in Geelong in 2002 (Courtney & Wilcock, 2005), followed by a third program that commenced at Monash University in 2005. Alongside its undergraduate programs, La Trobe University introduced a graduate entry program, Master of Occupational Therapy Practice, in 2004. Towards the end of the decade La Trobe University foreshadowed further changes with a proposal to introduce a new structure, a three-year Bachelor of Health Science with an accompanying program at masters level.

Influenced by the national mental health agenda and funded through a Federal grant, curriculum mapping exercises were undertaken during the first decade of the 21<sup>st</sup> century. OT programs participated in a review to investigate mental health inclusion in entry-level curricula. Concern was expressed that

mental health is only one of many areas competing for inclusion in a full curriculum. However, concern has been expressed about the ‘falling-off’ of mental health content in undergraduate curricula over the past few years. For example, employers of some new occupational therapy graduates have identified knowledge of assessments, models of care and the occupational therapy role in mental health, as areas that need greater attention in occupational therapy curricula. (Department of Human Services, 2009, p. 94)

### **5.6.2.2 Occupational therapy practice standards.**

In 2002, a series of practice standards resulted from the work of a project established under the Second National Mental Health Plan. This project, the National Practice Standards for the Mental Health Workforce (National Mental Health Education and Training Advisory Group, 2002), set out twelve Practice Standards for the five professions identified as key workers within mental health services: psychiatry, nursing, social work, psychology and OT. These Standards included upholding of personal rights of individuals, consumer participation in service delivery, integration of services and ethical practice. The national professional association for occupational therapists, OT Australia

participated in the development of practice standards by following up on the practice competencies and developing a position statement titled *Occupational Therapy in Mental Health* (OT Australia, n.d.). Summaries of the standards and competencies relevant to OT are presented in Appendix 5.

Two studies, funded by the Commonwealth Department of Health and Ageing, were undertaken by OT Australia to document the extent of mental health content in curricula of OT entry programs and to identify gaps that might exist in meeting the National Practice Standards for the Mental Health Workforce (2002). These standard setting exercises were part of a broader imperative across health care services that set an agenda of evidence-based practice. Early in the decade, occupational therapists responded to these moves with expressions of concern (Brandis, 2000; Lloyd, Bassett & King, 2002). Questions were posed as to the readiness of occupational therapists to work within the new practice contexts and to establish bases of evidence.

### **5.6.3 Practice settings for occupational therapy.**

#### **5.6.3.1 Comprehensive mental health services.**

By the start of this decade Victorian mental health services had been regionalised within a framework of what was intended to be a range of services available to people close to home, offering multidisciplinary teams primarily comprising the disciplines of medicine, nursing, OT, clinical psychology and social work. Services were divided into three main categories that were age-related and included acute and ongoing long-term support.

Acute and inpatient mental health services had moved completely from the large psychiatric institutions of the previous decades as the final stages of deinstitutionalisation aimed to create smaller, 'more home-like, less restrictive environments for patients requiring acute hospital based services' (Fortune & Fitzgerald, 2009, p. 81). These changes created new ways of working and challenged long held practices between disciplines. Occupational therapists within community-based teams adopted new roles to fit with directions in delivery of services, adapting to 'case management roles; to working within multidisciplinary teams and in partnerships with consumers and carers; and to



balancing the tension between specialist and generalist work tasks' (Ennals & Fossey, 2007, p. 11). They also recognised the role of OT in 'non-clinical' settings such as community-based rehabilitation, employment and recreation programs, many of which were funded under PDRSS programs (Mynard, Howie & Collister, 2009).

#### ***5.6.3.2 Institutional care: forensic mental health services.***

Within the community-based practice framework, institutional environments were maintained for distinct or specialised patient / client groups. Despite the move to primarily community-based services, institutions remained an environment of practice for occupational therapists, and specialist areas of practice knowledge were required. The forensic mental health service was established under legislation in 1986 to provide services for people within the Victorian justice system who were diagnosed with mental illness. Part of this service was a hospital (118 beds) situated in inner suburban Melbourne, which employed occupational therapists across its seven inpatient units. These occupational therapists worked within multidisciplinary teams in the acute and rehabilitation units. A strong discipline identity was maintained through a supervision and support framework, somewhat reminiscent of earlier institutional eras yet different in that the formal supervision processes were no longer through discipline structures (that is, no 'Chief Occupational Therapist'). Length of stay for patients within the institutional setting could be up to eight or nine years, so capacity existed for lengthy intervention programs (as compared to short stay acute mental health settings), with staff 'getting to know' patients for an extended time.

Although maintaining a link with past OT practice through both working behind the high walls and having underlying objectives of intervention, occupational therapists within forensic mental health services also embraced change in the structure and delivery of practice. Within the Victorian service, they shaped their work using the framework of the Model of Human Occupation (MOHO) (Kielhofner, 2008). Later, they blended their occupational approach with the 'recovery' model adopted overall within the service. Assessment tools linked to

MOHO were used, along with a range of other 'practitioner designed' assessments, as determined necessary to underpin OT intervention (OT:CC6).

Engagement in meaningful occupation was set as the focus of the daily routine of the forensic mental health institution. In contrast to earlier institutional times, the craft and activity areas and the industrial workshops were replaced by activities that were part of mainstream organisations. The tertiary education provider, TAFE, offered certificate courses within the institutional grounds and maintained a carpentry workshop. The YMCA operated a fitness and leisure program within the hospital walls.

#### Text Box 5.4 Describing OT practice within forensic services

*The focus of the hospital program, and in particular rehabilitation, was to facilitate transition to community living. At admission to the hospital initial assessment included identification of social background and the roles held by the patient in their social setting. Any links, for example within families, that can be realistically maintained became part of the patient's intervention program. Identifying and maintaining social links were considered especially important by occupational therapists. Rather than treatment being determined by the secure, restrictive hospital environment, individual needs were assessed and became the focus of the OT program. Occupational roles and interests are considered important, with a primary aim being to maintain any links possible with family or employers which are explored through occupational therapist contact. Keeping open a job for returning to, or maintaining a parenting role were part of the occupational links made through OT.*

*Transition planning could be a long process and occurred through transfer through various levels of secure ward, or unit, environments within the hospital. Issues like accommodation could appear on the intervention program up to a year before an anticipated move to living in the community as part of the service's community living program. Intensive rehabilitation occurred after transition through inpatient acute areas, and a series of high, medium and low security environments.*

*Occupational therapists described their role in this high security environment as one to facilitate opportunities for patients to test themselves:*

*... it's not about us, it's about them feeling confident that they can maintain their mental health ... juggling the balls of life as we call it, so juggling, testing themselves [managing] ... all of the stresses that surround them, being able to prove to themselves and say "that has been stressful, but I'm okay ... I don't have any warning signs and I'm feeling really well in myself despite the fact there have been stresses ...". (OT:CC6)*

### ***5.6.3.3 Practice within inpatient services.***

Within acute or inpatient services, occupational therapists were responsible for planning and implementing group programs, which might include morning discussion groups, and activity groups (Fortune & Fitzgerald, 2009). Aims underpinning these groups were to provide daily 'orientation' through updates of day and date, to set the framework for the day ahead and to 'engineer access to clientele, crack a joke, traditional meeting, I call it good morning re-socialise people' (OT:CC1).

Individual interventions included assessment and development of skills in basic self-care tasks like personal hygiene and meal preparation. Intervention was aimed at addressing aspects of illness, for example orientation in dementia, or assessment of the capacity for more independent living. For those patients with possible discharge options, occupational therapists were involved in planning the requirements for the possibility of living in a home or supported community setting (Fortune & Fitzgerald, 2009).

### ***5.6.3.4 Occupation in the community.***

Occupational therapists continued to face the challenge of transferring the occupational focus they maintained as the core of OT practice to community-based settings in the 2000s. For many clients, living skills remained a priority area of intervention. Even though they had not come from institutional living, many did not have the skills to maintain a living environment, to shop, cook, budget or work. Frequent periods of hospitalisation and insecure home environments added to the complexity of maintaining consistent living arrangements (OT:CC9). Community-based occupational therapists considered this a major area of OT input.

In community-based services that maintained discipline specific roles, occupational therapists aimed to retain their professional identity and the focus of their practice knowledge through use of 'occupational therapy specific assessments to measure change and goal attainment for functional performance' (Hitch et al., 2007, p. 221). They managed a dual approach to measurement of outcomes by using generic measures required by

administrative processes set at State and regional levels as well as the tools they chose to describe specific occupational therapy intervention.

Occupational therapists later in the first decade of the 21<sup>st</sup> century adopted a broad range of interest for OT intervention. In addition to living skills, they recognised recreation, work and social connectedness as important aspects of community living for people with mental illness. Having connections and occupational roles within the community had taken priority over earlier programs of participation within institutional settings.

#### **5.6.4 Review of 2000s: practice knowledge for interprofessional practice.**

By the end of the year 2000, all the major Victorian psychiatric institutions of the 20<sup>th</sup> century were closed. Alternative institutional settings had been established for acute services, forensic mental health and other specialised areas including aged and dementia services. Networks of community-based mental health services were established within Victorian urban and regional settings, with the aim of providing a continuum of assistance from acute hospital to rehabilitation and ongoing community support services.

Occupational therapists practised within these community-based settings. They translated their activity-based practice into interprofessional programs where the participation of clients in meaningful and productive occupations was the primary objective of intervention.

The most significant impact on professional practice knowledge during this decade was the integration of knowledge gained through research. Occupational therapists increased involvement in research about their practice. While influenced by the imperatives of evidence-based practice, especially within medical contexts, they challenged reliance on quantitative and measurement approaches to assert the value of qualitative approaches in the search for evidence about OT interventions. Reflecting the evolution of consumer-focused care models of service delivery, occupational therapists drew on theoretical practice models that incorporated client-centred approaches. Models consolidated the practice-based knowledge of earlier decades with 'person,

environment and occupation' confirmed as central concepts in a range of theoretical perspectives.

## **5.7 Conclusions: Practice Knowledge across Five Decades**

Occupational therapists in Victoria recorded their practices through publication in the national professional journal for more than seventy years. This chapter drew on these records to construct a text to describe OT professional practice across fifty of these years within the context of mental health services. Practice was recorded through descriptions of OT departments, the aims of treatment and measurement of intervention outcomes through evaluation processes. Reflection on the significance of OT as a component of services for people with mental illness was a key aspect of the records of practice across this time, and suggested issues of professional identity related to the capacity to articulate a clear rationale for OT intervention. The fifty years that were the focus of this hermeneutic study saw a progression from the asylum era of care for people with mental illness towards environments that promoted rehabilitation rather than custodial care and protection. The impact of these changes on practice knowledge was significant. From a treatment prescribed and directed by physicians, OT transformed from an era of craft activities and asylum routines to one of consumer-focused programs addressing self-care, work and leisure within interprofessional contexts.

OT professional practice knowledge, however, did not develop in a linear progression across the decades. The fifty years presented in this chapter represented times of challenge for the OT profession within mental health services, and periods of confusion and questioning the basis of knowledge that informed OT practice. In the next research phase, I sought to reach a deeper level of understanding of the factors impacting on the emergence and transformation of OT professional practice knowledge across these fifty years of practice, within both national and international contexts. Key influences emerging from the text presented in this chapter that informed the subsequent text construction and interpretation were social and policy influences on mental health services, environments of practice, the search for a core to knowledge and professional identity.

## Chapter 6

### Text Four: Transitions in Occupational Therapy Practice Knowledge

#### 6.1 Introduction

In Chapter Five I examined five decades of OT practice in mental health services. Over a period extending more than fifty years there were distinct yet interrelated contextual influences on OT professional practice knowledge reflecting phases, or eras, of practice. The contextual factors, viewed through my historical socio-political lens, suggested four significant transitions of OT professional practice knowledge in the mental health practice of Victoria. In this chapter I present the text constructed to identify these transitions in OT practice knowledge within the national OT practice scene. From an era of providing activities as prescribed by psychiatrists within psychiatric hospitals, OT evolved to community-based practice of interprofessional teams in the 21<sup>st</sup> century.

I constructed the text following a process of critical questioning of the dialogue emanating from the first three texts. I explored further horizons primarily through critique of work published in the *Australian Occupational Therapy Journal*, adding perspectives expressed in the writing of occupational therapists across other Australian states during the same fifty-year period. In addition to journal articles, I used critical conversations with practitioners to address these questions:

- How did contextual factors influence the development of OT professional practice knowledge?
- How did professional practice knowledge evolve in response to changing environments of practice within mental health services?
- What national and international trends influenced OT professional practice knowledge?

## **6.2 Transition 1: From Asylum Routine to Therapeutic Activities**

### **6.2.1 Social action and occupation.**

As I have presented in Chapters Three and Four, the use of occupation as part of asylum routines was traditional in psychiatric institutions in Australia.

Influenced by the convict era when occupation was used both as punishment and reward, early asylums used manual labour as a means to exert control and discipline over inmates. In the earliest years of development of Victoria's psychiatric institutions, inmates were considered as an unpaid workforce, whose labour supplemented the inadequate budgets for construction and running costs of much-needed facilities and services within the institutions. The lunatic asylums of 19<sup>th</sup>- and early 20<sup>th</sup>-century Victoria were harsh environments, despite their attempts to provide refuge and care for increasing numbers of the population.

Changing social attitudes created the political impetus for OT to emerge within the psychiatric hospitals of early to mid-20<sup>th</sup>-century Victoria. A desire to improve conditions for thousands of people incarcerated within state mental hospitals drove action within society. However, these aspirations were initially not enough to improve the care of people with mental illness in any substantial way. Crowded wards and harsh conditions were the result of many years of funding shortages and lack of political will to bring about change. As described in Chapter Four, women's auxiliaries and other community groups worked for better conditions. Advocates sought to exert community pressure, relying on the growing awareness of asylum inmates as worthy of more humane treatment. Significantly, they sought to raise awareness that the problem of people incarcerated in asylums was an issue to be addressed, not ignored; as Pardy (1937) put it, 'The main problem of the auxiliaries is to change the attitude of the public mind to persons suffering from mental disorders from one of apathy and distaste to helpful sympathy' (p. 29).

Community groups, wanting to introduce recreation programs within asylums, publicised the poor state of public psychiatric hospitals and criticised such lack

of attention to patient needs within the public health system as offering for that purpose a building that was

a primitive affair built of corrugated iron and quite unfit for even the simplest entertainment; in fact, if it were private property, the local municipal authority would have to condemn its use by human beings, under the provisions of the Health Act. (Pardy, 1937, p. 29)

The efforts of these auxiliaries eventually led to the introduction of craft activities, hairdressing, recreational and music activities for larger numbers of people in institutions. These reflected changing societal expectations for care of people in mental hospitals.

Gaining public support for OT also meant promotion of the capacity of patients to successfully produce craft items. In what was the first of several public displays of the results of OT, Mont Park Hospital held an exhibition of patients' handcrafts at the Melbourne Town Hall in November, 1937 (Pardy, 1937, p. 29). The auxiliaries of the Victorian psychiatric hospitals took up the call for an increase in nursing positions in order to develop OT services. Successful implementation of activity programs and the opportunity for patients to move beyond the ward spaces also provided new opportunities for staff who saw their role as more than that of custodians. The auxiliaries saw the role as being appropriate for nurses, and lobbied the government to provide funds to permit an increase in training:

it may be imagined readily what this opportunity to take part in some interesting occupation has meant to the patients who previously were condemned to sitting about, or aimlessly walking around airing courts. The auxiliaries are ready to sponsor further classes, but all rests on the training of nursers to carry on this essential adjunct to treatment. (Pardy, 1937, p. 29)

At this stage in the emergence of the profession, delivery of activity programs was envisaged as the core of practice. Nurses taking on OT roles were encouraged to have a repertoire of craft interests and skills to share with



patients. The medical profession extended the role of activity coordination to include therapeutic activity.

### **6.2.2 Influences of the medical profession.**

Development of the specialty of psychiatry within medicine in the state of Victoria reflected national and international endeavours driven by prospects of effective treatment and even 'cure' of mental illness. Many pioneering psychiatrists saw a role within new 'psychotherapies' for specific, prescribed activities that could enhance the treatment regimes they trialled. Although the medical profession continued to advocate the benefit of occupation for people with mental illness, the impetus to support employment of occupational therapists in Victorian mental health services did not arise until near the middle of the 20<sup>th</sup> century, when psychiatrists began to propose OT as a specific and specialised 'applied physical treatment' in psychiatry (Wechsler, 1951, p. 7).

Perceived links between occupation and health became the first tenet of OT professional practice knowledge within mental health services:

To define it in simple terms, Occupational Therapy is a healing treatment – prescribed by doctors to promote recovery from accident or illness. The treatment is any kind of work, occupational or recreation, and the Occupational Therapist, acting under the doctor's orders, guides and stimulates the patients' interest in the activity chosen, to help himself get better. (Philcox, 1951, p. 3)

Knowledge and skills were required by therapists in order to understand both the conditions and the range of possible activities. Doctors took the lead in prescribing activity, some being very specific about the link between the condition and the chosen occupation:

Occupational therapy, as a group activity, is an essential part of treatment of patients in psychiatric hospitals and wards and in day hospitals. In the management of a patient with an anxiety state in his home, new activities and interests which give opportunities for relaxation are of therapeutic value. Increased activity can provide satisfaction in fresh achievements and more energy for routine tasks and tends to lessen self-absorption. When the

occupation provides social contacts which were previously lacking in the patient's everyday life, it is of particular benefit. Work of a voluntary nature gives insight into the problems of other people in need of special help and leads away from self-centredness. Occupational therapy proceeds hand in hand with psychotherapy. (Gilchrist, 1965, p. 226)

While the importance of the therapeutic process rather than the activity itself was highlighted, the need for medical prescription and close supervision was stressed:

the Occupational Therapist is an intermediary – her chief duties and responsibilities being to interpret the wishes of the physician to the patient and the teacher of the patient and to observe the patient's reaction to the work and the instructor and report these to the physician. Post graduate instruction for occupational therapists should be in the fields of education, psychology, social work, aptitude measurement, job placement, etc. and not in craft work which is the least important of all channels of development for the occupational therapist. (Licht, 1949, reported in AOTJ, 1950)

Links with the medical profession supported the development of the role and professional practice knowledge for OT within mental health services; but it simultaneously defined and limited OT from the outset. Pioneers of OT, while wanting to fit within the developments of psychiatry, recognised that they could not rely solely on the medical profession to support and develop their practice:

I think it was at this point that we created our first image. We were landed with the symbol of the basket in the same way as the Psychiatrist had been landed with the couch. Due to the barriers of mystique and communication we didn't realise then that the psychiatrist was searching for an identity in the hierarchy of medicine, and was expending so much energy in establishing a role in the face of conflicting theories that he couldn't spare too many thoughts for Occupational Therapy as a viable source of assistance for his patients. By and large, he was contented for us to keep patients mobile and busy. Nevertheless there were the ties of history and

these, as we know, have been strengthened as time has passed. (Philcox, 1951, p. 12)

### **6.2.3 Impact of war.**

In the 1940s the women working to promote OT had been prepared to enlist in military service, to respond to the war effort and to be part of the medical auxiliary services. Most worked at the ranks of lieutenant or major: rank in the military set status and reflected the importance of this new form of treatment through activity (Anderson & Bell, 1988; Sims, 1967). Occupational therapists developed their professional practice knowledge within a pioneering framework, breaking new ground and creating a professional identity by 'doing all that painful groundwork of having to convince people of the purpose of occupational therapy' (Sloane, 1976, p. 8).

OT was identified as being important in stimulating inactive patients as well as working against, or even preventing, the effects of institutionalisation. While the first patients of OT were already housed in large institutions, following World War II 'new' patients arrived who were less commonly found in a hospital environment. Amongst these were the ex-servicemen diagnosed as suffering from war-related psychiatric conditions. Occupational therapists commenced working with these patients during the war, continuing into the early 1950s for those who remained hospitalised. One aspect considered important to this group of patients was to work against the tendency for them to become socialised within a hospital environment; occupational therapists broadened their practice to address the issues of hospitalisation and also to address the different characteristics of these patients, recognising the difference in working with people who were not long-term patients. Occupational therapists recognised and acted on 'the need for wider workshop activities ... to eliminate the light handicrafts and obtain a better workroom ... with a trade emphasis' (Rockingham Home, 1951, p. 3). Psychiatric services for returning servicemen not only reflected the importance of the treatment environment but offered a wider range of activities. At Rockingham, occupational therapists participated in a new approach, called a 'self management scheme' involving a patient

committee to develop rosters and take part in ward maintenance and garden duties.

The concept of reactivation, transformed into that of rehabilitation, carried on practice developed during and after the Second World War to treat the needs of large numbers of injured soldiers. Rehabilitation included re-adjustment to life, re-education of physical functions and re-training to gain skills for new occupations. Socialisation into once-familiar or new social settings at home and work, a process that had been disrupted by war or injury, was needed for resettlement. Occupational therapists during and after the war period realised that there was an interaction between physical and psychological problems experienced by injured soldiers; this understanding formed the ground for the development of OT's 'holistic' approach. At the same time, greater emphasis on the need for physical rehabilitation created a growing divide between areas of OT practice. Exercise programs, adapted equipment, prosthetics and orthotics became foci of OT as war injuries created the need for immediate rehabilitation leading to a return to civilian life. Subsequent moves to extend rehabilitation programs to civilian patients set the path for OT specialisations and a clear distinction between mental health and other areas of OT practice.

#### **6.2.4 Activities for health and cure of illness.**

While the early definitions of OT referred to the use of 'any kind of work or occupation', there were some activities considered particularly conducive to healing. Alongside handcrafts, 'music, games, dramatics, puppetry, gardening, study courses and even social events, all [had] a part in the Occupational Therapy programme' (Philcox, 1951, p. 10). Early OT practice was also influenced by experiences within British education and practice environments, with their

strong emphasis on structured arts and crafts, folk dancing and games ... hand weaving, spinning, vegetable dyeing, pottery were just a few of the many crafts that were taught with the same sort of zeal which must have inspired that great English scholar and craftsman, William Morris, in the 19<sup>th</sup> century. (Philcox, 1968, p.11)

Recreation activities became a significant part of OT treatment programs in psychiatric hospitals, thought to offer a range of benefits related to attitudes, contact with reality, social behaviour, direction of energy and release of unwanted feelings. Organised classes of physical activity could assist with energy release within confined spaces and stimulate participation for those who were otherwise disinterested in their surroundings. Engaging in pleasant, 'normal' activities that were fun could encourage other desirable behaviours. Such activities, like social dancing, were 'found valuable for mental patients especially when every effort is made to make such affairs as normal and gala as possible. Such an occasion stimulates pleasantly, and tends to call forth other normal emotions' (Zweck, 1951, p. 4).

The knowledge required to implement these programs went beyond organisation of a program. Attention was paid both to the level of function of the individual and the characteristics of the activity that made it suitable for patients who could master activities 'as well as any normal group', for those who were less alert but with some degree of hopeful prognosis and for 'chronic and deteriorated patents, whose exercises may seem uninspired but for whom the regular routine movements are most necessary and beneficial' (Zweck, 1951, p. 4).

Knowledge and skills were required by therapists in order to understand both the conditions and the range of possible activities that could be applied:

Occupational therapy in psychiatry is a particularly fine art. Emphasis should be placed on constructive projects to awaken new interest and skills, and these must be adapted to the patient's individual needs. The patient emerging from a manic phase requires limited diversional activities, as it may only increase his responsiveness to environmental stimulation. The depressive patient responds better to easy tasks, as complex activities, will increase his feeling of inadequacy. The emphasis here should be placed on diversion, which may take the patient out of himself. The schizophrenic requires activities symbolizing reality, the neurotic with pent-up tension should be occupied with activities that give him an opportunity for energy

release. Many patients will release more energy in witnessing international foot-ball match and by concentrating attention upon public affairs than in actual physical work. The patient identifies himself with his favourite player or team of players, political party or leader etc., and, by projecting himself in real or imaginary actions, he secures a release of tension.

(Wechsler, 1951, p.7)

Prescribed activities were not limited to indoor pursuits. Gardening was a major component of OT activities from the outset of practice. Lessons in horticulture were an example of the attempt to make stronger links with the outside world that would encourage patients to continue with interests upon discharge.

Early in the 1960s, craft was the core of OT programs, but alongside their 'traditional' use, new approaches incorporating psychological perspectives emerged. In response to new therapeutic approaches, a diverse range of activities became part of therapy regimes. Occupational therapists began to incorporate broader activities of life into their practice and were encouraged by psychiatrists to be involved in specific psychiatric treatments using activities. In these treatments, their roles were diverse yet closely prescribed. They were required to have a knowledge of treatment aims, of the specific psychodynamic rationale being followed, and of when and how to include both themselves and an activity in the treatment program. An awareness of the need for more comprehensive education evolved from this time.

The concept of reactivation in mental hospitals was introduced in response to the realisation that there were thousands of incarcerated people with little purpose in their lives apart from any role they might play in keeping the institution in food (men) or sustaining the routines of housekeeping and laundry (women). The torpor of such a purposeless life needed to be offset by adopting reactivation and total push regimes. While the new drug treatments assisted the reactivation process by dealing with some symptoms, the use of activity and routine offered hope of introducing meaning into daily life.

Within the profession, there was a realisation that craft itself was not seen as having scientific value. The core of treatment moved further towards identifying

the meaning and purpose of the activities being prescribed. Definitions of OT echoed this view, like the one that Pedley described as 'the treatment of man the totality, through his active participation in purposeful activity' (1968, p. 15). Growing concern about the limitations of an activity approach to treatment prompted occupational therapists to expand their view of OT interventions and extend their practice knowledge. OT practitioners sought greater knowledge of psychiatric conditions and in particular of *treatments* that they could apply to specific elements of illness. Studies in sociology also began to influence the profession as it sought to achieve professional status and, in the process, question the role of medical practitioners in prescribing and directing OT interventions.

### **6.3 Transition 2: Seeking the Science of Occupational Therapy**

#### **6.3.1 Beyond craft to scientific occupation.**

As OT became accepted as more than just occupying waking hours in the institution, occupational therapists sought scientific explanations and approaches to their work. They wanted to show that the selection and implementation of activity could 'effect the greatest alteration in all the patients total life pattern' (Lindsay & Honey, 1960, p. 8). The aim to be more scientific required study of behaviour occurring as a result of OT, and occupational therapists sought to extend their roles in mental health services and to develop professional practice knowledge in psychotherapeutic approaches to psychiatric treatment. The content of entry level training was reviewed by occupational therapists as the quest for a 'scientific' profession continued. Occupational therapists identified the need for ongoing education, realising that postgraduate learning would be necessary if the profession was to develop.

The newly introduced course in Victoria took different directions to the one already established in New South Wales (Philcox, 1968). The curriculum expanded beyond the strong core of arts and crafts of earlier courses. Rehabilitation perspectives created growing attention to 'purpose' in relation to OT activities chosen for intervention, reflecting early tensions about the core of OT knowledge:

There began to be less crafts taught and used, and more purposeful activities substituted – purposeful in the sense that they had a stronger relevance to the individual’s daily life, including work, and were therefore compatible with the principles of rehabilitation. (Philcox, 1968, p. 14)

Occupational therapists required ‘skills more related to problems of everyday living, rather than the craft skills of the earlier period, and a deeper knowledge of general and psychological medicine and technology and their influence on people and the social pattern’ (Sims, 1967, p. 43): a reference to the need to incorporate a broader knowledge base in curricula to strengthen OT knowledge. It was necessary, firstly, to understand the psychological impact of illness or injury and the implications of motivation, as well as the ability to cope personally with disability. Secondly, there needed to be strategies to encourage retraining in relation to individual practice in rehabilitation – the concepts underpinning the ‘rehabilitation model’. Sims also referred to the need to understand sociological concepts, realising that occupational therapists worked at levels beyond individual ‘treatment’. Understanding emerging social issues of ageing and disability, for example, would assist occupational therapists to ‘meet the challenge of a change in social outlook’ (Sims, 1967, p. 43).

### **6.3.2 Rethinking practice.**

During the transition of OT from craft to science concern was expressed about seeking scientific practice regarding techniques being used, and efforts were made to seek new knowledge and new roles. Questions were raised as to whether occupational therapists were applying specific knowledge to the techniques in use, or whether their techniques belonged to other members of treatment teams. Industrial therapy, strongly promoted during the era, was one area subject to critique:

The use of “Industrial Therapy” has been one of the more recent developments, but this has not been wholly accepted by all members of the Profession<sup>10</sup> as being a legitimate role of the Occupational Therapist, and

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<sup>10</sup> i.e. the OT profession



this view is also shared by others outside the Profession. (Wylie, 1966, p. 15)

There was recognition that occupation could be both a treatment technique and an end point, but there was a need for clearer distinctions between work used for therapy and work that became part of daily routine, and used for 'patients who have reached their maximum potential and can receive no further benefit from therapeutic treatment' (Wylie, 1966, p. 15). Occupational therapists were cautioned that their efforts to promote work as therapy might be used to benefit others and not the patients who were carrying out the work:

Therapists must also become aware of how attractive a well organised unit appears to the businessman who is desirous of getting work done at charged rates under supervised conditions, and the dangers of time limits being placed for the delivery of finished work which can easily result in too much pressure being placed on patients to ensure that contracts are finished on time. It is easily seen how this aspect can destroy any therapeutic value and result in tensions building up in the workshop. (Wylie, 1966, p. 17)

### **6.3.3 Evaluating practice to develop scientific occupational therapy practice knowledge.**

Early in the 1960s the first written paper recording OT outcomes in a systematic way was published (Lindsay & Honey, 1960). The 'experimental' program involved sixty patients who had previously been unoccupied within a ward environment of 120 female patients. Initial assessment included orientation to the surroundings and to the therapy program, with the therapist using observation to 'ascertain what skills and social graces remained. Creative painting and games were the two activities used and they revealed much. It was possible then to decide what subsequent techniques could be used' (Lindsay & Honey, 1960, p. 11). The OT program included group activities and development of a 'community spirit' to enhance motivation to participate. The groups worked to beautify the surroundings of the OT centre, which was made accessible to patients at all times, not just during the employment hours of the occupational therapist. Craft activities were used, graded according to patient capability, and each small component of the activity was designed to contribute towards a

group project. Therapists also tapped into the “mothering” instincts still present in the patients’ make-up’ (Lindsay & Honey, 1960, p. 12). Patients made items for a local babies’ home and were ‘eager to care for the orphan lambs, the puppy and the goldfish brought to the centre by the therapist’ (Lindsay & Honey, 1960, p. 12).

Subsequent assessment of patients during the program classified and studied patients according to age, other characteristics and the demands of activity. Those ‘only capable of simple repetitive activity went down the ladder to the second [group]’ (Lindsay & Honey, 1960, p. 13). Those over fifty years of age ‘capable of a more complex activity’ (p. 13) went ‘up the ladder’ into the first group. The higher functioning group was found to be capable of high-grade social activities such as well organised sports and discussions. They were brought into contact with the outside world by going on excursions to places associated with their activities, such as a woollen mill for knitting wools or to nearby swamps for reeds for basket making materials. They also entertained the children from the home at a Christmas party for which they did the baking and decorating (Lindsay & Honey, 1960). In such ways OT created a strong link between the environment of the hospital and the outside world. As a result of this particular program, out of 112 chronic psychotic patients involved at various times during the year, 77 improved and four were able to leave the hospital during the study period. To create these outcomes, the occupational therapists applied their knowledge of ‘environment, community spirit and the method of presentation of the various occupational media’ (Lindsay & Honey, 1960, p. 17).

#### **6.3.4 Occupational therapy skills: more than treatment.**

During the 1960s, occupational therapists saw that professional practice knowledge needed to incorporate more than craft-based treatment skills. Occupational therapists required ‘skills more related to problems of everyday living, rather than the craft skills of the earlier period, and a deeper knowledge of general and psychological medicine and technology and their influence on people and the social pattern (Sims, 1967, p. 43). The subsequent decade embedded the increase in OT practice knowledge:

So basically, the 70s saw this incredible boom in knowledge and understanding ... I think a lot of OTs, my colleagues, including myself, we all accepted the moral therapy as a point from which we operated. So that the dignified quality of the interpersonal relationship between therapist and patient was very different to the wards, which were very much a prison system, very little opportunities for the ward staff to develop ongoing relationships that were therapeutic, there was a dependence, but not moving people on so the medical model promised us opportunities, team work, we all then grabbed for a parcel of the shopping basket that the medical model brought with it, so a lot of our therapy became clinical type therapy in other words we started to do psychological things and you know ... I can remember [one OT] was our psychodrama expert and I was a gestalt rational emotive client centred ... they were the tools I tended to use but within the context of engaging people in a functional focus, so even though I was an occupational therapist who used activity I was starting to emphasise and stress a psychological emphasis in the task, so that I became very conscious of my manner of speaking, the psychological dynamic nature of the relationship techniques that might now be used in team building. (OT: CC1)

In the transition to scientific practice, occupational therapists sought to continue alignment with the medical profession by developing skills in psychotherapy.

#### **6.3.5 Education: reviewing the curriculum.**

Early OT education in Victoria was influenced by international practitioners involved in education and employment of occupational therapists. The first Director of Training at the Occupational Therapy School of Victoria was recruited in 1948 from England, followed in 1950 by the appointment of an academic from the USA, a decision having 'far reaching long range effects on educational standards and professional attitudes' (Philcox, 1968, p 13). The new director brought what were received as very different approaches to education, drawing on American educational philosophies and a very direct approach to addressing the need for marketing and communication.

To counter the ambivalence of the medical profession and the ignorance of the community in general of the new profession of OT, the School embarked on ventures to educate the broader community about OT treatment, with displays of therapeutic equipment, posters, photographs of graduates in treatment areas, demonstrations of physical activities and a film depicting the value of OT (Cameron, n.d.). Observers at the time attributed the instigation of these activities and the attempt to attract the top echelons of Victorian society to the 'School Director whose drive and creative energy made consideration of such elevation seem normal' (Cameron, n.d., p. 43). The Director 'really stirred up Melbourne's interest in Occupational Therapy ... it was timely and only an American could have done it. Nothing would stop her; she would go to the "top". Her dedication and belief in the importance of it all made people stop and think' (Davies, cited in Cameron, n.d., p. 44). This 'American influence' extended to the content and detail of the curriculum and addressed contemporary ambivalence about the need for OT practice knowledge:

we changed the term arts and crafts to 'therapeutic media', and did it with such unseemly speed that I rather think now we were somewhat sensitive of our image, and thought, perhaps naively that a new label might improve matters. The acquisition of a special language seemed to counter the trauma of the image. There can be no doubt, however, that the American influence did a great deal to make us think in terms of better organisation and administration and to evaluate more crucially our curricula. (Philcox, 1968, p. 14)

Changes in the curriculum reflected the influence the Director of the Victorian School of OT brought from the progressive education movement in the USA, which subsequently informed the newly developing specialty of rehabilitation medicine:

this philosophy of American general education ... found a more than ready acceptance in Australia at that time. Clichés such as 'the development of personality', 'education of the whole child', 'fostering self expression', 'reality-oriented experience', 'the needs of the child' form part of our vocabulary. (Philcox, 1968, p. 14)

These changes reflected directions for OT practice and education being advocated in the USA, and were reported in the *Australian Occupational Therapy Bulletin*.

### **6.3.6 Education: health sciences emerge.**

The move of the OT School to new premises and co-location with the other disciplines of physiotherapy and speech therapy led to an innovative approach to paramedical education that was well received, as is indicated by Wedlick's remark that 'We regard the combination of the three disciplines in the one building as of vital importance, and elsewhere in the world this has rarely been done' (1967, p. 830).

It was considered important for disciplines to learn to work together. If located together students would learn about each other's work and doctors were 'sure this will tend to minimize the gap which unfortunately exists at times between occupational therapy and physiotherapy, for example. We are quite certain that ultimately this can result only in better teamwork' (Wedlick, 1967, p. 830).

Along with the expanded curriculum, the education program was modified to allow inclusion of skills such as managing meetings and speaking in public about the profession. Students still studied a range of crafts, but the number had been reduced; they could select three from a list of several, including bookbinding, cooking, design, gardening, leatherwork, needlework, pottery, printing, puppetry and typing (Rayne, 1960). Industrial skills that had been part of the curriculum at the Occupational Therapy School of Victoria since inception were reviewed and updated to fit with the current practice of expanding industrial therapy. Educators identified a need to respond to the expanding nature of OT practice:

It is recognised, and is being brought home to us ever more forcibly, that it is not enough to train graduates only to treat their patients as well as possible. Members of a young and vital profession must be zealous in guiding its growth. This involves the dissemination as well as the absorption of information, and the undertaking of the vast amount of research waiting to be done. Are we preparing our students for the broader

concepts of their professional growth? How can this best be done? (Rayne, 1960, p. 9)

### **6.3.7 Asserting the scientific profession of occupation.**

As dissatisfaction grew amongst occupational therapists with approaches to the OT role, they aimed to establish their role as an independent profession:

In the past, some Occupational Therapists have taken a certain pride in being 'jacks of all trades'. Now, however we live in an era of specialization when a well educated knowledgeable public expects the best in medical attention. We are part of this treatment and it is not sufficient for us to fill in the gaps left by other specialties, we too must be specialists. (Braga, 1969, p. 6)

Occupational therapists asserted their position as being able to determine their intervention for patients according to presenting symptoms and client interest without being so reliant on medical referrals:

we tried to be saying yes, we are occupational therapists, we are not just occupying people, not just not previously socialisation, something like that, but running sports groups, this was we were saying, no we're occupational therapists we know about occupation, we are skilled in this area, we are going to interview, assess people, and put them into a program occupational program that most suits their needs ... so I ran a home management centre, and someone else had screen printing, and a whole broad range of occupation, or activities that people would go to at different periods during the day. So there was individual program – this was your program of the day, and people went to groups according to what we thought their needs were and what their interests were; so we had carpentry, ceramics, a person who did picture framing, a large industrial section, as well as other creative areas, so we had this range of activities and occupations. (OT: CC5)

At this time there were calls for development of knowledge on a broader level and for ongoing development of skills after graduation:

It is obvious that no course of training, however comprehensive, can prepare graduates to meet all demands of their professional life. At this stage of its development, the profession needs more graduates willing to qualify for teaching and administrative positions, and to undertake research into the profession. (Sims, 1967, p. 43)

### **6.3.8 Professional identity.**

Discussion of the need to organise professional practice knowledge within mental health practice occurred as part of a wider debate about the need to adopt more scientific approaches to practice as a means of securing the future existence of the profession: Farquhar (1980) noted that 'Australian O.T.s have come to recognize that a more scientific approach to the practice of their profession is required if it is to survive as a worthwhile and contributing member of the health care professions into the 1980's' (p. 21). The 1980s were described as a time of identity crisis for the profession. Australian occupational therapists, and in particular those working within mental health practice, looked to the broader international debate about the need to adopt unifying theoretical concepts within the profession:

In the past decade, the profession has again witnessed significant expressions of concern over the apparent lack of consensus on a generic, theoretical and philosophic base for occupational therapy practice. An examination of the occupational therapy literature reveals a plethora of arguments propounded to explain this current ideological confusion or identity crisis. These range from a concern over the profession's affiliation with a reductionist medical model to alarm about the perceived dislocation of occupational therapy from its original activity-oriented base. (Alexander, French, Graham, King, & Timewell, 1985, p. 104)

Concern for the 'original activity-oriented base' was relevant for mental health practice, to which many therapists linked the philosophical basis of OT and identified the core of its origins within institutional settings. Changing practices within mental health challenged not only professional practice knowledge, but also raised the link between professional survival and the need for 'scientific theories' on which to build practice:

occupational therapy has been beset by confusion, disillusionment, and fear for its survival which has been attributed to its losing sight of the paradigmatic values and beliefs on which it was founded. As a result, there is no consensus on what occupational therapy is or ought to be as a health profession and no common theoretical base by which everyday practice is guided. (Lyons, 1985, p. 52)

In contrast to this concern, others within the profession saw professional uncertainty as part of what Kuhn (1970) described in his concept of paradigms related to scientific knowledge, the 'body of theory and practice which guides any learned group or community (and that includes occupational therapists)' (Clancy, 1984, p. 156). The 1980s was therefore a time of professional debate, a process of change during which a set of beliefs about practice was challenged. It is important to acknowledge that if new ideas are not challenged, they are unthinkingly consolidated into practice. By encouraging occupational therapists to deal with the insecurities surrounding the determination of the core aspects of professional practice they were able to work against the adoption or continuation of unsubstantiated practice, recognising that 'A tradition of open-minded debate is a safeguard against dogmatic protection of modes and practices that fail' (Clancy, 1984, p. 159).

Pressures of service provision were acknowledged as part of the challenge to establish theoretical bases of practice and demonstration of effectiveness or otherwise of approaches to intervention, because 'occupational therapists struggling from day to day to maintain and improve services to clients ... can lead us to accept a concept and use it as a tool, without crucial examination of its philosophical validity' (Cusick, 1985, p. 112). Within education programs, lack of unifying theoretical concepts led to concern about the capacity to provide students with direction about the use of activities or 'treatment media', and how best 'Students should be taught to assess the compatibility of different media with the philosophical base and treatment goals of occupational therapy, and to be provided with frames of reference supporting the use of media in therapy' (de Jonge & Vanclay, 1989, p. 209).

In particular, concern about the professions 'scientific' status related to the



lack of outcome studies available to validate professional practice ... such studies must look at occupational therapy practice as it is perceived by the patient, just as much as by the referring doctor, or for that matter by the occupational therapists themselves. (Alexander, et al. 1985, p. 107)

### **6.3.9 Seeking models of practice.**

Against the background of philosophical and theoretical debate in the profession, occupational therapists working in mental health services adopted 'models' to organise their professional practice knowledge. Activities to be used in intervention were discussed in terms of purpose and meaning. With the increasing variety in practice settings, environment appeared both as part of the design of treatment and as a factor influencing patient presenting factors and the outcomes to be expected from OT involvement.

Within the prison setting, acknowledgement was given to the need for a model to direct the newly established OT program. Referring to patient capacity to undertake community living, occupational therapists introduced concepts of competence:

Success of occupational therapy intervention is not based on treating and/or curing criminal behaviour, but on prisoners acquiring knowledge and skills to exercise their capacity for improving their self-esteem, and experiencing feelings of control. This is achieved by developing an awareness of life style options, making decisions and developing competence in various areas of living. (Farnworth et al., 1987, p. 43)

In other psychosocial settings where patients had various diagnostic labels, occupational therapists identified 'similar skill deficits' related to personal understanding of individual strengths and limitations, based on the 'assumption that psychosocial dysfunction is learned maladapted behaviour' (Evans, 1984, p. 28). The therapeutic model adopted centred on the successful completion of tasks within an activity-based group, and involved positive feedback from others to build competence and confidence:

feedback from peers and the group leader may provide the individual with a realistic view of his/her own skills and worth as a person. This, combined

with careful grading by the therapist to provide no-fail experiences, will allow the patient to develop self confidence and increased self-esteem. (Evans, 1984, p. 28)

#### **6.3.10 Identifying gaps in professional practice knowledge.**

Despite interest in community practice and being part of new approaches to psychiatric care, occupational therapists were challenged by the changes in their own practice. Workforce shortages created stress in hospital settings and presented challenging new opportunities to establish OT within community programs. Occupational therapists were required to keep up with developments in mental health, and criticised for not contributing to literature on their work:

It seems occupational therapy is lagging behind waiting until the work is done by other professions before joining the team. Perhaps in this journal we could have more psychiatrically orientated articles and so keep up with the new concepts of psychiatry as we do with other physically orientated fields. (Perry, 1970, p. 13)

The adequacy of OT knowledge for this transition of service was questioned, and a *lack* of knowledge became the issue. Occupational therapists were not active researchers and therefore were not contributing to the ongoing development of professional practice knowledge through their own research endeavours (Mocellin, 1979). Occupational therapists considered their work roles to be all-consuming, and their organisations did not structure schedules to permit time for research activities. No occupational therapists working within the Victorian Mental Health Authority were first authors of research papers in the period 1956–1971, and only three were co-authored by occupational therapists employed by the Authority (Mocellin, 1979). Occupational therapists had not traditionally learnt research skills in their education, which had retained its *training* focus during the institutional practice eras.

### **6.4 Transition 3: From Department to Community**

#### **6.4.1 Group processes within the occupational therapy department.**

Group approaches to treatment were common practice early after the introduction of OT into psychiatric hospitals. This was a way of dealing with the

significant numbers of people found to be lacking occupation in the psychiatric hospitals, but even more importantly, occupational therapists used group processes in the belief that OT could create a desire to interact with others, promote acceptable social behaviour and foster a 'community spirit' within the OT department. Psychiatrists had determined that a predominant issue for many patients was difficulty in making and sustaining interpersonal relationships; consequently, medical prescription for OT included the aim of developing 'normal' social behaviour. OT departments became a focus of prescribed treatment for social behaviour. Patients behaved 'differently' (that is, were more engaged and more socially acceptable) in OT departments. Expectations set by OT staff meant that patients were expected to display 'manners and social niceties, as demonstrated by the occupational therapists. We used china cups and saucers for morning tea. Patients were expected to be polite, to use knives and forks, and to engage in conversation' (OT: CC1).

The group nature of OT departments also represented the strength of the service within the institutional context:

it was a sort of quite stimulating centre really, you had lots of psychiatrists, so it was well staffed and OT had a very good strong reputation ... it was very instrumental, it had a strong position in the running of the service provided to the patients, they were patients then ... we had very large groups. (OT:CC5)

#### **6.4.2 On the move: community transitions.**

Early in the existence of psychiatric hospitals, the potential benefit of care provided in the community was identified. Although auxiliaries who promoted the introduction of OT saw it very much as an active part of the hospital routine, they also recognised the need for support for people leaving the psychiatric hospitals:

The auxiliaries are endeavouring to bring people to the realisation that few cases are really hopeless, and that real cures are being effected constantly. Much harm is done to patients after their discharge, and a return to hospital rendered necessary, by the unsympathetic attitude and lack of

encouragement they meet with in their endeavours to rehabilitate themselves. Some form of bridge between the hospital and independence is urgently needed, to find the patient a breathing space in which to adjust himself to changed conditions. (Parry, 1937, p. 30)

Employing more occupational therapists became a goal of the reorganised Victorian Mental Hygiene Authority in the late 1950s and the early 1960s. With their increasing numbers the profession faced the challenges of growth and change, and set out to consolidate the role within hospitals as 'an integrated member of the team' (Rayne, 1960, p.7).

During the 1960s, mental health practice environments diversified to include acute wards in general hospitals. OT remained within an institutional environment, but adapted to fit the characteristics of the changing environment and the changing timeframe of treatment approaches. Patients' length of stay changed dramatically, and could be less than three weeks (Jacob, 1964). In these hospital wards, the 'team' concept emerged more strongly – psychiatrists, almoner /social worker, physiotherapist and dietician worked together with the aims of understanding the patients and assisting them 'to get back into the community to lead a full life (Jacob, 1964, p. 11). Occupational therapists described psychiatric illness in the realm of a 'disability' framework, one to which society could relate:

We all know that life is not easy and everyone has some kind of a personal disability which makes life a little more difficult than it might otherwise be. It is not so much the disability that is important but the way in which we face up to it. We have to learn to minimise it and to live with it. This is the outlook of a mature person. This is an outlook for which we all strive and so few of us ever attain. (Jacob, 1964, p. 11)

Political priorities and lack of funding influenced many aspects of mental health services. They might be identified as essential, but the hard fact was that because 'the government was financially over-committed in its mental health planning, [it] looked favourably on the erection of a day centre through voluntary efforts (Bower, 1969, p. 1048).

### **6.4.3 Identifying the need for change.**

OT programs in mental health services during the 1980s faced change with the ongoing progression of hospital-based services moving into the community. Professional practice knowledge used by occupational therapists was in a period of transition. Practice reflected the traditions of the institutions from which the profession had emerged, and was often in contrast with the aims of new areas of community-based practice. Some practitioners saw the limitations related to the knowledge and status of the profession as hampering progress in the move of the profession to community-based services. In particular the lack of consensus about the theoretical basis of OT raised questions about how the profession would continue to develop within changing mental health services.

The 1980s, a transition time from institution to community, was a period of questioning regarding OT's 'fit' within medical approaches to professional practice knowledge. Medical practitioners continued to see OT within a framework of 'therapies' that could be used as part of a medical regime for the treatment of psychiatric disorders. OT was acknowledged only as a technique that had many forms in its approach to addressing personal characteristics and provided 'an opportunity for people to gain confidence in themselves and social confidence in group activities' (Strauss, 1980, p. 182).

Occupational therapists grew critical of the linkage between OT and the medical model, and of the seeming reluctance of their peers to embrace the community as a place of work. The decade of the 1980s was a time of potential change to the structures in which occupational therapists worked and to their professional beliefs:

The discipline of occupational therapy is steeped in medically-oriented traditions where the patients are generally expected to be passive recipients of health services. The majority of occupational therapists work in bureaucratic health organisations and by and large indicate that they are content to stay there. Lip service is given to extending their professional services into the community and providing access to a wider range of people. How many occupational therapists are actually prepared to leave

the security of hospital based departments and work in isolation or in new areas of work? How many occupational therapists are really prepared to seek or create new avenues in which to provide their professional services in industry, schools or local communities? (Millsteed, 1981, p. 93)

Occupational therapists continued to express the concerns of the 1970s, questioning the proposition that new ways of delivering service meant effective care. In community-based services they saw much that still needed to change in practice. As Jacobs (1982) commented, 'the high walls are down, the majority of the wards are not kept locked, and the general air of openness prevails. However, on closer examination, the locks and walls remain' (1982, p. 153).

Community facilities were inadequate in both number and in their capacity to deal with people with mental illness returning to communities from hospitals, or those who could not gain access to the newer services. Without adequate measures in place to address community living needs, there were questions about the effectiveness of services being made available through the deinstitutionalisation process, and the capacity of the community to care generally for those with mental illness (Jacobs, 1982; Weir & Rosen, 1989). Despite these concerns over their availability and effectiveness, the need for community-based services remained strong. Growing recognition of the complexity of mental health in communities, and therefore the shape of services, meant that service development went beyond medical treatment to include personal skills development and family support and education. The establishment and use of community-based resources required far more than access to a hospital or medical service. Occupational therapists described a clear role for themselves as part of community-based services aimed at intervention in four main areas of practice:

1. To increase each person's effectiveness in daily living skills, social skills and interpersonal relationships;
2. To educate clients and their families or social support systems about psychiatric disorder, effective and up-to-date management strategies and how to become actively involved in their own management;

3. To establish and widen the social network and support systems for these people; and
4. To encourage the use of existing community facilities and resources  
(Weir & Rosen, 1989, p. 86).

Occupational therapists were seeking a more consolidated identity and ways to present their profession and their knowledge, and thus evidence, underpinning practice in a manner that established credibility with others. Yet the pressures to manage overwhelming workloads worked against this aim. The majority of occupational therapists did not produce written reports or evaluations of their services, and reported they had insufficient time even to assess clients adequately or learn about assessments and recent developments in approaches to intervention:

The occupational therapist who sees patients all day and therefore has no time to stop and document change, or review the literature to learn about new techniques, or attend continuing education workshops that update skills ... the occupational therapist has become bogged down by what appear to be critical needs. Thinking, learning and planning have become luxuries that have no place in the work day. (Hansch, 1981, p. 6)

Occupational therapists did nonetheless recognise the need for exploration of 'more innovative methods of assessment, programme planning and implementation' (Farnworth et al, 1987, p. 45), even given the pressures of time. They acknowledged the need to develop frameworks for practice and organisation of professional practice knowledge.

#### **6.4.4 Diversifying practice: gains and losses.**

Occupational therapists became interested in applying new techniques, and in seeking methods that were more closely aligned with the medical profession. This resulted in a range of approaches, losing the focus on craft and other indoor, table-type activities. Occupational therapists became interested in techniques of psychotherapy and psychoanalysis,

so I think the 70s and the early 80s were periods of uncertainty. A lot of therapists were being tossed between ... will I develop skills in family

therapy? or ergonomics? Or [they were saying] ... 'I'm doing this course because just OT on its own was not perceived as good enough.' (OT: CC1)

Moving from the protected and isolated environments of psychiatric hospitals brought practice into complex community environments, leading to changes that were on the one hand progressive, but on the other experienced as loss of valued activities. Development of industrial therapy required negotiation with unions and employer bodies, at first with agreement but later becoming more complex. Many patients valued industrial therapy, and missed industrial work when it moved out of smaller OT departments as unions raised issues of pay and conditions. As one therapist put it, 'with industrial therapy it became not the in thing so much, it was the union issue .... so we closed our workshops down, VATMI<sup>11</sup> had these large workshops, and in a way that was better, and again, patients loved the work, they could do it'(OT: CC5). Tension also grew around education programs and the changing emphasis of the role of activity for OT practice. Disagreement arose between OT educators and clinicians as to whether therapeutic activities should constitute the principal nucleus of professional practice (Mocellin, 1984).

Deinstitutionalisation created concern and challenges, as doubts were raised about the level and adequacy of services in the community:

Many caring staff worry about the problem of discharging the patients into a community where the necessary facilities do not exist. Although the number of in-patients has decreased, the number of admissions to mental hospitals has actually increased. Not only have the overall admission figures risen but the proportion of those seeking readmission has also continued to rise. The gibe is often quoted now 'they race the ambulance back home' – has the revolving door become the spinning door? While acknowledging that the labelling of patients is not desirable, a group of chronic and institutionalised mentally ill patients does exist and the problems of rehabilitation into the community cannot be minimized, nor

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<sup>11</sup> Victorian Association for the Mentally Ill



are their problems and needs the same as those of the short stay patient.  
(Collins, 1978, p.8)

The rights of individuals also became an issue. The process of deinstitutionalisation caused significant ambivalence and debate both within groups of professionals and within the community generally:

We now seem to find ourselves on a tightrope between two very dangerous and dichotomous alternatives. On the one hand there are those who would press for individuals, inadequately accommodated in the community to be returned to the State hospitals, arguing that it is more humane, provides better programming and is less disruptive to the community. The second side of the situation is presented by the group of people who insist that persons have the right to live wherever they choose, even if they choose to live in sub-standard accommodation. They insist others have no right to make judgements about inadequacy when a former patient chooses to reside in poor quality accommodation with no contact with social agencies, eats poorly, possibly drinks heavily and lives a marginal existence, both physically and socially.

Perhaps we have come a full circle and that the community has become the back wards of inferior quality care and little or no follow-up. Perhaps the convalescent hospitals and hostels of the community are the equivalent of the private Madhouses of the middle of last century. If ever there was a need for leadership and direction in psychiatry it is now. (Collins, 1978, p. 9)

One of the most significant changes of the 1970s to be experienced by occupational therapists was the opening of community mental health and general community health centres, a major departure from previous models of practice. Occupational therapists were for the first time 'rostered in front line of assessment' (Kewish, 1979, p. 129). The move to generalist roles was challenging and many felt untrained and unprepared to take on the new processes which were 'exciting, frustrating and [made it] very different to conceptualise cultural backgrounds of clients. The dilemmas in practice [were] not understood and some questioned the legitimacy of OT being involved in

progress and at social and political change' (Kewish, 1979, p. 129). Occupational therapists working as case managers, particularly in community-based crisis intervention teams, faced new challenges in their daily work practices. While services acknowledged that clients were responsible for their own lives and related decisions, teams were often on the scene at a time of crisis, responsible for implementing intervention that would be the most effective and least disruptive to clients and families. For occupational therapists, the location and timing of intervention was a new aspect of the work role:

two areas of crisis work which will be new to most occupational therapists. The first is the level of responsibility for client care ... total responsibility of the client's care, such as decisions about admission, discharge and treatment changes. The second area is time of intervention. Traditionally occupational therapists have not been involved at the initial point of contact with psychiatric clients in crisis. As a crisis worker the occupational therapist may be involved in seeing the client in the accident and emergency department of a hospital, at the client's home or work place, or in the police station. As a member of an extended hours team the occupational therapist will be involved with the client from the very first point of contact. (Miller & Robinson, 1991, p. 144)

#### **6.4.5 Environments of practice: beyond the departments as the base for practice.**

At the beginning of the decade the OT department was a focus for OT practice and the core of therapeutic activity. During the decade this focus of practice changed, and OT Departments were established as a space within hospital wards, or an office in a community centre. Traditional crafts were supplemented by a range of other activities, including relaxation, social outings and films. Occupational therapists started the era looking out from inside the walls and took their work beyond the walls. Hospitals became more active social communities and occupational therapists placed more emphasis on the interaction and the input of the therapist, rather than a product being created through occupation. Once the centre of activity, departments became less of a focus for OT. Activities within departments were acknowledged by some to be

part of the institutional environment and even drab, repetitive and often uninteresting for patients (Davies, 2007).

In the 1970s different characteristics brought about by changing medical practice were spurred on by the development of knowledge in psychiatry across all disciplines. Long-term hospitalised patients still resident in large psychiatric hospitals were assisted by new medications. Hundreds of patients were 'unlocked' from custodial approaches and 'made more accessible' to therapists and therapy (OT:CC1). Patients were given new roles as 'citizens', considered capable of taking on many of the tasks previously denied to them. They were encouraged to make friends and take on interests beyond the hospital walls; they were exposed to current affairs, managed their own money to varying levels of responsibilities, and were responsible for deciding what they would eat, wear and do with their time.

The changing client groups also influenced the type of care needed. The focus of treatment became the prevention of long-term hospitalisation, which was no longer considered a desirable solution for dealing with mental illness. The experience of the previous decades had brought the realisation that people had potential despite their disabilities, and that the effects of institutionalisation were part of the problems of hospital life.

#### **6.4.6 Cultural issues and practice.**

Cultural issues associated with community-based services were first identified in the late 1970s when community health services created access to wider groups of people. Occupational therapists came into contact with many people who previously had difficulties accessing health services (Kewish, 1979). In the 1990s, questions arose as to whether, despite awareness of cultural issues and inclusion of cultural content in undergraduate curricula, occupational therapists were in practice demonstrating culturally aware practice and 'addressing the issues most relevant to intercultural interactions' (Fitzgerald, Mullavey O'Byrne & Clemson, 1997, p. 1):

On two points there is complete agreement: (i) that occupational therapists must enhance their cultural competency, which includes enhancing their

understanding of the concept of culture and how it affects their interactions with clients and their families; and (ii) that culture is an important issue in occupational therapy practice, and one therapists must address. But our work supports even more strongly the literature on cultural competency and values that suggests that, while it is important that therapists increase their understanding of the culture of others, there is an even greater need for therapists to become more aware of their own cultural backgrounds. In particular, they need to become more aware of their own values and value assumptions and those of their profession. They need to recognize that these can also become barriers to successful and satisfying intercultural interactions. They must be cautious about making simplistic evaluations and assumptions about the issues that can affect intercultural interactions and how these may affect the interactions. (Fitzgerald et al. 1997, p. 15)

#### **6.4.7 Tensions in practice.**

Despite occupational therapists identifying their role as important to community-based mental health practice, concerns were expressed about the limited number of therapists available to work in the field and the OT profession's capacity and willingness to ensure OT continued in mental health services:

I am ... concerned that, whilst in Australia there are a few pioneers from the occupational therapy profession currently establishing innovative services, administration and coordination, and some who are becoming known at an international level, there are limited numbers of occupational therapists currently working in newly evolving community mental health services. Most tend to work in the traditional psychiatric or general hospital units and provide traditional occupational therapy services, even though bed numbers have dramatically reduced and length of stay minimised. If we do not keep up-to-date with policy, planning, legislation and new trends we will be left behind and even excluded from mental health services in the future. (Weir, 1991, p. 191)

The concern for mental health services was echoed in broader concern for the OT profession:

The profession and occupational therapists in practice everywhere are at a crossroad. We have important choices to make. We can choose to be reactive and ebb and flow in response to external forces or we can choose to be proactive and become active players in the system. If we choose to be reactive, there is danger of the profession being edged out of service areas and our roles being diminished; if we are proactive, we can work to ensure valued ongoing roles in the changing human services. (Poulden & Oke 1990, p.147)

While many occupational therapists made a transition to community-based mental health positions during the 1990s, many others considered the profession to be threatened by the interdisciplinary nature of work in the community, preventing them from making the best of opportunities for the profession to contribute to mental health services. Yau pointed out that 'The number of practitioners working in community mental health is still relatively small compared to other occupational therapy speciality areas' (1995, p. 129).

Questioning the viability of the profession was related to acceptance of the move away from traditional models of practice within the medical institutions of the past:

A medical view of disorder has had a very constraining influence on the growth of our profession ... occupational dysfunction can result from bodily disorder or mental disease, but as long as we are constrained by these categories we fail to see and work towards alleviating occupational dysfunction from social, political and ecological causes that are reaching epidemic proportions all over the world. These causes impact on our traditional client group, but we feel powerless to act in the larger struggle because we have not thought about ourselves as the profession with expertise about the occupational nature of people, but rather about serving the needs of a small group of people with occupational dysfunction of a medically determined nature. (Wilcock, 1999, p. 2)

On the other hand, some occupational therapists had recognised benefits in community-based practice, finding that 'One of the most satisfying aspects of

the work is that of being in charge of the way in which we work. Occupational therapists may feel limited by the constraints of the medical model in many other settings' (Miller & Robinson, 1991, p. 146).

Underlying assumptions of competence in living skills was the importance of environment as part of intervention approaches in community-based settings:

the belief is that people removed to hospital generally do not learn coping skills to deal with the environmental stress, though certainly they get relief from it through separation ... it has been shown that repeated admissions to hospital reinforce symptomatic behaviour and shift responsibility and there is an unhealthy, non-coping mechanism. (Jacobs, 1982, p. 154)

Within the challenges posed by the move to community-based mental health care and early intervention teams with their multidisciplinary and generic roles, OT aimed at recognising the importance of the client's environment and in particular the social relationships of clients, and drew on a range of theoretical approaches, using a model that was viewed as 'growth, actualization, or educational rather than based on disease, medicine or pathology' (Jacobs, 1982, p. 154). Practice drew on multiple approaches, many of which had commenced within institutional settings. For instance, 'a crisis team would need to have members who had an understanding of most theories – rational-emotive therapy, gestalt, family therapy, behaviour therapy, transactional analysis, chemotherapy and so on' (Jacobs, 1982, p. 154). For occupational therapists working in mental health, the focus on environment moved from the OT department of previous decades to creation of spaces with domestic characteristics and a 'culture of informality, warmth, caring and friendliness so that an atmosphere of trust evolves' (Weir & Rosen, 1989, p. 86).

The 1980s decade saw a stronger statement from occupational therapists about the 'client-centred' nature of their professional practice knowledge. Adopting a model of client-centredness meant that, while the occupational therapist was determining the overall approach for the intervention,

a vital element which needs to be understood is that competency based programmes maximise the function and achievement potential of an individual, and the task and level of potential is determined by the individual, not by the therapist. Ideally the therapeutic process revolves around responding to priorities as perceived by the client and/or assisting the client in the identification or modification of life priorities at different stages of treatment. (Farnworth et al., 1987, p. 44)

Despite their expressed interest in the development and use of theoretical models and unified approaches to practice, occupational therapists reported generally little use of ongoing education, and limited use of text books (Bartlow & Hartwig, 1989). The text first produced in the 1940s, *Willard and Spackman's Occupational Therapy* (by then in its sixth edition), was reported as the most common text used; and the most common approach in the area of mental health to be that of behavioural techniques (Bartlow & Hartwig, 1989).

Occupational therapists identified limited consensus in methods of assessment of client functioning, and a limited 'uniform concept of the scope of practice, or knowledge about which assessment tools are to be administered, [and] no defined pattern for delivery of services representing clear theoretical approaches' (Bartlow & Hartwig, 1989, p. 190). In addition, limited knowledge about how to use OT frames of reference meant that guidance was not being given to students learning about practice, so that 'the dire implication is that students have little opportunity to learn assessment procedures either in the classroom, in fieldwork, or in observing experienced clinicians as role models' (p. 190).

#### **6.4.8 Establishing a place in community.**

During the transition to community-based practice, concern was expressed within the profession that other health professionals and administrators were not readily embracing the expansion of occupational therapists into wider community-based roles. Previous clinical roles for occupational therapists aligned them with activity and group work; and lack of understanding of OT in the broader sense of health promotion, such as working with youth, hampered

the efforts of occupational therapists to extend their professional practice knowledge and contribute to health initiatives (Stephenson & Vanclay, 1989).

Occupational therapists were looking for new areas of practice. In claiming a new area of practice in adolescent mental health, the importance of activity knowledge was emphasised: 'only occupational therapists know how to correctly analyse and effectively adapt activities to achieve specific objectives' (Shaw, 1985, p. 164). Dealing with eating disorders, in particular treatment programs relating to anorexia nervosa, built on work of the previous decade and a role for OT was identified:

treatment areas such as development of self-concept, self-perception, independence, relaxation, social skills training and self-expression techniques, are skills that could be specifically incorporated into the occupational therapists' contribution to the overall treatment of anorexia nervosa in relation to establishing a more accurate body image for the patient. (Trevan-Hawke, 1985, p. 8)

Changes to future health science education were also predicted in the 1980s. In particular the nature of multidisciplinary practice already occurring in community-based mental health services meant that there could be increasing emphasis on

the core studies common to most of the health professions, such as: community studies (including health promotion), client-professional communication and evaluative skills, an understanding of health costs and the ethics of the delivery of health care ... to equip occupational therapists to participate with other allied health professionals in the major efforts in health promotion which are likely to develop in the 80s ... leading to a realistic development of health teams, much talked about in the 70s, but rarely successfully implemented. (Binns, 1982, p. 26)



## 6.5 Transition 4: The 'New' Community

### 6.5.1 Models of practice: strengthening 'occupation' as a concept of practice.

In transition from the 1980s and through the 1990s, occupational therapists continued to question the inherent nature of OT and the unique role it might play in community-based health services. By the beginning of the 21<sup>st</sup> century, mental health services were situated in community-based, interprofessional teams, interacting with a broad cross-section of community services. Explaining occupation as a unifying concept, even to occupational therapists was a challenge. In particular, efforts to expand OT's expansion and therefore impact, especially in community-based, non-medical areas of practice, proved elusive:

Occupation is so taken-for-granted that many occupational therapists who involve people in 'doing' do not speak about occupation. Leaving occupation implicit rather than explicit makes our important contributions to community development, organization of services, and policy development invisible. Unlike health services where occupational therapy is somewhat understood, many educational, social, transportation, corrections, and other services are unable to recognize occupational therapy's contribution unless the occupational perspective and collaborative approaches are made explicit. (Townsend, 1999, p. 157)

While Australian occupational therapists mostly adopted models of practice from other countries, they were reported as reluctant to adopt some approaches directly related to OT in mental health. One such approach, CDT (Cognitive Disability Theory), used the ACL test (Allen's Cognitive Levels), developed by an occupational therapist. There was reluctance to use this assessment because it was based on a leather lacing task; occupational therapists rejected the assessment 'because they believe[d] that its craft-based nature makes it professionally demeaning, and that it lacks face validity ... [yet others believed] ... that clients who refuse to complete more obvious functional measures will often attempt the ACL' (Hayes & Keller, 1999, p. 189). The inference was that occupational therapists had limited knowledge and understanding of how to apply a model of practice to cognitive disabilities and

that they were reluctant to be critical about their use of evidence related to practice. They were cautious about adopting an approach that was

a little hard to understand at first, or disagrees with one's gut feelings regarding the human condition, [but that] does not mean that it should be abandoned. As an ostensibly scientific profession, we should be using evidence-based practice, and there is certainly plenty of evidence to support CDT in the face of common criticisms. (Hayes & Keller, 1999, p. 190)

### **6.5.2 Client-therapist relationships.**

A key factor of the deinstitutionalisation period was the changing nature of client and therapist interaction. The client-centred nature of practice emanating from the 1980s continued into work, with individuals and groups within community-based settings:

The main goals of occupational therapy in this practice area are: to work together with clients and those who care about or for them; to assist clients to resume previous occupational roles or adopt alternative roles if the previous ones cannot be maintained; to facilitate clients' reintegration into society through skills acquisition or retraining in occupational performance areas; and finally, to assist them in becoming viable contributors to their community. (Yau, 1995, p. 131)

Occupational therapists viewed their roles as being practical, sensible and related to everyday aspects of life. Yet they also tended to the essence of living, for 'Working with individuals, communities, or the policies and funding which determine how we live, occupational therapists have ideas and approaches which are both practical and profound' (Townsend, 1999, p. 158).

Working in community settings allowed occupational therapists to consolidate the client-centred nature of their work and to extend their roles beyond what might have been possible in previous settings:

the opportunity exists for client and therapist to develop a more flexible approach to treatment ... [that] allows therapist and client together to make

decisions about the course of therapy ... [the] range of clientele in the community is much wider than that normally found in a hospital setting ... [the] occupational therapist draws upon, develops and fine tunes a broad range of skills including assessment, problem-formulation, practical living skills and supportive counselling. (Miller & Robinson, 1991, p. 146)

However, despite an approach that suggested concordance with client and community views and a very practical approach to intervention, occupational therapists faced the prospect that many in the community did not really understand 'OT'. Most of all, occupational therapists were concerned that confusion about their purpose extended to the clients they sought to assist.

### **6.5.3 Consumer involvement in occupational therapy intervention.**

One element of transition from the 1990s into the 2000s was the focus on consumer and carer involvement in service design, implementation and evaluation. Despite the direction set by the Australian government in the 1990s through the National Mental Health Plan, challenges existed for mental health teams to establish sustainable mechanisms to ensure consumer participation and for carers to gain information and be recognised within service processes (Chaffey & Fossey, 2005; Fortune et al., 2007). Occupational therapists identified with the change in direction of Victorian health services, yet remained challenged about the implementation of their philosophical ideals into practice (Ennals & Fossey, 2007; Chaffey & Fossey, 2005):

While consumer participation in adult mental health services has supported the service ethos to become more consumer-focused, it is argued that the aged mental health sector still adopts a somewhat paternalistic or maternalistic view of its consumers. In order for consumer participation to thrive, there is a need to create a cultural value where the consumer's perspective is considered, not in light of illness, but valued in light of knowledge, experience and wisdom regarding their situation. (Fortune et al., 2007, p. 72)

#### **6.5.4 Professional practice in interdisciplinary settings.**

The interdisciplinary environment emerged out of the earlier decades of multidisciplinary teams. Within interdisciplinary teams, roles did not need to be designated according to discipline, and professionals were employed more for their personal experience and characteristics, than for the background they would bring to the team (OT:CC1; OT:CC3; OT:CC8). While the value of such interdisciplinary approaches is a strong feature of mental health service reform internationally, tension still existed concerning the manner in which work was organised. Occupational therapists were unclear how to manage the transition, and others did not easily adapt to case management roles, to working within multidisciplinary teams and establishing partnerships with consumers and carers (Ennals & Fossey, 2007). Many positions were lost (OT:CC3).

In community-based teams, management also seemed to be influenced by the individual skill and experience of both occupational therapists and the manager of the team:

if you can see some of the OTs who are case managers but they draw on their OT expertise, and some people can do it better than others, whether it's to do with the team who allows them to do it, and I think we still some quite problems with whoever is managing the team in some areas, still there very much may be people from other disciplines who really constrain what an OT can do, even come across some OTs who can manage the two roles and are okay with it (OT: CC5).

Occupational therapists also experienced a tension between their underlying practice philosophy that was to enhance occupational function, yet were also constrained by a role as a manager of a 'case':

In contemporary mental health practice, occupational therapists may be functioning in case manager roles that are office based and include primarily monitoring and counselling duties within an illness model framework. In this setting, the link between occupation and health and ways to facilitate engagement in occupation are overshadowed by the assessment and review functions of the case-manager role. Opportunities

for facilitating the engagement of clients in meaningful activities that strengthen their sense of self and promote recovery require renewed attention. (Kennedy-Jones et al., 2005, p. 123)

#### **6.5.5 Evidence and occupational therapy professional practice knowledge.**

By the early 2000s, occupational therapists were being encouraged to learn about evidence-based practice. More so than in previous decades occupational therapists questioned their professional practice knowledge by seeking and using evidence to substantiate OT intervention in all practice areas. While there was a push within the profession to use evidence, there was limited indication that evidence was routinely being incorporated into practice (Hayes, 2000; Cusick & McCluskey, 2000). Occupational therapists within mental health faced barriers to adopting an evidence-based practice (EBP) approach to practice, including a lack of OT research relating to practice. Where OT research was reported, the diversity of such research in terms of focus made synthesis of findings difficult. Further, questionable methodological rigour of research added to the limited benefit of application of findings to practice.

Throughout the early years of the 2000s, occupational therapists pursued development of knowledge around EBP and confronted issues of gaining appropriate skills and tackling time management issues of practice and research (Bennett & Bennett, 2000; McCluskey & Cusick, 2002; McCluskey, 2003). Early in the EBP debate, Australian occupational therapists raised the question of defining *evidence* from the perspective of research paradigm (Cusick, 2001; Bennett et al., 2003). They identified the limitations of quantitative methodology being given superiority over qualitative approaches, particularly within the medical approaches to EBP. Qualitative approaches, on the other hand could:

provide information about occupation that is essential for the informed conduct of occupational therapy. We desperately need this at a time in our profession's history when we are discovering, defining and refining the uniqueness of our service and our professional focus (Cusick, 2001, p. 109).

Throughout the decade, increasing focus on evidence and in particular, the diversity of approaches required for the generation of knowledge required for OT practice was apparent in the *Australian Occupational Therapy Journal*.

Towards the end of the decade, occupational therapists were keen to highlight the link between occupation and health, reporting:

mounting evidence that engaging in occupation can increase health and well-being and thus strengthening occupational therapists' confidence in this fundamental belief of occupational therapy (Iannelli & Wilding, 2007, p. 292).

They were also willing to debate tensions around measurement of outcomes that revolved around the types of assessments tools used. Occupational therapists maintained a growing awareness that assessment tools used in practice needed to be congruent with the model of practice in the community, concentrating on 'strengths' of a person, rather than the former approach of identifying 'problems' and seeking treatment options. A range of assessment tools might be required, with ongoing review and reflection about their use, with willingness to discard processes that may have been in use for many years, but might no longer meet standards of evidence and timeliness in administration. Assessments developed 'in house' to meet local needs might not be valuable in the long term (Hitch et al, 2007, p. 222). While diverse approaches to assessment and intervention were required, so too was evidence that assessments were subject to a process of evaluation.

Many occupational therapists in mental health services continued to face challenges to fitting confidently into community roles, especially in the diverse practice environments. They lacked 'clarity regarding rationale for treatment action' (Fortune & Fitzgerald, 2009, p. 84). Within the interprofessional environment, confusion about role and the lack of evidence to substantiate the rationale for OT intervention meant occupational therapists struggled with professional identity and continued to:

perpetuate role incoherence because of difficulties in articulating the nature and aims of their work, how it relates to occupation, and how it

differs but complements others' paradigms (Fortune & Fitzgerald, 2009, p. 84).

Despite significant gains in EBP, issues of evidence, identified in earlier decades remained and:

pressure to identify the ways in which therapeutic actions enable engagement in meaningful occupation and how this contributes to health and well-being is a current issue for the profession (Fortune & Fitzgerald, 2009, p. 84).

## **6.6 Summary: Transitions of Practice**

OT practice changed significantly during the period 1960 – 2009. Professional practice knowledge moved through a series of transformations, reflecting changes in social structures, government policies and practice environments. Four transitions in professional practice knowledge were identified through a hermeneutic research approach involving interpretation of multiple OT texts. OT professional practice knowledge emerged in asylum environments during an era when occupational therapists were part of a change process. This change process, reflected in the transitions of professional practice knowledge, continued across five decades during which occupational therapists moved from the asylum environments. Practice moved to community environments while ties with hospital remained. In subsequent years, a different community context developed as services moved to case management models of care and adopted 'consumer oriented' approaches as the Victorian government implemented changes that were promoted by National Mental Health Plans.

This chapter has illuminated the nature and evolution of professional practice knowledge in OT as follows:

- occupational therapists at first used practice knowledge 'borrowed' from the medical profession, relating to the therapeutic use of activity, based on prescription by physicians;

- occupational therapists responded to changing practice environments by adapting traditional craft-based approaches to introduce 'purposeful activity' as the core of OT practice knowledge;
- 'scientific' approaches to practice were adopted, based on the early practice of using activities to facilitate therapeutic goals towards 'reactivation' of people who had been long term residents of psychiatric hospitals;
- the process of deinstitutionalisation of mental health services created an impetus to review the core of OT practice knowledge to incorporate living skills, therapeutic community approaches into OT practice;
- the move to health sciences education influenced OT practice knowledge, supporting multidisciplinary practice and creating opportunities for postgraduate and continuing education;
- throughout these transitions across the five decades of practice, links were evident between professionalisation of OT, development of professional identity and evolving professional practice knowledge.

In Chapter 7 I present a further cycle of hermeneutic dialogue to address the research question seeking deeper understanding of OT practice in Victorian mental health services. Considering this fourth text portraying transitions in practice, I was drawn to explore deeper aspects of OT professional practice knowledge and prompted to question what aspects of practice knowledge had changed and what was retained in the progression of practice from one generation of practitioners to the next.



## Chapter 7

### Text Five: Linking Past and Future: OT Professional Practice Knowledge and Professional Identity

#### 7.1 Introduction

In Chapter Six, I portrayed my interpretation of evolving phases of OT practice knowledge during five decades of OT practice in public mental health services in Victoria. Considering the transitions in professional practice knowledge during these decades prompted me to extend the critique and seek further horizons of understanding to explore the dimensions of professional practice knowledge. In this chapter I present the fifth and final constructed text.

Challenges to professional identity were raised in my initial consideration of OT roles in mental health practice. In this final phase of the circular hermeneutic approach, I returned to consideration of practice knowledge and professional identity. I engaged in further critical conversations with practitioners, returned to mental health and professional literature, Australian and international, and reflected at a deeper level on the knowledge I had gained from my roles as practitioner and educator. I sought deeper understanding of OT professional practice knowledge in Victoria during the fifty years that were the focus of my study in the context of national and international practice. Process questions for this phase were as follows:

- What characteristics of practice knowledge continued or disappeared across these fifty years of practice in mental health services?
- How did occupational therapists respond to the challenges of developing practice knowledge in changing practice contexts?
- How were OT practice knowledge and professional identity linked across these fifty years of OT practice?
- How was evolving professional practice knowledge in Australian mental health services situated within an international OT context?

In my search for the past and its links to present and future, six themes emerged as transcending the fifty years of OT practice in mental health services. These

themes related to professional practice knowledge and professional identity. I called these themes knowledge 'strands'. I conceptualised these strands as threads of ideas, of actions, or of words reflecting professional practice knowledge as it was recorded or remembered. The strands linked concepts of OT professional practice knowledge that were the same, yet different; constant, yet changing across the five decades of my study. Some of these strands were unbroken, some were twisted. Other strands were thin, almost to breaking point, before becoming entwined with another thread through a knot, so that they and their influence continued. I visualised these strands as being string or rope, wool, leather lacing or cane, all materials of OT practice at the time when it was introduced into mental health services. These strands evoked images of practice that linked the professional practice knowledge and professional identity suggested within the texts portraying OT practice in mental health services.

My search for past OT practice led me to images and 'relics' of practice. My own keepsakes and those of colleagues reflected endeavours of the past and student efforts to demonstrate proficiency in the crafts of the era. A selection of these images and artefacts of practice are recorded in Appendix 6. The photographs were collected through the text construction phase, and many as I toured asylums sites as they are today. Through these visits, I sought deeper understanding of early environments of practice. The images evoked the era of institutionalisation and high walls that contained and restrained occupation.

The basis for the diagram I used to portray the strands of practice knowledge was a student 'sampler' of macramé from 1956. I envisaged these knotted threads as forming interlaced strands of concepts linking decades of OT professional practice knowledge. The 'sampler' had a circular core and six 'samples' of knotting. These threads came together, weaving patterns, creating spaces and using knots to link and start new directions. While each strand emerged as a separate 'line', they were linked through a central point, the convergence of each separate influence on professional practice knowledge.

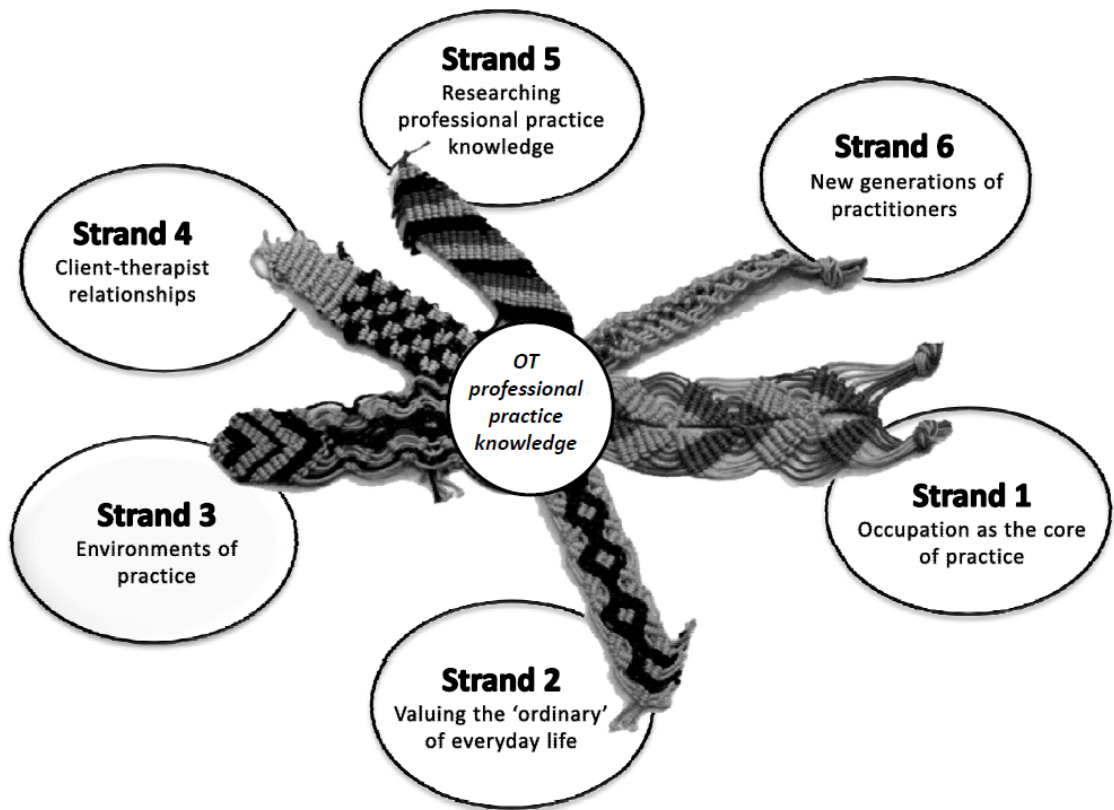


Figure 7-1 Strands of professional practice knowledge

## 7.2 Strand 1: Occupation as the Core of Practice

### 7.2.1 The rise and fall of craft activities.

In early OT practice, occupational therapists adopted handcrafts, art and recreation activities as their means of occupation within mental health institutions in Victoria, reflecting the international beginnings of OT practice. As was presented in Chapter Four, early proponents of OT in the USA extended the use of work in psychiatric institutions to include handcrafts and recreation. Extending hospital occupations meant providing a range of activities available for treatment beyond what was offered by kitchen, laundry or farming activities, which were traditionally used to engage patients in work. The greater range of occupations meant that physicians could design treatment according to activity characteristics and as linked to psychiatric conditions. Patients could also have some choice in what might be interesting to them, as identified by the occupational therapist.

The move to activity also moved control of patient routines from hospital administration to the realm of medical intervention, as was discussed in Chapter Four. Physicians needed other staff to implement the programs: hence the introduction of occupational therapists with specific knowledge and skills to use crafts. Craft activities were 'prescribed' with specific aims to 'provide motivation along the pathway to recovery, to relieve personal anxiety, and to substitute creative activities for destructive fantasy' (Barton, 1957, p. 180). Early practitioners in Australia, with their strong links to both the USA and UK through study and travel, brought these aims and techniques to OT in Victoria. Their text books, such as Willard and Spackman (1947) and Haworth and Macdonald (1940), were those of the pioneers of USA and UK, and the activities they learned were similar, including weaving, basketry, puppetry, bookbinding, clay modelling and printing (Occupational Therapy School of Victoria, 1949).

Early OT professional identity was constructed through the premise that being actively engaged in activity was important for mental and physical health. The philosophical stance of occupation linked strongly to underlying assumptions about the nature of human beings and the need for productive and meaningful activities. Being involved in activities allowed expression of culture within society, created opportunities for learning by doing, and defined many aspects of both individual and group roles within family and social settings.

Occupational therapists developed practice knowledge through learning about and using craft activities. Their skills resided in their ability to link an activity with the physician's prescription for a desired treatment outcome and the patient's interest and potential. The use of craft activities was strongly embedded in the OT professional identity of early mental health practice.

The 'craft strand' of professional practice knowledge was challenged in the early decades of OT practice in Victoria. By the early 1960s, occupational therapists sought to link their work in psychiatric treatment more closely with approaches being used in physical rehabilitation, in which aims of treatment were expressed through involvement in meaningful activities (Macdonald, 1964). As was discussed in Section 6.3, occupational therapists sought 'scientific' approaches to their work and identity as health science practitioners. Across a

range of varying diagnoses in psychiatry, occupational therapists saw the use of activity as fulfilling several common aims, including distracting patients from a preoccupation with their illness; modifying inherent 'drives' leading to pathological behaviour; preventing deterioration of intellect or personality and ongoing morbidity; preventing effects of long-term hospitalisation, and maintaining 'normal' personal, social and work habits (Macdonald, 1964).

As scientific approaches were encouraged and further developed, there was 'embarrassment' and doubt about craft as 'scientific' practice: one practitioner noted, 'I was often called the 'craft lady' ... the mention of 'basket' or 'moccasins' made me cringe ... I didn't study all those years to be a craft expert ... yet I knew some patients were pleased with their work' (OT:CC10). Towards the end of the five decades of practice contained within my study, occupational therapists considered it timely to question whether there was renewed interest in the use of craft as part of OT's range of occupations. It was clear that there was a significant shift away from craft as the main focus of OT intervention, and very few occupational therapists blended craft activities with case management roles in their move to community-based practice; yet craft activities continued to be part of the range of occupations in society. Some OT practitioners considered that within the diversity of practice it was possible to continue the strand of craft-making and affirm 'the value of craft as a valuable therapeutic medium that may be suitable to use with some of our clients to achieve a number of person-centred goals' (Harris, 2008, p. 141).

The reflection of a practitioner using craft in a range of occupations suggested practice within a current social context, rather than a return to traditional practice. Through the 1990s and into the 2000s a resurgence of interest in craft occurred, especially among the younger generations (von Busch, 2010). Interest in knitting, scrapbooking, sewing, card-making and many other crafts was evident through the rise of craft shop franchises, magazines and, more recently, website pages, blogs and other social networking media. Craft moved from an individual or home-based activity to one that could be a networking tool or vehicle for social activism (Greer, 2008). Valuing 'handcrafted' goods was

in marked contrast to workplaces that over decades had valued mechanisation over craftsmanship (Sennett, 2008).

The place of activity, and in particular craft, remained an ongoing issue of interest for occupational therapists. Rather than a matter forgotten after the move to 'scientific' approaches, activity emerged as having new dimensions of interest. Pierce (2001) argued that, rather than relegating 'activity' to history, engaging in further critique and delineation of activity and occupation would assist occupational therapists to clarify theoretical perspectives. Such definitions would provide consistency and facilitate research into the two concepts, in particular applied to efficacy of OT intervention. Pierce used the analogy of 'threads' of practice representing the two concepts and 'knots' in these threads as the issues to be 'untangled' in order to clearly delineate activity and occupation as separate entities for exploration (Pierce, 2001, p. 139). Tubbs and Drake (2007) built on the renewed interest in activity, publishing a third edition of their manual on crafts in OT. Advocating the continued, and extended, use of crafts and creative media as part of therapy, Tubbs and Drake linked the historical and philosophical origins of the profession with more recent research that had produced evidence of neurophysiological links between activity and brain function. Tubbs and Drake maintained the use of crafts fitted within commonly accepted models of OT practice:

No occupational therapy model of practice, based on its beliefs about human activity, would exclude the use of crafts as a treatment medium. Some models, however, might use crafts as a means only and not as an end. This will affect which crafts are offered, which tools are allowed, and/or the context in which they might be used. (Tubbs & Drake, 2007, p. 16)

### **7.2.2 Habits, manners and living skills.**

Early years of OT practice reinforced the importance of 'habit training', particularly in personal care and appearance. In parallel with their aim to increase activity levels of patients, occupational therapists maintained the importance of patients having access to the 'normal' items of life – toiletries,

mirrors, toothbrushes, combs and make-up. In many institutions achieving such access occurred only after significant effort:

Care of appearance as well as bowel and bladder training are important. The patient may have to be retaught table manners and normal social customs as well as being retrained to occupy himself. Such aims cannot be realized unless the staff are willing to be patient and persevering and unless the training is made easy and pleasant for the patient. (Macdonald, 1964, p. 118)

The OT departments, as discussed in 6.4.1, were environments where patients were expected to behave according to the social niceties of the time.

Occupational therapists were identified with a friendlier, less harsh manner of treating patients:

OT people had a dignified way of looking at people, very much that moral therapy model, and we just treated people with courtesy, kindness and a bit of dignity and this seemed to have a great therapeutic effect ... we treated people like human beings, not like prisoners. (OT:CC1)

Daily programming introduced in early OT practice remained a core aspect of OT treatment approaches throughout the five decades of practice studied. Adding routine to what were unstructured days was a key factor in OT programs within long-term institutions. By the 1970 and 1980s, the routine and 'habit training' features of early OT practice were incorporated in theoretical concepts proposed for adoption by occupational therapists, primarily in the Model of Human Occupation (MOHO) (Kielhofner, 2008; Kielhofner & Burke, 1980). Occupational therapists working in mental health services adopted MOHO to shape and explain their practice. OT programs with an emphasis on the individual's roles and routines considered MOHO to fit well with their OT philosophical approach and the recovery model adopted by services (OT:CC6).

Occupational therapists revised their approach towards occupation and reinterpreted the concept for the 'new community'. Reflecting on what was once the 'pride' of institutional OT, practitioners looked to broader and more meaningful activities for the clients of the time. They acknowledged practice of

past eras as having limited perspectives on meaning for patients as the social context changed:

if we're talking about the occupation of rehabilitation that it is truly meaningful to the person ... then we used to use basket weaving which we realised was not meaningful and in fact incredibly patronising, then when we looked at living skills they were very meaningful when people had left institutions ... valuable and meaningful as they didn't know how to tie shoe laces. Then 20 years later when there are people who never went into an institution and they are still learning how to tie shoelaces, then that is incredibly patronising ... we had a guy who had been going to an eight-week communication group, the same group over and over for eight years ... this is not client-centred or meaningful practice. (OT: CC4)

In the 'new community' practice environment, occupational therapists highlighted participation in social contexts as important to practice. The importance of 'everyday' activities and the value of social connectedness became a central concept:

we can lose the concept of 'meaningful' ... [the program] is structured so that you don't do anything that is not needed, whether it is answering the phone, or you are cooking because everyone is coming to eat, you are celebrated because others need you ... the human need to be needed makes the process of recovery very meaningful ... you are valued by others – self worth that comes from someone needing you. Even if you are really unwell, you can water the plants ... or put out the knives and forks and make the tables look pretty ... and in the process develop a really strong routine, being part of a social life. (OT:CC4)

The impact of the ongoing stigma attached to mental illness meant that people who had experienced mental illness experienced difficulty in realistically achieving the goals they set. The National Mental Health Plan (2006) and State implementation strategies recognised stigma as a key barrier to social participation. Initiatives to support employment and participation in social activities received more attention as community-based mental health services



sought to address the issue of stigma around mental illness and barriers to social inclusion (Lloyd et al., 2008).

### **7.2.3 Work and mental illness.**

When more OT positions in Victoria mental health services were proposed in the late 1950s, a major aim was to increase paid employment for people with psychiatric illness. The days of inactive lives within long-term hospitals were destined to be filled with employment, albeit at reduced income levels compared to the 'outside' workforce. Establishing links with industry gave credibility to the work being done, despite the simple and repetitive tasks being used within the sheltered workshops set up in hospital grounds. Further credibility was ensured through development by occupational therapists of measurement systems and assessment of worker capacity in relation to industry norms. Hocking and Wilcock (1997) attributed the work focus of occupational therapists, along with independence in self care, during this era of practice as related to the influence of the American social scene. Echoing the American direction, Australian political rhetoric promoted individualism and contribution to society in the context of low unemployment rates (Hocking & Wilcock). The philosophy of rehabilitation, and similarly the aim of psychiatric treatment were influenced by the view that everyone should aspire to a productive role in society. Employment by people with long-term disabilities was a sign, not only of individual stoicism, but also a measurement of the success of rehabilitation professionals. It was possible to overlook the often 'boring' nature of the work by considering a small contribution to a greater whole and the 'normal' routine created by having work hours like those living in the community (OT:CC10).

During the 1980s and 1990s, the place of work in OT programs decreased. The early 1980s saw changes in rehabilitation, influenced by the broader social impact of rising unemployment rates, the role of trade unions in negotiating pay rates and the impact of changing social views of disability, expressed through the 'normalisation' movement (Tipping, 1992). Normalisation was a term adopted during the 1960s in Scandinavia to refer to changes in approaches to services for people with intellectual disabilities and was subsequently used to

reform rehabilitation services that 'labelled and devalued individuals' (Tipping, 1992, p. 160). Industrial therapy delivered through OT departments and sheltered workshops was replaced by community-based programs aimed at preparing people for work in supported employment programs or for 'open employment' (OT:CC10).

By the decade of the 2000s, paid employment as an area of interest by occupational therapists for their clients had again strengthened:

Occupational therapists need to actively facilitate opportunities for paid employment with their clients, acknowledging the central role that productive occupations have in maintaining health and well-being (Kennedy-Jones, 2005, p. 123).

Occupational therapists worked in a diverse range of organisations, private, public and 'not-for-profit' sectors. Within the 2000s, Disability Employment Networks were established through Federal funding. Some of these networks had a specific focus on psychiatric services and offered 'occupational' perspectives for support of people seeking employment out of the supported employment environments (Cocks & Boaden, 2009). Ongoing development of employment programs remained as a thread in the 'occupation' strand of OT professional practice knowledge at the conclusion of the decades studied in this research. Occupational therapists are likely to be employed in a diverse range of positions within future community-based services, including roles of policy development and implementation and service management within consumer and carer groups. These roles will complement those existing within community-based interprofessional teams and will require knowledge that recognises political and social contexts of practice.

#### **7.2.4 Recreation.**

Recreational activities were a mainstay of OT in long-term institutions. Opportunities to participate in leisure and enjoyable activities were seen to balance the 'work' carried out in OT programs. The view that daily routines should contain both work and leisure was deeply embedded in the beginnings of OT. Adolf Meyer, in his statement introducing work and occupation as the

philosophy of 'occupation therapy', reiterated the importance of 'work and play and rest and sleep' (Meyer, 1922/1977, p. 642). Subsequent OT pioneers advocated a range of activities for therapists to choose according to patient need. While occupational therapists determined sets of activities according to *work and play* and *occupation and recreation*, they acknowledged that this distinction would be determined 'only by the patient's reaction and acceptance of a given activity, factors that are influenced by his former experiences and his present state of mental health' (Wade, 1947, p. 87).

As the era of 'new community' practice progressed during the late 1990s and 2000s, recreation received renewed interest by occupational therapists. Non-government organisations had taken primary responsibility for recreation programs, and occupational therapists identified a role within these organisations that incorporated 'therapeutic goals' into leisure activities:

therapeutic value of community-based sport or leisure occupations organised with the involvement of an occupational therapist ... occupation that is meaningful, pleasurable and culturally valued ... providing a sense of personal satisfaction and enhancing self-esteem. (Mynard et al., 2009, p. 272)

Occupational therapists sought evidence that involvement in sport teams produced positive outcomes, reporting that team membership could 'be used therapeutically to provide such benefits as development of an occupational identity and a sense of achievement and enjoyment and [might contribute] to health improvements' (Mynard et al. 2009, p. 273). The leisure and recreation aspects of occupation emerged as an ongoing thread of professional practice knowledge, offering opportunities for renewed critique and understanding by occupational therapists.

## **7.3 Strand 2: Valuing the 'Ordinary' of Everyday Life**

### **7.3.1 Simple achievements, significant gains.**

Through the transitions of professional practice knowledge described in Chapter Six, OT practice maintained its focus on everyday aspects of life. Within

institutional environments, occupational therapists reinforced the importance of routine, developing social links and behaviours and using activity to create a sense of achievement, however small that achievement might be. Simple cooking classes, social evenings and making goods for sale or for use by others were seen as contributions to society.

Within 'new community' practice, everyday activities were still valued as important within OT professional practice knowledge: as one practitioner commented, 'Sometimes the tasks are simple, like growing a plant in a pot, learning to organise clothes in a wardrobe ... these are the things often valued by those we are working with ... yet they seem so simple' (OT:CC10). Simple tasks could also be part of roles perceived as important for individuals, linked to their identity and sense of contribution to a group effort, because 'We know that his role is setting the tables for lunch, no one else can take this on, and even on days he says he is not well, he will be there for this task, it's his' (OT:CC4).

The element of meaning within the occupational view of practice adopted by occupational therapists was central to evolving practice knowledge and an enduring focus of OT practice. Occupational therapists conceptualised meaning at both individual and social levels. At an individual level occupational therapists, whether working with patients or clients, sought a connection through occupations that held meaning for the person. At a group or social level, meaning was enacted through the purpose of occupation – the 'purposeful activities' of earlier eras and the 'occupational roles' of later eras. Individual therapists incorporated the meaning of occupation, as portrayed by the patient or client, into the intervention process. Awareness of this 'core' of OT practice evolved during the fifty years of practice. Concurrently, a closer study of professional practice across a range of health disciplines created new knowledge of the thinking, decisions and action of practice: of *clinical reasoning*. For OT practice, clinical reasoning revolved around 'narratives' of practice, formed from past experiences of OT, knowledge gained through interaction with the client and considerations stemming from the therapeutic context (Chapparo & Ranka, 2000; Ryan, 1999).

### 7.3.2 Participation and belonging.

Daily and OT routines within psychiatric institutional settings were straightforward. The OT department was the accepted place for 'occupation' to occur. Times were allocated, and 'working' hours of the day were for 'doing'. Participation occurred in an organised fashion. Group participation was encouraged when considered an appropriate element of the therapeutic prescription. Alternatively, occupation might be individual, but carried out within a group setting where others were working on their own projects. The occupational therapist was a 'facilitator' of participation, encouraging, cajoling – but *not* exerting pressure to participate.

As patients moved to community settings and the 'department' focus disappeared, participation took on different meanings. Being able to participate in community-based activities did not necessarily occur instantly for people, who for many years, had been isolated from the community, yet routinely organised to participate in terms of their of daily activities (Burnett & Barker, 1976; Manderson, 1979; Tooth, 1979). However, community-based practice from an 'occupational perspective' reinforced participation as a core of practice for occupational therapists. The everyday routine of life focused on 'doing' aspects of OT.

As occupational therapists extended their critique of the interactions between occupation and health, they turned their attention to understanding aspects of 'being' and 'becoming' (Wilcock, 1999). This was reflected in Australian practice through the consideration of spirituality and participation in meaningful social interaction through work, and leisure activities (Kennedy-Jones et al., 2005; Tse et al., 2005; Wilding, May & Muir-Cochrane, 2005; Yuen & Fossey, 2003). Recognising participation as central to meaningful lives for people with mental illness led occupational therapists to strengthen the occupational core of professional practice knowledge.

## **7.4 Strand 3: Environments of Practice**

### **7.4.1 Practice within high walls.**

The environmental strand of professional practice knowledge was an element that changed significantly across the five decades of practice studied. The move from OT department to multidisciplinary team, presented as a major transition in practice knowledge in Chapter Six, was evidence that practice environments exerted strong influences on OT professional practice knowledge and professional identity. Early OT professional practice knowledge was constructed around the departmental structure and the control that occupational therapists had over their practice environment, the OT department. Professional identity was linked to these departmental structures through a hierarchy of positions, and included supervision of junior staff by those more senior, and staff development activities.

When mental health services moved to general or community-based hospital settings, many OT practice environments were still constrained by hospital walls, over which occupational therapists had less control than in the days of OT departments. Within these new institutional environments

the behaviour of patients in such occupationally un-engaging environments, who may be bored and unable to exercise their capacities, may be taken as evidence of continuing poor psychiatric status. Viewed in this light, the occupational environment of the psychiatric ward is a powerful determinant of patient status and subsequent treatment decision-making, for example the use of restraint and other physical and behavioural strategies, medication and discharge options. Staff relationships, respect and difficulties in task cooperation clearly impacted on patients' occupations and their well-being. (Fortune & Fitzgerald, 2009, p. 85)

### **7.4.2 Practice outside high walls.**

Faced with changed practice environments, occupational therapists took on generic, multi-skilled roles, becoming case managers, work consultants and team leaders. OT had moved away from the prescription of activity, adopting

occupation as a broader concept. While occupation could involve activity, it also encompassed diverse aspects of life, including education, work and spirituality.

Occupational therapists in Australian mental health services found themselves in community-based services where they lacked strength in terms of workforce positions and professional confidence (Lloyd et al., 2002). In Victoria, they confronted many professional identity issues during the 1990s and 2000s, expressing doubt about their capacity to take on the roles required in community-based practice. The direction for mental health services was clear as a government policy direction and community-based services were established, yet occupational therapists were challenged to frame their practice knowledge within the new practice environment. The challenges of the 1990s forced the profession to rethink the focus of OT, now that occupational therapists no longer had the environment of the department or a professional structure for supervision and support.

For occupational therapists in the community, the professional task became that of seeking to gain a fuller understanding of people's lives, both through research and through the tools of practice. A professional identity of being client-centred and holistic was strengthened:

we have been a bit limited at times in our history – we have specialised, as with psychotherapy groups, and ... I think if you are a community OT now, there is an awareness you've got to look at the physical health, as well as the mental health even if you are case managing, you have to look at the physical health of your client. (OT:CC5)

However, within acute mental health settings and within some community clinical services, occupational therapists were challenged to keep a focus on occupation within a medical model:

It's a bit like a casualty department. Once you are diagnosed, put on antipsychotic drugs then you are out the door, maybe in six to ten days. No one says 'what about your development, your self esteem, are you driving, working?' For me, it means a continuing effort to retain occupational

therapy input into decision making for the patient – giving information to the team about the client’s function. (OT:CC1)

Occupational therapists wanted to see the ideals of their practice knowledge actioned within the context of health services. Often they were disappointed by the structures that worked against what they saw as paramount for creating participation around personal relationships and interaction at a social level:

I went to an area health service to visit another OT and was sitting in the patient waiting room and there were probably 20 consumers there and none of them knew each other ... there was silence ... and I thought ‘crikey this is really sad - you feel completely isolated and alone’. (OT:CC4)

The challenge to work within organisational structures, many of which purported to be ‘client-centred’ or ‘consumer-oriented’ but failed to live up to this goal, was a significant issue for occupational therapists (Fortune, 2002; Fortune & Fitzgerald, 2009; Townsend, 1998). For OT practice in mental health services in Victoria, the ‘thread’ representing community-based practice remained one of evolution and continuing challenge.

#### **7.4.3 Professional identity in interdisciplinary settings.**

The interdisciplinary environment emerged out of earlier decades of multidisciplinary teams. Within these teams, roles were not designated according to discipline, ‘you were hired more for who you were and the skills you had, not that you were an OT, so OT specific skills weren’t valued as much as your interpersonal skills’ (OT:CC7). While the value of interdisciplinary approaches was a strong feature of mental health service reform internationally, tension still existed in Australia around the manner in which their work was organised, as ‘adaptation to case management roles; to working in within multidisciplinary teams and partnerships with consumers and carers; and to balancing the tension between specialist and generalist work tasks, [was] not clearly understood’ (Ennals & Fossey, 2007, p. 11).

I identified four interrelated factors as having significant influence on the way OT practice occurred in mental health services of the decade of the 2000s as a result of this interdisciplinary nature of practice environment. Firstly,



occupational therapists, faced with their own lack of clarity around explanation of their professional practice knowledge, also faced the challenge of presenting it within a team. Activities such as cooking and gardening were perceived by other team members as being 'for fun' and 'too ordinary'. Secondly, new graduates were not necessarily prepared for the complexity of the team working environment and might be 'trying to work collaboratively with other professionals who did not necessarily share the occupational therapist's view of what was best for the patient' (Fortune & Fitzgerald, 2009, p. 83).

A third significant factor occurring in the interdisciplinary environment of the public mental health services was the financial and management challenges of dealing with demand and balancing individual needs against waiting times, bed vacancies and the balance between acute and longer-term services. In acute services, where bed management was a concern and where 'throughput' was important, short stays in the hospital ward were a potential area of concern and tension for occupational therapists wanting to work on longer-term issues related to the return to community living. When occupational therapists within acute settings had a role in decision making about discharge, they often felt their role was devalued and the contribution based on their professional practice knowledge considered lower in worth than that of another profession, for example social work, which might be more closely linked to a patient leaving the ward early. The occupational therapist wanting to address financial management, interpersonal relations or driving skills was left feeling that 'management doesn't want to hear about these things' (OT:CC1). If the inpatient setting was an acute ward, the occupational therapist did not expect the patient to stay very long: 'they access the system long enough to deal with positive symptoms, then they are gone' (OT:CC1). This short contact did not permit the occupational therapist to make strong connections with the patient, to address ongoing occupational issues:

working within a system dominated by an illness focus, and with limited resources, has meant longer term treatment and support is sacrificed to improve throughput, and reactive management of crisis situations are prioritised over planned rehabilitation (Ennals & Fossey, 2007, p. 12).

In community-based teams, management also seemed to be influenced by individual skill and experience of both occupational therapists and the manager of the team:

if you can see some of the OTs who are case managers but they draw on their OT expertise, and some people can do it better than others, whether it's to do with the team who allows them to do it, and I think we still some quite problems with whoever is managing the team in some areas, still there very much maybe people from other disciplines who really constrain what an OT can do, even come across some OTs who can manage the two roles and are okay with it (OT:CC5).

Finally, and related to interprofessional understanding, the design of service and the tensions of resource management, occupational therapists also experienced a tension between their underlying philosophy of enhancing all facets of occupational function, yet being constrained by a role as manager of a 'case':

In contemporary mental health practice, occupational therapists may be functioning in case manager roles that are office based and include primarily monitoring and counselling duties within an illness model framework. In this setting, the link between occupation and health and ways to facilitate engagement in occupation are overshadowed by the assessment and review functions of the case-manager role. Opportunities for facilitating the engagement of clients in meaningful activities that strengthen their sense of self and promote recovery require renewed attention. (Kennedy-Jones et al., 2005, p. 123)

If occupational therapists are not supported to maintain their profession-specific role, they may eventually start to devalue it, thus reducing opportunities – that consumers value – to work on occupational issues in case management. (Ennals & Fossey, 2007, p. 19)

#### **7.4.4 Practice in 'policy' environments.**

Beginning with the early moves towards deinstitutionalisation in the 1960s and 1970s, mental health services in Victoria experienced five decades of changing

state and national policy environments. From a seemingly simple concept of hospitals for care of people with mental illness during the first twenty five years of community psychiatry, the 'development of the present community psychiatry services [became] very complicated' (Dax, 1992, p. 299). The mix of people and organisations involved in care expanded. In addition to public and private medical services, voluntary groups expanded, non-government organisations were funded to provide rehabilitation and community bodies were established, 'supposedly to protect patients in mental hospitals from involuntary treatment, illegal detention and incarceration' (Dax, 1992, p. 300).

In the early 2000s, Victorian mental health services, responding to the National Mental Health Plan, entered a phase known as 'new directions' with the release of its *New Directions for Victoria's Mental Health Services: The Next Five Years* (DHS, 2002). The general policy directive was accompanied by planning documents addressing specific target areas, including *Cultural Diversity Plan for Victoria's Specialist Mental Health Service, 2006–2010* (DHS, 2006) and *Planning Framework for Public Rural Mental Health Services* (DHS, 2006). Occupational therapists recognised that the new shape of practice would necessitate 'looking at practice not only for the aspect of skills ... but attitudes and values congruent with current government policies' (Lloyd et al., 2002, p. 164).

Confronting the dynamic nature of practice between clinical and community participation raised the question as to whether occupational therapists were still operating within medical models or whether a model of community development influenced practice:

While consumer participation in adult mental health services has supported the service ethos to become more consumer-focused, it is argued that the aged mental health sector still adopts a somewhat paternalistic or maternalistic view of its consumers. In order for consumer participation to thrive, there is a need to create a cultural value where the consumer's perspective is considered, not in light of illness, but valued in light of knowledge, experience and wisdom regarding their situation. (Fortune et al., 2007, p. 72)

## **7.5 Strand 4: Client-Therapist Relationships**

### **7.5.1 Therapeutic relationships.**

Early OT practice in mental health across Australia was firmly established within a medical model of treatment, as described in Chapters Four and Five. The nature of therapeutic relationships was primarily prescribed, as were the activities of practice. Occupational therapists were to be warm and friendly, yet maintaining a personal distance from patients. For roles assigned to occupational therapists within psychoanalytic approaches, expectations were prescribed and the 'physicians' assistant' role emerged.

In the newer hospital settings of the 1970s, changes occurred to the nature of therapeutic relationships. As a member of the therapeutic team, an occupational therapist could be involved in counselling, or be the key contact for a person in the acute ward. Meaningful relationships with the occupational therapist were important if aims of therapy were to be realised (Bailey, 1971, p. 14). The focus of OT care moved away from the notion of a large group attending the department to the individual being seen alone or as part of a group dynamic created within a ward or outpatient setting.

In contrast to the isolated nature of institutions, families could also be involved in treatment programs. The goal was to not separate the patient from their family or work context but to provide support into these environments when a patient left the acute hospital environment. Occupational therapists could be a model for behaviour and learning, or re-learning social skills (Bailey, 1971).

### **7.5.2 Client-centred practice.**

One element of transition from the 1990s and earlier models of practice was the focus on consumer and carer involvement in service design, implementation and evaluation. Despite the direction set by government in the 1990s through the National Mental Health Strategy, challenges existed for mental health teams to establish sustainable mechanisms to ensure consumer participation, and for carers to gain information and be recognised within service processes (Chaffey & Fossey, 2005; Fortune et al., 2007). Occupational therapists identified with

the change in direction of Victorian health services, yet remained challenged about the implementation of their philosophical ideals into practice (Chaffey & Fossey, 2005; Ennals & Fossey, 2007, Fortune et al., 2007).

Clients appreciate relationships with workers that are long-term, supportive, and from which they experience encouragement and hope ... as is widely understood in occupational therapy, the place of meaningful occupation cannot be underestimated. (Kennedy-Jones 2005, p. 121)

Within community-based services, occupational therapists saw a tension in maintaining the 'professional' service model of practice while perhaps ignoring the value of

really valuing environment which means huge amounts to people's recovery. People's recovery always involves other people that have been down the same journey or going along it with them ... I think there is a push for one on one [services] and that there is a removal of all of the structures that allow peer support that there's so little value ... there is this feeling that people with mental illness will infect other people, and it's best to keep them out of the system because being in the system you will be chronically ill. (OT:CC4)

Occupational therapists claimed client- or person-centred practice as a core professional value and an element of practice knowledge through theoretical frameworks (Townsend et al., 2008). Working in community settings created opportunities to embody this value as part of practice, not only with consumers but with carers, as

Occupational therapists could make a distinct contribution to enhancing carers' well-being, if they explore[d] these occupational issues directly with the cares and assist[ed] carers to identify ways to become or remain involved in occupations that have personal meaning and provide time away from caring. (Chaffey & Fossey, 2004, p. 201)

Occupational therapists also identified inconsistencies in the translation of espoused values into practice:

Does being client-centred mean you are working in an empowering way? I don't think you are necessarily going beyond that. Do we say 'goals that we will work on are your goals not my goals'? It rings so true, staff will talk the talk but when they then analyse the files, which happen to be staff files, not the clients', the goal will be that 'the client will be compliant with medication'. Now this wouldn't be a goal a client would set ... there is an understanding but the translation into genuine practice is not there yet. (OT:CC4)

In particular, the move to generic positions in interprofessional teams was considered a potential hazard to maintaining the client-centred focus of individual practice:

I think they start off being client or consumer-centred, but once you are in a multidisciplinary team and the only OT, then it's hard to maintain that focus unless the service has those goals ... when you are the sole position of your discipline you adopt the outlook of your service rather than the outlook of your discipline. (OT:CC7)

## **7.6 Strand 5: Researching Professional Practice Knowledge**

### **7.6.1 Research, evidence and writing about practice.**

Throughout five decades of practice, occupational therapists sought evidence that their work was effective. In 1958, occupational therapists in Victoria formally established a research committee (Anderson & Bell, 1988) as part of the Victorian division of the national association. The first journal article reporting an evaluation of OT intervention in Victoria appeared in 1960 (Lindsay & Honey, 1960).

However, more than in previous decades, occupational therapists of the 2000s questioned their professional practice knowledge by seeking and using evidence to substantiate their intervention, in all practice areas. Early in the decade, the profession strongly encouraged occupational therapists to learn about evidence-based practice and 'to identify the ways in which therapeutic actions enable engagement in meaningful occupation and how this contributes to health

and well-being is a current issue for the profession' (Fortune & Fitzgerald, 2009, p. 84); but there was no strong evidence to suggest it was routinely being incorporated into practice (McCluskey & Cusick, 2002). Occupational therapists did report 'mounting evidence that engaging in occupation can increase health and well-being', which strengthened their 'confidence in this fundamental belief of occupational therapy' (Iannelli & Wilding, 2007, p. 292), but many occupational therapists still lacked 'clarity regarding rationale for treatment action' (Fortune & Fitzgerald, 2009, p. 84). Within the interprofessional environment, confusion continued about role identity and the need for evidence to substantiate the rationale for OT intervention. This confusion led occupational therapists to 'perpetuate role incoherence because of difficulties in articulating the nature and aims of their work, how it relates to occupation, and how it differs but complements others' paradigms' (Fortune & Fitzgerald, 2009, p. 84).

By the 2000s, occupational therapists also became more aware that aspects of practice required consistency. Many were unfamiliar with how to use evidence:

And I think it's about evidence OTs don't feel comfortable with being in an area where the evidence is not yet developed, and this makes it hard to go into new areas of practice. Very few models have been thoroughly examined with enough rigour to be Cochrane studies ... there are few interventions that happen to be one to one, so they say this is what we are going to do now ... (OT: CC4).

Occupational therapists also identified the need for assessment processes to be linked to the theoretical models being used, rather than to tradition. For example, the use of assessment tools needed to be congruent with the new models of practice in the community. Practice in the 'new community' concentrated on the 'strengths' of a person, rather than the former approach of identifying 'problems' and seeking treatment options. The 'strengths' approach meant a range of assessment tools was required, with ongoing review and reflection about their use. Therapists had to be prepared to discard processes that had sometimes been in use for a long time, but were no longer meeting the standards of evidence and timeliness. Further, assessments developed in-house,

even though they were familiar and seemingly congruent with OT practice knowledge, might not have long-term value if they were not underpinned by rigorous processes of evaluation (Hitch et al., 2007).

Occupational therapists recognised that outcomes of services could be measured in broader terms than employment outcomes:

you hear people talking about participation and at the end of the day they really are talking about employment ... there needs to be much more respect ... you are disrespecting what participation is for some people... employment is not a priority or perhaps through experience they have made a choice that to stay well and healthy it is better to participate or dabble in very part time work, and that works for them. There is little respect for that individual ability to say 'I know what works for me in terms of participation'. (OT:CC4)

As discussed in Chapter Six, occupational therapists grappled with the prevailing paradigm of EBP introduced during the 1990s. Approaches to clinical reasoning supported consideration of interaction between the person, the meanings they ascribed to occupation, their personal attributes and the environmental contexts: clinical, home and social. Yet such a quantitative approach that recognised a hierarchy of evidence to judge effectiveness of intervention failed to recognise the focus of many health professionals (Cronin-Davis & Long, 2006; McKay, 2008; Rycroft-Malone et al., 2004). Occupational therapists sought to broaden the approach to research that aimed to inform EBP:

The heterogeneity in client groups seen by occupational therapists necessitates an individualised approach that cannot be informed by quantitative research alone. A client-centred approach that facilitates collaborative problem solving, through the use of clinical reasoning means therapists need to balance and draw on a range of information, which may include research evidence, qualitative and quantitative assessment results, contextual factors, motivators, personal experience and client preference. (Bennett et al., 2003, p. 20)



Understanding that research related to practice could, and should, draw on multiple perspectives and incorporate various methodologies was firmly embedded in the strand of researching professional practice throughout the five decades of practice. The most recent decade reinforced research and, in particular, the use of qualitative methodologies that addressed questions related to a greater understanding of concepts of occupation as the basis for OT practice:

In championing the case for qualitative research as a valid and valuable form of evidence to inform practice, it is important to highlight both its distinctiveness and how it allows us to address different types of questions related to health, wellness and, in occupational therapy, to occupation itself. (Whiteford, 2005, p.41)

Research reported in the Australian context demonstrated a wide range of approaches to questions related to clinical practice. One focus not yet to appear to any noticeable extent was the use of approaches that recognised client-centred research as important within the OT philosophy of practice and evidence. At an international level, and in particular in mental health services, by the 2000s occupational therapists were writing about participatory research involving clients or consumers in design and implementation of research related to OT programs (Rebeiro, Day, Semeniuk, O'Brien, & Wilson, 2001; Townsend et al., 2000).

#### **7.6.2 Creating a view to the future.**

Throughout the transitions in professional practice knowledge, a common thread existed to link past and future practice through professional dialogue. Learning from past experiences was a goal of both educators and clinicians, who identified work environment changes and sought to alert upcoming generations of the skills needed to forge alliances within their practice teams, to develop the skills needed to deal with workforce issues and to prepare for a future of evidence-based practice.

In recording their current and past practice, occupational therapists created links to future professional practice. During the 2000s, occupational therapists

saw that preventive mental health programs and developing skills for community living would be an area of growth for OT, and that 'the community is where we should direct our energies to assist people to be well, to be busy ... in a way, to not need to see us' (OT:CC8).

The dilemma to work across both clinical and rehabilitation services also led occupational therapists to 'wonder if we are not capitalising on our strengths ... by staying in clinical services, we are not making the most of our occupation focus' (OT:CC7). Prevention of future disability was also a concern:

it's about prevention – looking to the future for clients who have no money, no discretionary budget very few personal skills; they will get older and more dependent, in say ten to fifteen years, with poor state of health ... we should be channelling them into TAFE colleges, social programs. (OT:CC1)

Within the 'new community', understanding what was meant by occupation became an area for developing OT professional practice knowledge.

Occupational therapists might have established the importance of occupation for setting routines, for providing meaning in a day, for being a productive member of society and 'earning' leisure, but the complexity of community living raised the prospect of less than positive effects of occupation. Occupational therapists considered that 'exploring the negative effects productive occupations may have on mental well-being would also allow further understandings to be developed' (Iannelli & Wilding, 2007, p. 292). Concern was also expressed about 'the relationship between a lack of experience in productive occupation and mental health' (Iannelli & Wilding, p. 292).

Being prepared to identify and study the complexity of occupational issues and mental health reinforced professional identity as having a research and evidence focus. Seeking evidence for the effectiveness of OT intervention was one aspect of research endeavour. A second became that of potential preventive roles for the use of occupation in mental health programs, although this aspect was not yet readily accessible to practitioners. These preventive roles included exploring issues concerning the promotion of mental health and the role of occupational therapists in looking to future challenges that would be faced by

their current clients: one practitioner wondered ‘what will happen to these young people in the future ... they haven’t been in institutions, but they do know hospital wards ... we don’t have time to work on personal skills ... where are our preventive approaches?’ (OT:CC9). Occupational therapists who felt constrained within clinical services saw these ‘gaps’ for the future. Their involvement in mental health promotion programs provided opportunities for continued professional growth. Mental health promotion was identified as an area for further development of OT professional practice knowledge involving both discipline-specific and related knowledge.

## **7.7 Strand 6: New Generations of Practitioners**

### **7.7.1 Practice created by women.**

One of the most profound effects of the involvement of the medical profession in the establishment of OT was the unquestioned view that the role of occupational therapist would be taken on by women. Prescription and direction of activities was to be the sole responsibility of doctors, part of the treatment they devised. Occupational therapists would be involved in the selection and design of tasks and occupational programs that required organisation and administering to individuals, all with a sensitive and caring approach. This ‘caring’ element was perceived as a female trait, and the introduction of OT programs were seen as an extension of nursing in the psychiatric hospital environment. When the profession first emerged, the role of occupational therapist was described as one ‘which should particularly appeal to the girl who is interested in people’ (Philcox, 1951).

Skills required by occupational therapists were seen as a combination of training and inherent qualities, brought to practice before education started. Training programs and the professional association were focused on young women who were ‘suited’ to working with people and able to provide ‘sensible’ and positive approaches to illness:

The girl who hopes to make Occupational Therapy her life career must possess the gift of human understanding, with all that goes with it of empathy, tact and persuasion. She must also develop a keen insight into

character, and appreciate the many difficulties, both social and economic, that so often accompany long illnesses and severe crippling. It is her job to assist in reconstructing the lives of those for whom a normal life, as we know it, is impossible. She will find immense satisfaction in helping her patient to face up to the handicap, and to live as full a life as possible, in spite of it ... In the mental hospitals, an Occupational Therapist will work with patients who have lost contact with reality. Recreation and group activity of all kinds provide valuable outlets for deep feelings of inferiority and anxiety. (Philcox, 1951, p. 11)

The aim of reinstating patients back into productive roles in society fitted with the occupational therapists' personal values, which they brought with them from their social position. OT was 'a way of serving others, a way of life' (Philcox, 1968, p. 11). Nevertheless, the pioneering era of OT practice knowledge in the 1940s and 1950s was a time for women who were prepared to be different and to explore new fields of work. Many had previous qualifications and work experience; 'they were mature and dedicated people' (Sloane, 1976, p. 7). The first occupational therapists had trained in the USA, or the UK, or both if they pursued postgraduate study. Many had work experience overseas, and often in two or more states of Australia.

Employing more occupational therapists became a goal of the reorganised Victorian Mental Hygiene Authority during the late 1950s and the early 1960s. With increasing numbers of occupational therapists working in mental health services, the profession faced the challenges of growth and change and set out to consolidate their role within hospitals as 'an integrated member of the team' (Rayne, 1960, p.7). There was a move away from the idea that the job was for young women with an interest in helping and caring, particularly in the field of mental health; instead,

the profession should become more attractive to men with the expansion of industrial workshop in psychiatric and rehabilitation centres. This would give more stability in the staffing of these Departments and an overall improvement in salary rates (Sims, 1967, p. 42).

Attracting men to OT was seen as a way to raise the profile of the profession and to consolidate its transition from a group of activity leaders to a recognised health profession. During the 1980s, increasing numbers of male students undertook OT study (Mocellin, 1984) but, despite the predictions of greater numbers of men in the OT profession, by the 2000s the percentage of female occupational therapists still outweighed men. The gender imbalance was representative of the profession internationally, and remained an issue of debate (Brown, 1998). The predominance of women in OT was frequently linked with professional image difficulties for the profession, such as the lack of understanding of OT within medical services, the failure for OT to be recognised as a profession and ongoing lack of development of the profession (Irvine & Graham, 1994; Shah & Cooper, 1992; Whyntie, 1967). Yet the feminine nature of OT was also considered a strength for a profession that claimed its focus as the link between occupation and health that encompassed the meaning of everyday occupations for individuals, families and communities (Frank, 1992; Miller, 1992). Within mental health services, stereotypes of care-giving and the tension between being seen as taking decisive leadership versus maintaining a nurturing, caring role presented a challenge for occupational therapists:

If occupational therapists are hand-maidens to medicine they are *not doctors*, and they are *also not-a-lot-of-other-health-professions*. Occupational therapists still struggle to define professional boundaries, seeking recognition by medicine and outnumbered by professions who are ignorant of their roles. (Pollard & Walsh, 2000, p. 429)

In setting the scene for the next generations, gender, power and professional practice remained part of the complexity of practice within mental health services. Generational issues, technologies of practice and re-thinking gender roles within occupational contexts and as related to OT professional practice knowledge continued through the 2000s as challenges embedded in professional debate.

### 7.7.2 Practice knowledge: shared and discipline specific.

Early in the 'new community' era, professional practice knowledge was portrayed as being both discipline-specific and, importantly, shared within practice teams. The concept of shared practice knowledge in mental health services was established within the framework of the Second National Mental Health Plan 1998–2003. The *National Practice Standards for the Mental Health Workforce* (National Mental Health Education and Training Advisory Group, 2002) set out twelve standards to 'provide a realistic benchmark for the levels of practice mental health professionals working in mental health services will require in the 21<sup>st</sup> century' (National Mental Health Education and Training Advisory Group, 2002, p. 1). OT Australia represented occupational therapists, one of the five professions addressed through the standards. OT Australia undertook a commitment to use the standards to complement discipline-specific practice knowledge and to 'address the shared knowledge and skills required when working in a multidisciplinary mental health environment' (National Mental Health Education and Training Advisory group, 2002, p. 1). A review was undertaken to identify the capacity of OT education programs to define competencies for practice to meet the national standards. Findings presented in the report, *Review of Mental Health Course Content in Australian University Occupational Therapy Programs* (Weir, 2003) identified the commitment of universities to develop programs to meet the standards, and the incorporation of all standards to varying extents within curricula; but the study also reported that 'there is no evidence as to what type of approach best equips undergraduates to be mental health occupational therapists' (OT Australia, 2008, p. 6). It was agreed that preparation of new graduate occupational therapists required a significant commitment to learning in the field. The latter decades of practice saw difficulties in finding sufficient numbers of fieldwork placements to support learning for the increasing student numbers in OT educational programs. University programs and practitioners extended the boundaries of fieldwork education to include areas in which OT might once have had a presence but had had no position for several years, a result of the deinstitutionalisation process. Other placements occurred where the OT role was absent, or where occupation was a core to a service but no occupational

therapist was employed (Fortune, Farnworth & McKinstry, 2006; Thomas, Penman & Williamson, 2005). Lack of student placements with occupational therapists was seen as an issue in encouraging future generations of practitioners, because 'If a student has a really good placement it really is influential ... if they come across someone who is passionate about their work – that really is the thing that influences them isn't it?' (OT: CC5):

'I supervised a student [at a NGO where there was no occupational therapist] and every week she told me it wasn't a real OT job and every week I argued it was ... the work was so OT, all about living skills' (OT:CC7).

'I know the pay was not as high, but I enjoyed the work ... but in the end ... I wanted to work where I was recognised as an OT ... I wanted to have more influence' (OT:CC8).

### **7.7.3 Shaping occupational therapy identity for the future.**

Pioneer occupational therapists seemed clear about their vision as they set about establishing a profession. Those early health professionals specialising in occupation saw a future that involved work within a medical model of practice, yet at the same time making links with community living and the rights of the individuals with whom they worked. As the practice world changed so did the ability of the OT profession to state its purpose with confidence and clarity. Towards the end of the five decades of this study, clearer choices for future directions were being identified. Occupational therapists could see the relevance of a wider set of potential influences on OT practice. Practice that was diverse yet sharing a common focus on occupation was clearer in professional literature and supported through practitioner reflections.

Community development as an influence on OT practice led to consideration of the role of occupational therapists in community projects:

perhaps the time has come for the profession to debate the scope of its practice and seek avenues to secure the further involvement of qualified therapists in local, community projects that are better placed to support the

continuing health of people who are unemployed or marginalised because of long-term illness or disability. (Mynard, et. al, 2009, p. 273)

Convincing other team members of the importance of OT was still a challenge for occupational therapists, as in earlier decades. While in previous eras the structure of the OT department had given a public face to OT, the transition through specialisation, deinstitutionalisation and then community-based interprofessional practice meant that individual occupational therapists were identified more as individuals than as members of a department. Practitioners passed on the message that

to keep a job, you use the training to the most benefit ... opportunities become less because employers look at what you develop in yourself, your reputation ... they will take you on board because you have a repertoire of skills ... not because you are an OT. (OT: CC1).

Despite the tensions and the dissonance, and the work still to be done in fully understanding the impact of OT in community mental health, occupational therapists agreed that the community was the 'right' practice environment for them. As one said, 'the bottom line is that really OTs belong in the community. Acute services might be great learning, you hone your clinical skills, but we are essential in the community and our training is socially relevant' (OT:CC1).

## **7.8 Summary and Review: Strands of Change and Professional Identity**

The period 1960–2009 was a time of significant change in Victorian mental health services. Across these fifty years of OT practice, significant transformations occurred in OT professional practice knowledge. In seeking to understand these transformations, I was inspired by both the change and consistency of practice within the profession as it responded to change within Victorian mental health services. Six 'strands' emerged that reflected these elements of change and consistency. I envisioned these strands as linking past and future dimensions of the OT profession, and in particular professional practice knowledge and professional identity. The strands represented a 'flow'



of practice, with no distinct stopping and starting times or dates when one idea replaced another.

Occupational therapists constructed early practice around occupation, which remained the core of practice fifty years later. This core did not go unchallenged during five decades of practice. Professional identity was questioned when the traditional occupations of craft, industrial therapy and institutional life were placed under scrutiny as policy changes started a process of reform in mental health services. Some core activities were considered unscientific, and branded as symbols of institutional care. Occupation was reinterpreted in the context of community-based living and emerged as a stronger thread of OT practice towards the end of the fifty-year period. Occupational therapists reinforced participation as a concept of practice in both institutional and community environments of practice. This was closely linked to occupation, as occupational therapists maintained their focus on everyday aspects of life. This strand of professional practice knowledge also came under challenge when occupational therapists sought more 'scientific' activities and aimed to link their practice more strongly with medical procedures within mental health treatment.

Environments of practice changed significantly during the fifty years of practice studied. Changing environments reflected the major changes in mental health services brought about by policy changes at national and state levels of government. OT practice was both invigorated and challenged by these changes. Facilitating participation in meaningful occupations was the very reason to be involved in mental health services, so the community seemed an ideal environment. At the same time, however, the loss of professional identity, caused by closure of OT departments, took many years to address. Occupational therapists struggled with practice within models of service delivery where roles were generic and focused on case management. Role changes also affected the nature of relationships between therapists and patients. Occupational therapists maintained a 'client-centred' approach, yet some questioned the possibility of implementing this within the context of the 'new community' practice models.

The final two strands of professional practice knowledge related to research and writing about practice and passing this knowledge to the next generation of practitioners. A consistent vehicle for review across fifty years of practice was the *Australian Occupational Therapy Journal (AOTJ)*. This publication was established in the 1940s when the first action was taken to form the professional group that later became the national professional association, AAOT. Occupational therapists used the publication to record and critique practice. The AOTJ presented a forum for sharing professional practice knowledge and presenting it for scrutiny by the professional group. As such, it represented a strong link to the past and a view to the future of OT practice. Looking forward required a consideration of past and present practice. Occupational therapists reviewed professional identity in the context of changing practice models, the tensions they identified as existing when operating in either medical model or community-based frameworks. The position at the end of fifty years of practice remained one with ongoing challenges.

The transition to community-based practice exerted a strong influence on the evolution of OT professional practice knowledge. In the time of transition, the core of *practice knowledge* influenced the shape of practice that became embedded in the community. Future challenges faced by the OT profession included the recognition of the need to maintain an occupation-based focus in the climate of both medical model and community approaches to mental health services. Further, the valuing of quantitative, clinically-focused evidence for the effectiveness of interventions presented a challenge to occupational therapists to draw on qualitative research methodologies as ways to create knowledge and evidence of practice. Passing professional practice knowledge to future generations also required consideration of emerging generational issues, technology and the challenge to consider OT roles within non-government and consumer-led organisations.

The strands of practice across the four transitions discussed in Chapter Six are presented in Figure 7.2. I portrayed each strand with two key threads representing historical and future perspectives of practice.

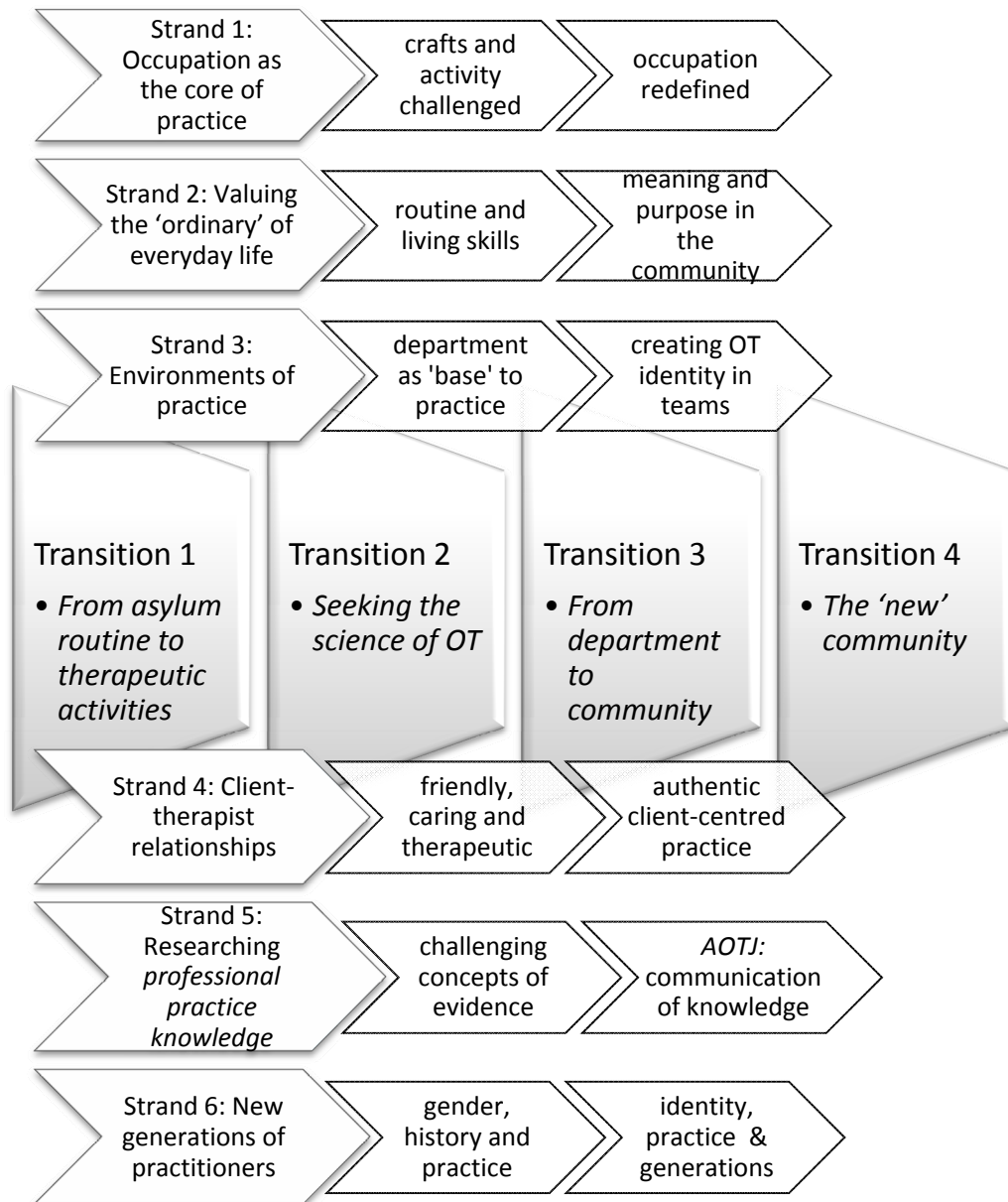


Figure 7-2 Transitions of practice and strands professional practice knowledge, 1960–2009

## **Chapter 8**

### **Conclusions and Critique**

#### **8.1 Introduction**

In this final chapter, I present a summary and critique of my findings as a contribution of new knowledge concerning OT practice in mental health services. In my study I illuminated factors that influenced OT professional practice knowledge and I reflected on the profession's responses to broader contextual factors within public mental health services of Victoria, my home State. The product of my research was a set of five texts constructed and interpreted through a hermeneutic process of dialogue. Through these texts I aimed to achieve deep understanding of OT professional practice knowledge as it evolved through five decades of mental health practice. Using this hermeneutic approach I achieved my goal, answering the primary research question:

What factors shaped OT professional practice knowledge as it evolved in mental health services in Victoria, and how is this knowledge emerging to guide current and future OT mental health practice?

Factors shaping professional practice knowledge were interpreted in the form of four transitions of practice and six strands of professional practice knowledge, which are presented and critically interpreted in Section 8.1. Through critique of the transitions and strands, I considered the ways in which professional practice knowledge was emerging to guide current and future OT mental health practice, the second component of the research question. I present a discussion of these perspectives as related to practice, education and research in Section 8.2. In the concluding phase of the study I undertook a critique of the project to establish the credibility and authenticity of my findings/interpretations within broader perspectives of mental health and OT practice, presented in Section 8.3. Finally, I reflected on the study and my role as researcher and interpreter of historical writing within the profession of OT, as presented in Section 8.4.

## **8.2 Factors Shaping Occupational Therapy Professional Practice Knowledge**

### **8.2.1 Transitions in practice.**

Mental health services in Australia had a unique beginning, dating from the convict era of the 18<sup>th</sup> and 19<sup>th</sup> centuries. Occupation within institutional environments during the convict era was harsh and punitive. As the convict era drew to a close, towns across the colony were established, populations grew and increasing social and health issues emerged. The transformation from gaols to asylums for people with mental illness was documented as a sign of progress in the infrastructure of 19<sup>th</sup> century Australia. Following the trends of the home country, communities established grand, isolated buildings for the separation of 'mad' community members. These benevolent institutions valued occupation as work, primarily to support the operation of the asylum and to maintain order among inmates. Asylums and hospitals retained some harsh features of earlier convict times, often serving the interest of the institution rather than the inmates or patients. Leisure activities provided a mantle of normality within asylums and were a demonstration to the outside community as to the humane treatment towards and the effectiveness of care of inmates. These large, overcrowded and isolated buildings were the environments into which occupation as treatment was introduced, and the OT profession emerged in the mid-20<sup>th</sup> century.

During an era in which mental illness resulted in separation from family and community for treatment, occupational therapists developed their practice around activity and group participation as core concepts of professional practice knowledge. Occupation was enacted primarily as craft, creative and recreational activities, with productive and useful intentions. Patients contributed to the sense of community within the hospitals as well as benefiting from prescribed activity as a core part of treatment. Occupational therapists created an environment of social interaction which valued individual interests and behaviour.

The fifty years of practice in Victorian mental health services, portrayed through my interpretation, represented a time of significant challenge to occupational therapists. As the use of handcrafts became contentious, occupational therapists sought more scientific ways to use activities within psychiatric treatment. Occupational therapists linked occupations to psychological processes and treatment approaches and took on roles as 'assistants' to psychiatrists in treatment programs and in particular psychoanalytic approaches. Individual therapists in Victoria began to specialise and develop their psychotherapeutic skills, including behaviour therapy, psychoanalytic approaches, Gestalt therapy, and family and group therapy. During this time, occupational therapists considered their practice knowledge as a beginning point for advanced practice. They considered it necessary to add further qualifications and experience to establish their credentials as mental health practitioners. While many therapists continued to incorporate activities within their specialty, others moved away from the traditional activity base towards techniques and psychological treatments. These tensions in practice reflected a time of uncertainty about the basis for OT professional practice knowledge in mental health.

During the fifty years of practice represented in the hermeneutic texts, occupational therapists demonstrated commitment to community living for people with mental illness. As the deinstitutionalisation process commenced from public psychiatric hospitals to community living options, occupational therapists were instrumental in developing programs for living skills, moving practice into day hospitals, community health centres and supported employment. OT departments, once the centre of practice, were gradually closed in favour of community-based programs and multidisciplinary teams. While offering many options for new approaches to practice, the transition to community also presented many challenges to occupational therapists working in mental health services. OT positions were lost and many services failed to transfer into the community.

The first decade of the 21<sup>st</sup> century represented the fourth and final transition in practice to emerge through the hermeneutic examination of practice. Occupational therapists sought to redefine their roles and seek new ways to

implement occupation as a core to practice in mental health services. A new level of reflection on practice challenges was evident. Occupational therapists engaged in research, using a wider range of methodological approaches in the search for new understanding of participation in meaningful occupation. Exploration of evidence-based practice became a focus with consideration of qualitative as well as quantitative approaches to critiquing practice, adding a further dimension to using practice to inform theoretical underpinnings of OT.

The transitions of practice identified through this study are unique to the Australian practice environment. While many experiences of practice are similar to those reported internationally, the findings of my study reflect what occurred in the Victorian practice environment, reflecting the implementation of national policy directives.

### **8.2.2 Establishing strands of professional practice knowledge.**

The final text of my research illuminated strands of professional practice knowledge that emerged and were sustained across fifty years of OT practice in Victorian mental health services. These strands represented themes of practice knowledge that emerged through the interpretation of the perspectives of practice recorded by occupational therapists. Each strand represented aspects of practice knowledge that remained constant in some ways, yet changed according to responses to the many influences exerted over time.

My interpretation of historical texts critiqued the evolution of OT in Victorian mental health services, identifying the notion of occupation as the core of OT practice. Practice knowledge around occupation was consolidated across five decades and is now universally accepted as the core of OT practice. My study illuminated occupation as the focus of knowledge that shaped practice, and in turn revealed that knowledge development was informed by practice. From the early days of the profession, occupational therapists were seen as being different from other health workers, primarily due to their use of activity as a treatment modality. Occupational therapists appreciated the value of occupation in the broadest sense within the context of practice. From the earliest introduction of OT classes in Victorian mental health services, therapists

sought to utilise activities to establish therapeutic relationships with people who had been isolated within dehumanising environments. Occupational therapists facilitated routine for patients and set them purposeful aims within each day. In turn, the products of activity were promoted as worthy contributions by individual patients to the social activities of the institution and the broader community.

In the beginnings of OT professional practice, being busy and having a daily schedule were considered core concepts of occupation for patients. Occupational therapists presented occupation as a means to routine and habit formation, powerful social morés of the mid-20<sup>th</sup> century. Activity was also seen as a means to bring a level of organisation to cognitive aspects of behaviour for individuals within institutional environments. The process of deinstitutionalisation of mental health services in Australia, however, challenged concepts of what occupation meant to people experiencing mental illness. The previously well-accepted OT departments, industrial therapy workshops and organised outings were no longer part of services.

As practice changed, occupational therapists realised that the activity, or occupation, itself might not have been the key concern. Participation in meaningful activity with others emerged as a core concept of professional practice knowledge. Occupational therapists sought to understand more about what occupation meant to individuals, their families and social groups, and to bring more meaningful opportunities within community settings. I argued that participation was consolidated as a practice concept in two ways that reflected the different meanings of the word realising. First, in coming to understand the importance of participation, occupational therapists re-conceptualised occupation as more than a focus on individual function, moving towards group and community perspectives. Second, occupational therapists participated in efforts to create participatory opportunities in the community for people with mental illness. In this way practice experiences informed professional practice knowledge.



The strand of professional practice knowledge relating environment to practice knowledge reflected the many ways in which occupational therapists constructed the notion of environment, as well as the way in which environment was used in practice. Over time, yet early in the history of the profession, occupational therapists recognised that the institutional environment was a barrier to meaningful occupational engagement: an awareness that both facilitated and challenged the growth of OT professional practice and development of professional practice knowledge in mental health services. The texts constructed and interpreted through the hermeneutic process highlighted the role occupational therapists played in deconstructing institutional care models. Facilitating independence was a core aspect of professional practice knowledge, and occupational therapists aimed to create and support patients to be active in life beyond hospital environments. However, occupational therapists faced significant challenges in shifting practice from its traditional environments into the community-based services created by the process of deinstitutionalisation. From an era in which hospital OT departments were the base for activities and social interaction, came a time when practice was relocated to shop fronts, office, homes and other community-based locations. When community-based services were established, the familiar environments of OT departments were lost as structures supporting the occupational therapists. OT departments created a structure for communities of practice to exist, identifying OT as having physical space. Community-based services moved out of hospital environments, closer to client communities and away from the distinctive identities of hospital and departments.

Closely aligned to environments of practice, a further strand of professional practice knowledge emerged which I named 'client-therapist relationships'; this strand was established through approaches to practice, and changed significantly during the fifty years represented in this study. Occupational therapists demonstrated a common thread of client-centred approaches to practice across the decades. From being therapists within a protective care environment, occupational therapists became facilitators of occupation. Challenges remained in integrating professional identity, originally formed

within a medical model of health, with the emerging consumer- or client-managed approaches to intervention programs.

Two strands of professional practice knowledge link past and future practice related to professional development and transition of knowledge across generations of practice. International links were established very early in the Australian OT profession. Australian pioneer occupational therapists set up educational programs, research committees and a newsletter that became the professional journal as part of their endeavours to create a strong knowledge base. These professional pioneers balanced their subservience to medicine and institutional settings with their drive to develop the OT profession and their interest in the importance of occupation in psychiatric hospitals. They sought development of knowledge through research, evaluation of their work and critique of practice through an international professional network. Education standards were developed and mandated also, at the international level through the Minimum Standards of OT Education, first promulgated through WFOT in the mid-1950s. The *Australian Occupational Therapy Journal* was established as a link between practitioners, students, academics, researchers and the professional association. While concerns, reports and celebrations of practice changed over the decades in terms of focus, communication of these professional issues was interpreted as a record of emerging developments in professional practice knowledge and a signal to future generations of practitioners.

Education of future generations was the final strand identified as an enduring link of practice knowledge. As with other strands, the preparation of future practitioners transformed during the five decades of practice. Changes in practice environments were a significant influence on education. Early practice within institutional settings created a professional learning environment where students became part of departmental activities and where professional behaviour could be modelled. The move to community-based multidisciplinary teams and the introduction of case management models changed the knowledge and skills required for practice and challenged educational programs to integrate new models of practice. Loss of OT - designated positions also had a

profound effect on fieldwork placement availability, reducing opportunities for learning in the field which had been a traditional part of OT training. Changes in education also had a significant influence on practice. As educational programs were designed that would align OT with other health sciences, postgraduate education, research and interprofessional learning became more highly valued. The traditional learning of craft and activities was replaced with learning of psychological techniques and, later, theoretical models of OT practice. The high value placed on fieldwork learning throughout the transitions was constant, but as fieldwork places became fewer in number, fewer new graduates considered themselves adequately equipped for mental health practice on graduation. Multidisciplinary teams and case management roles were rarely considered conducive to the transition from student to practitioner roles, given the lack of professional support and supervision.

### **8.3 Guiding Current and Future Practice: Implications of the Historical Interpretation**

#### **8.3.1 Occupational therapy: a quiet yet consistent place in mental health service history.**

The historical role played by OT in mental health services was largely unrecognised outside the literature of the profession. Historical accounts of the development of mental health services, and in particular those written from medical perspectives, paid only passing attention to the part played by occupational therapists, and there was minimal recognition of the knowledge brought to mental health practice through the study of occupation and in its impact on the lives of people with mental illness. The limited presence of OT in histories of mental health services has been identified in the broader context of Australian health history. Coleborne (2003) described the value of collections of historical items from psychiatric hospitals to inform education programs, increase public awareness and to be available for interpretation by historians, noting that 'Major gaps in the collection, possibly the result of the haphazard collecting practices of the psychiatrists, were seen to be items related to children, entertainment of patients and occupational therapy' (Coleborne, 2003, p. 187).

Robson (2006) acknowledged the role OT played in asylums and psychiatric hospitals. Documenting the collection and preservation of art works from psychiatric hospitals, Robson noted that occupational therapists were at first unaware of the use of art as therapy, but were taught by Dax to appreciate the art created by patients as worthy of collection. The Dax Centre in Melbourne was established to preserve such artworks, initially as a record of art being used in medical treatment. The purpose of the collection has transformed over the years to the role of community education about mental illness. Nevertheless, the collection remained as a link to past OT practice and continued to employ occupational therapists and be supported by volunteer therapists keen to preserve a link with the occupational and participatory nature of art.

Within the international context, recording history has been identified as an important means to remember practice, to review OT role in health services and to critique the contribution OT has made on local and international levels. Wilson (2003) critiqued the history of OT practice in New Zealand and highlighted the influences of gender and organisational practice environments on the professionalisation process of OT, factors evident in my study. The British Association of Occupational Therapists commissioned a significant study of OT in Britain (Wilcock, 2001) resulting in two volumes chronicling the emergence of occupation for therapeutic purposes as well as the evolution of the professional body. Anniversaries of practice or the beginning of professional associations have prompted similar reflections. Both the American and Canadian Associations of OT (AOTA and CAOT) have produced commemorative issues of their respective professional journals (AJOT, 1977; CJOT, 1986). Canadian researchers studied primary texts and documents of the Toronto Canadian Association and health services to explore the beginnings of OT practice in mental health from 1925 to 1950 (Sedgwick, Cockburn & Trentham, 2005). The authors concluded by 'highlighting the importance of historical documents and archival practice' to reflection on professional histories as a way to understand OT practice and shape future directions (Sedgwick et al., 2005, p. 415).

Continuing a 'quiet' role in historical stories of practice in Australia will counter the lack of recognition given to the important part occupational therapists have played in innovative approaches to mental health care. Practitioners of the future may well continue to be innovative as they respond to the challenges they confront. At the same time, research that seeks to establish and critique the ways in which OT professional practice knowledge contributes to a vital area of health in the community will offer opportunities to create new possibilities to enhance occupational engagement in communities. Seeking to understand historical perspectives of practice underpins an approach to education that reinforces practice knowledge as 'uncertain and always changing through continuous conversation within a professional community' (Hooper, 2010, p. 105).

My work reported here leads to further questions. Are historical perspectives of professional practice knowledge similar in other areas of practice, or is mental health practice unique? A theme emerging through critique of practice, and reinforced through critical conversations, was the 'separation' of OT practice into discrete, or diagnostic, parts. While history will record practice as being distinct, will professional practice of the future recognise closer connections between physical and mental illness? How will occupational therapists prepare for, and respond to, the political and social challenges of the future?

### **8.3.2 Linking historical and (re)emerging influences: implications for practice.**

Through my study, I showed that early OT practice in mental health services in Victoria was influenced by pioneering work in the USA and the UK, destinations to which many early Australian occupational therapists travelled. Handcrafts, games and light industrial activities promoted by international OT pioneers were adopted in Victoria. Occupational therapists in Victoria adapted activities to suit their practice settings. In particular, they were keen to extend their work through links with the communities that existed around the institutions. Patients were encouraged to participate in activities for social good, helping those in other institutions or caring for animals. Even if at times OT aims were at odds with institutional directives, occupational therapists persisted. With

outings beyond the hospital grounds, shopping trips, concerts, walks and picnics, occupational therapists encouraged a positive view of life for patients in the community behind the walls.

Through the changing times of practice, occupation remained the core of OT professional practice knowledge. Although there were changing ways in which occupation was interpreted through the decades, core aspects of work, leisure and daily activities continued as central to OT practice. Combined, these aspects of occupation represented a focus on 'ordinary' life in family and community settings. 'Ordinary life', however, was transformed during the five decades of practice as environments of practice changed, representing the link between each of the strands.

Critical appraisal of practice is required to meet the obligations held by practitioners to their communities. Accepting a role as a health professional requires occupational therapists to be critical and reflective as they implement their goals to facilitate the participation of people with mental illness in community-based occupational ventures.

The scant attention and limited recognition of OT meant there was little in-depth analysis by researchers of the role of occupation in the promotion of mental health. Opportunities exist to reflect further on practice, and to convey through research findings the potential of occupation to impact on individual lives as well as to contribute to the development of strategies at a community level in Australia. Such a position is supported by the acknowledgement that 'perhaps the area of meaningful occupation as a driving force of societal mental health has not received its due attention' (Sedgwick et al., 2005, p. 415).

Wright St-Clair (2001) argued strongly for returning to, and reconsidering concepts of practice and philosophical underpinnings of practice. Her analysis of caring as the basis for professional practice highlighted complex and intertwined historical, political, cultural and gender factors within a New Zealand OT practice context. A further dimension for consideration of professional practice knowledge issues emerging from my study is that of the caring nature of practice as reflected in Wright-St Clair's concluding statement:

We need to continue unpacking and interpreting what being caring means to us and to others, how caring motivates moral choices in practice and what sustains those of us who work in caring occupations. We can draw strong threads from the implicit place of caring in our history but these must be woven together with new ways of knowing, interpreting and reasoning to effect good occupational therapy practice in contemporary Aotearoa/New Zealand. (Wright-St Clair, 2001, p. 198)

### **8.3.3 Concepts of occupation and participation.**

My portrayal of practice in previous chapters primarily revolved around the evolution of professional practice knowledge in response to external imperatives in the health service environment and within a medical model of health, as distinct from the social model of health that emerged as an influence in the later decades of this study. In early practice, occupational therapists described their role largely within the parameters of medicine; however, in contrast to the acceptance of a role often regarded as subservient to medicine, they were often at the forefront of initiatives that brought about significant changes within mental health services.

Concepts of occupation and participation in the context of occupational therapy practice have been further developed through the emergence of occupational science (Zemke & Clark, 1996). While early occupational therapy concentrated on 'doing' as a concept of practice, theoretical development over time acknowledged a complexity beyond individuals and their ability or capacity to carry out certain actions or functions. Social situation and the social meaning of the actions became part of broader study. Similarly, in the context of practice research, dimensions of practice extend beyond the individual practitioner. In an earlier section of this thesis (see 1.4.2), I mentioned concepts of mental illness as being open to challenge within broader consideration of social and political concepts. Practice can also be transformed by consideration of the broader contexts including social, political and economic factors, complex forces, yet often invisible within scrutiny of practice (Whiteford, Wilding & Curtin, 2009).

A strong theme emerging from my findings was the importance of OT professional practice knowledge and its focus on everyday issues and concerns. Occupational therapists valued the 'ordinariness' of daily tasks and routines, and sought to understand client and carer perspectives. While recognising the everyday as a strong aspect of practice, occupational therapists were also challenged by the apparent lack of recognition by others of the 'professional' nature of such practice interests. The move away from the beginnings of OT philosophy and towards reductionist approaches in OT practice are documented as paradigmatic change in the quest for alignment with the medical model and mechanistic approaches to knowledge (Kielhofner, 1998; Reed & Sanderson, 1992; Shannon, 1977).

Occupational therapists reported merit in adoption of models of practice that supported everyday concerns. Publication of the *International Classification of Functioning, Disability and Health* (ICF) (WHO, 2001) assisted occupational therapists to interpret practice within a framework that created a 'translational bridge' between the medical model of health and the 'everyday' life conceptualised by occupational therapists (Polatakjo et al., 2007, p. 33).

Adoption of the ICF seemed 'common sense' to many occupational therapists. Using the framework allowed development of intervention approaches and clinical language that would have credibility, both in the professional world and with their clients. Similarly, adoption of recovery models of care reinforced the daily living interests and aspirations that occupational therapists sought to support through intervention and that Baum and Baptiste (2002) identified as the

challenge to redefine the medical model to incorporate health, wellness, and a focus on function. This redefinition requires occupational therapists to move beyond setting goals to achieve functional independence and into a client-centred approach that makes the individual's need for occupation central to the treatment process and has participation as the outcome.

(Baum & Baptiste, 2002, p. 3)

Occupational therapists in mental health services in Victoria were challenged by the need to work within the parameters of clinical services while recognising



the value of psychosocial rehabilitation, as practised within the non-government sector. The challenge was signified by differing concepts of practice. My interpretation of practice within mental health offers a challenge to practitioners and researchers to confront the issues of models of practice. Does OT fit solely within the medical model of practice, and if not, how do we incorporate the broader perspectives of client-directed services? Further, are there other models, or paradigms, of health to be considered, such as salutogenesis<sup>12</sup>? (Langeland et al., 2007; Ventegodt & Merrick, 2009).

#### **8.3.4 Language and practice.**

Integral to professional practice knowledge and the explication of concepts of practice is the language used to describe, evaluate and record practice. My study provided an interpretation of professional language across five decades of practice. The language of occupational therapy practice was often contentious, unclear and reflective of uncertainty within the profession. Confusion over such terms as *activity*, *occupation*, *performance* and *function* hindered links between theoretical perspectives, practice and the everyday lives of clients who received OT intervention. Occupational therapists were ambiguous in their portrayal of the core professional concepts, and struggled at times to delineate their practice from that of other disciplines. Communication with clients suffered through attempts to adopt 'scientific' approaches and at the same time deal in the 'ordinary'. While study of the language of practice was not my focus, issues emerged that warrant further research. Language is a key aspect of professional clinical reasoning (Loftus & Higgs, 2008). Difficulties faced by occupational therapists in explaining their practice are worthy of investigation in the context of clinical reasoning relevant to mental health intervention, in particular from the perspective of the 'new community' roles undertaken by occupational therapists, where expectations are for case management as well as possible discipline-specific intervention. The language of community mental health, where a social or participatory model informs practice, is very different from

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<sup>12</sup> Salutogenesis refers to a model of health that links stress experienced by humans and their capacity to be healthy, in contrast to a 'pathogenic' model with a focus on disease and illness. See <http://www.salutogenesis.fi/>

that operating in a medical model. The former recognises inherent power in language that empowers and enables participation in care, while the latter has a greater emphasis on illness and treatment.

The influence of models of practice and at the same time, some confusion (or lack of influence) about theoretical perspectives became evident during my interpretation of practice knowledge. During the more recent decades, occupational therapists began to adopt the professional language emanating from primarily North American models of practice. The MOHO<sup>13</sup> (Kielhofner, 2008) was developed with a very clear set of terms aimed at establishing a client-centred approach that focused on 'occupational performance' rather than illness or impairment. The American Occupational Therapy Association also promoted a uniform approach to practice language through the *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2008), an updated version of the Association's 2002 framework. Such frameworks establish common terminology and set the language for assessment, intervention planning and reporting, but do not necessarily ensure uniform approaches to practice at an individual level, nor learning about practice (Hooper, 2010). In contrast, Canadian occupational therapists established a client-centred approach within the framework of *Enabling Occupation II* that set a standardised process and language to client-centred OT practice (Townsend & Polatajko, 2007). Australian occupational therapists have no such national guidelines about professional language, nor directives about common models of practice. Instead, they draw on many perspectives, describing their practice as designed to meet individual needs within the prevailing social context. As a result they use diverse professional language with a strong focus on 'occupation' at the core.

Uncertainty or a lack of confidence with professional language did reflect on professional identity in my study, and remains an area for further research. Hermeneutics offers an approach to study the language within practice contexts

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<sup>13</sup> Model of Human Occupation

and in particular those related to clinical reasoning (Loftus, 2006). Alternatively, linguistic studies with a focus on discourse analysis offers the possibility of further in-depth study of OT within the power dynamics of organisational structures in mental health services. My interpretation of the difficulties faced by occupational therapists in making transitions in the face of organisational change suggests an area of research that identifies the manner in which language maintains or changes power relationships in organisational structures (Fairclough, 1989).

### **8.3.5 Gendered practice of occupational therapy.**

A significant strand identified in this study was the influence of gender in the profession. As recently as 2007, reference was made to the nature of OT's place in mental health services as the 'handmaiden to psychiatry' (Krupa, 2007, p. 1). Krupa, describing a discussion with leading psychiatrist John Strauss, reported that Strauss maintained that

occupational therapists in the mental health field have tended to characterise their work as complementary, but secondary, to biomedical treatments that are directed to the 'real work' of ameliorating illness. He [Strauss] argues that in practice our profession does not reflect its underlying ideology that proposes links between occupation and improved mental health. He contends that while we may consider ourselves to be experts in occupation and health, we are not pressing the mental health field to seriously consider occupation as a means to health. (Krupa, 2007, p. 1)

Reflecting on my study, I was prompted to consider this statement. Has OT maintained the 'biomedical' focus of the 1970s and 1980s? Are we really making the most of opportunities to assert a greater contribution to mental health rehabilitation and to the promotion of health and wellbeing? Does the profession allow gender to reflect professional status? Female dominance in professions is generally equated with the caring nature of roles allied, and in most cases subservient to, the medical profession. OT, with more than 90% women internationally, 'has retained an idea of the therapist as an engaged

caregiver, concerned with resolving the client's functional difficulties and making connections with diagnoses supplied by medical professionals' (Pollard & Walsh, 2000, p. 425).

The gendered nature of the profession is a strong thread linking past and future practice, and is identified as an area for ongoing research that examines practice and potential future influences on professional development. Additionally, research approaches that recognise alternatives to the male/medical domination of mental health services have the potential to recognise the interests of occupational therapists in supporting the promotion of mental health.

### **8.3.6 Implications of this study for education.**

My interpretation of OT practice across five decades identified the ways in which new generations of practitioners were influenced by significant changes in practice and in education policy. The absorption of the Occupational Therapy School of Victoria's training program into the higher education institution during the 1980s transformed the earlier paradigm of 'training' for OT practice to one of health science education, interprofessional learning, the search for knowledge through research and encouragement of postgraduate qualifications.

Creating learning for future practice is the role of both profession and educators, as are the setting and measurement of competency standards established by the professional association for occupational therapists working in mental health. Within the existing university OT courses, curricula in mental health were measured against external criteria, the national frameworks that set practice standards for mental health practice. Opportunities exist to adopt innovative ways in which to teach, and learn, the knowledge and skills for modern mental health practice. One standard of practice yet to be fully met by universities is the recognition of the role of consumers and carers in the design and delivery of curricula related to mental health, and in particular to developing an understanding of client experiences (OT Australia, 2008).

Professional education extends beyond preparation of graduates for professional practice. The increasing complexity of practice and the need to

develop skills and knowledge for taking on advanced practitioner roles was highlighted by Ryan, Esdaile and Brown (2003). In my interpretation of practice, I identified the changing nature of interprofessional roles within mental health, and especially recruitment to positions through personal knowledge and skills, beyond basic qualifications. Occupational therapists were not employed by title or position, but for their individual contribution to the interprofessional team. The knowledge of socio-political influences, understanding of the 'big picture', and being able to develop personal knowledge and competencies through continuing education and practice experience, as identified by Ryan et al. will be essential to the ongoing capacity of OT to contribute to mental health services.

### **8.3.7 Places and spaces of practice.**

An important aspect of understanding professional practice knowledge was demonstrated to be the many dimensions of the practice environment. During the five decades, practice environments changed and became more complex in the manner in which practice was created. In making the transition to community-based practice, many OT positions were lost, and as a result the professional practice knowledge brought to mental health practice by occupational therapists was missing from many community-based teams. In addition to the 'physical' environment, other features of practice environments became influential. Occupational therapists were at times responsive to the policy environment around them, but at other times did not fully anticipate, or perhaps fully understand, the changes ahead. The restructure of funding to mental health services in Victoria during the 1990s created distinct programs within clinical and rehabilitation services, challenging the ways in which occupational therapists were accustomed to work. Many of the programs in the non-government sector were 'occupationally focused', but were not seen by many occupational therapists as appropriate settings for their role. The contribution of 'occupational expertise' to services was lost, not by a failure in relevance of practice knowledge and skills but by policy, environmental and administrative issues such as salary levels. Professional status, viewed in the traditional medicalised settings, did not transfer to community-based programs within the non-government sector.

### **8.3.8 Understanding the Australian scene.**

This study was situated within Australian OT practice, drawing on records and experiences of practice primarily within the context of Victorian mental health services. The broader context of Victorian mental health services was established through national policy initiatives, described in this study. I have recorded OT practice within this national context as it evolved across five decades. While the detail may be different in other states, the transition from institutional to community practice shared similar paths. The institutional and departmental base established in the 1960s faded during the 1990s. Specific discipline roles became less common, and many therapists were daunted by the move to case management roles. Added to this was the imperative to create and maintain an 'occupational' focus to their work. The systems and structures for developing and transmitting practice knowledge were not automatically part of their work environments, and many therapists became isolated practitioners. The stories collated and interpreted through my study are reflected in other literature describing events across Australia and in many other countries where OT is practised. Understanding this historical perspective assists in developing educational and professional support for occupational therapists working within diverse and, at times, professionally isolated contexts.

National health policies exerted significant influences on mental health services and created the impetus for major change in service delivery models in Victoria. The shape of OT services changed significantly through the transition to institutional to community-based contexts of practice. The inclusion of client involvement in service planning and delivery altered and deepened the meaning of 'participation' within mental health services; the key features of client involvement were the interpersonal and emotional aspects of the environment and the actual occupations or activities offered within programs.

OT professional practice knowledge in community-based mental health services is yet to be fully developed. Occupational therapists claim a strong and unique contribution to mental health practice, yet experience difficulties translating the occupational core to interprofessional settings based on evidence-based practice. Occupational therapists claim a strong role within psychosocial

rehabilitation, yet are ambivalent about developing strong links with non-government organisations.

## **8.4 Reflections and Critique of the Study**

### **8.4.1 Critical appraisal of methodology and processes.**

This study drew on several sources, primarily texts from the OT national professional journal, the *AOTJ*. Other sources included professional association records, reports, newsletters and transcripts of critical conversations with practitioners. Further sources could have provided broader perspectives but this was beyond the timeframe feasibility of the study. A broader exploration with wider sources (including documents pertaining to other regions of Australia) warrants future investigation. Sources not addressed within the context of my study included proceedings from a range of professional conferences, both discipline-specific and, more recently, broader in their approaches. My decision primarily to use written records was to maintain consistency in the manner in which professional practice knowledge was presented. While some professional conferences include peer review, I consider that the presentation of practice in an oral form might be different to that recorded for peer review and publication. However, conferences have other benefits for historical analysis, in that they may record more recent practice, without requiring a lengthy publication process.

Some aspects of professional practice discussed in this thesis are limited to the state of Victoria, but it is realistic to assume the transferability of these findings to Australian OT mental health services generally. While there are some historical differences, and even current differences, in structure and function of the services in which occupational therapists in different states and territories work, there are far more similarities. By drawing on national perspectives in developing the transitions in practice, I sought to develop a broad view; and I contend that OT practice in Australia and, to a significant extent, internationally, is comparable. As occupational therapists Australia-wide continue to draw on the ICF (WHO, 2001) and other common terminologies of practice models that are being developed, opportunities will be created to establish a professional

language, and to foster intellectual debate and research that is both practice-based and theoretical. The challenge for OT is to build on international links and at the same time create practice that is diverse and culturally sensitive and specific. In particular, the nature of client-centred practice and the tensions of 'treatment' versus participatory care remain to be addressed by the OT profession.

This study was situated within publicly funded mental health services. Critique of professional practice knowledge occurred within psychiatric hospitals and the community-based services that developed with their closure. For the majority of the fifty years of practice being studied, public services were the major employers of occupational therapists. With more recent funding models, such as *Better Access Health Care*, occupational therapists are now working in a wider range of services, for example as private practitioners providing services to people with mental illness. Private sector medical services played a significant role in the development of mental health services in Victoria and generally within Australia (Dax, 1992). Future research, related more to mental health services than mental health practice knowledge, is warranted to look at employment patterns, workforce involvement and the ways in which occupational therapists were, and are, able to provide services within mental health programs.

New roles may well emerge within mental health services as Australian communities face emerging challenges to mental health, such as trauma created by natural disasters (Macdonald, 2009). These challenges create opportunities for meaningful contributions by a profession with knowledge based on the benefits of occupation and an understanding of the impact of disruption on family and social activity caused by illness or trauma. Understanding the broader contexts of practice and how the professional contribution is made will enhance the capacity of the OT profession to maintain its professional responsibility to society and continue to reshape its practices as a profession.



#### **8.4.2 Limitations of historical approach.**

Of significant relevance to my study were the historical perspectives gained by documentation of professional practice knowledge as recorded by Australian occupational therapists in their professional journal. Accounts of practice were a source of rich descriptions of the many ways in which occupational therapists enact their practice knowledge. While analysis and review of the *AOTJ* was beyond the scope of this study, it is evident that the journal continues as a major record of the evolution of OT professional practice knowledge. Australian OT literature suggests future directions for reporting evidence of OT outcomes in a wide range of OT programs in mental health services. While it is beyond the scope of this study, further research is recommended to identify the influence of OT professional practice knowledge on mental health promotion programs. My findings suggest that, while occupational therapists claim that occupation is beneficial for mental health, it still remains to be evaluated whether the outcomes of mental health promotion programs substantiate these claims.

Taking a more formal historical analysis of the five-decade period is worthy of consideration for future research. Anderson and Bell (1988) compiled a record of the first two decades of OT practice, and I have presented historical perspectives of one field of practice during the subsequent fifty years, but with limited attention to the specific 'people and dates' that are also important to record in a profession's history. Recording oral histories, documenting personal contributions and the involvement of occupational therapists in specific events would enrich the history of mental health services. Without ongoing efforts to record its history, OT remains at risk of being hidden in time or being misrepresented through its characterisation by other disciplines as having a purely 'entertainment' role in psychiatric history. My study contributes to the record of what is a far more significant contribution than the 'diversionary' aspects of being occupied.

#### **8.4.3 Reflection on the hermeneutic approach.**

Hermeneutics provided a framework for the construction of texts based on my interpretation of what occupational therapists wrote about their practice and published in the national professional journal. Within the hermeneutic

approach, I developed a series of process steps to collect and develop interpretations, based on 'dialogue' with texts and the use of critical questions and conversations with practitioners. The constructed texts represent the outcomes of the circular hermeneutic process, and are my written interpretations of the many complex historical stories. I chose this approach because it is recognised as leading to deep reflection and interpretation of written texts. I sought an approach that would enable me to engage with ideas and views expressed through recorded historical material. My aim was not to interpret what writers intended as meaning, but to challenge ideas and seek new horizons of understanding through critical questioning of what was written. I also sought new understanding by interrogating my own writing, using the questions relevant to my primary research question that were identified in the circular process of interacting with texts. Other approaches, however, could have been selected and might have shaped findings differently. For example, taking a hermeneutic phenomenological approach to this research question would have resulted in a different emphasis on the lived experiences of occupational therapists in the transitions of the five decades of practice. Such a study would have had the potential to illuminate the personal elements of practice knowledge and specifically to enhance the analysis of clinical reasoning, the use of personal practice models and the recognition of individual contributions to practice.

My study provided rich understanding of OT practice, presented in the form of historically based accounts of practice across several decades. Occupational therapists recorded OT practice from the earliest days of the profession's formation in Australia. In particular, the records of practice I accessed through the committee records, the professional journal and the critical conversations of practice in Victoria provided vivid reflections of people, contexts and interactions occurring through the shared experiences of mental health services as they were transformed across the decades.

Adopting a hermeneutic approach allowed me to identify myself within the text construction and interpretation process. Through acknowledgement of my pre-judgements and interests in the area, I actively engaged, with the texts, while

aiming not to dominate the writing process. My voice is present only as far as it is one reflection on practice knowledge, based on my professional experiences.

From the distance of the 21<sup>st</sup> century I created mental images of punishment and of the desolation of a strange environment that was so distant and so different from the homeland of the people removed from Britain to the penal colony. Without even contemplating the right or wrong of penal servitude, the disciplinary approach of hard labour and the imperative to establish a new settlement was evident through historical writing. Images of occupation as leisure and reward for hard work and good behaviour were evoked through accounts of life in the new settlements.

The hermeneutic process influenced my role in the research. As I became aware of my historical position with respect to the texts, and the manner in which my pre-judgements influenced my role in the reading process, I adopted an approach of critiquing professional practice knowledge through written accounts of OT practice, requiring a level of critical reflection. In particular, constructing texts involved decisions about what factors to include to portray the ways in which broader contextual issues influenced OT practice.

#### **8.4.4 Alternative approaches to consider.**

In this critique of my work, I note that I have critiqued aspects of OT practice within what I have accepted to be a reasonably sound system established to provide the level of care desired by the society in which mental health services operate. I could have taken other approaches. Adopting a Foucauldian approach, for example, would have led to analysis considering the role of individual and state. Mental health practice is possibly one of the most graphic examples of connection between state and individual within all areas of health. National policies shape services in all states of Australia and legislation sets parameters for diagnostic processes, levels of care, and the rights and obligations of individuals receiving care and their families or carers. Legislation dictates many aspects of medical treatment, enforced treatment and review mechanisms. Future possibilities for professional critique and research are open for the OT profession to contribute to understanding the implications for individuals and

communities of these legislative dimensions of practice from occupational perspectives, offering opportunities to design and implement services that are meaningful and responsive to individual and community needs. Contemporary practice remains complex, continually changing and yet needing to address many core needs of clients who access services. Attention to the paradigms of practice, identifying past strengths and recognition of occupation as the core of practice influence current practice in mental health. Practice paradigms that link historical and current dimensions of practice offer alternatives for greater depth of critique. As an example, recent work in education highlights the contribution of cultural historical activity theory, first elucidated by Vygotsky in the mid-20<sup>th</sup> century, as a framework for finding solutions to current practice challenges (Roth & Lee, 2007).

My study presented a professional perspective of mental health services. While I drew on my own experiences of working with many people over the years, and my critique of recorded stories of practice, I have not sought to represent the voices of people who experienced services from a client perspective. My report is written in the language of my practice and not that of the world clients live in. I acknowledge the limitations that such perspectives might bring. Future research lies in seeking understanding of different life worlds and experiences.

Further, my interpretation of occupational history and professional practice knowledge is compiled through my adoption of a research approach and is not written for generalisation to other areas of practice. I acknowledge that how we interpret and use language to describe the world we live in may be different from the language used by policy makers or clients. Future challenges remain to bring different worlds of experience and understanding closer together. I hope that practitioners reading my work will recognise aspects of their experience within it, and further my work by applying aspects of my findings to practice. This work also represents a change in my own practice, as an occupational therapist, educator and researcher. The process required intellectual challenge and while not exclusively an account of my own practice history, my personal development is to some degree mirrored in the professional evolution described in my writing. The research process of reading, listening, text

construction and writing required reflection and deep questioning of practice as I saw it and as explored through horizons that were historical, present and future.

## **8.5 Final Reflection**

I chose the context of mental health services for my study because mental health is a significant issue for individuals, families and communities collectively. As a national health priority, mental health attracts substantial levels of attention and funding. During the five decades of practice included in my study, major changes occurred in society's approaches to mental illness. Moving from an institutional care model, occupational therapists were involved in shaping new services and the adoption of approaches to mental health promotion; yet still, significant problems continue for individuals of all ages and for the communities in which they reside.

How we replenish our knowledge and hand it to the next generation for continuation is a worthy area for professional study. This account of OT in mental health services showed how each generation facing new policy and practice environments confronted challenges and passed on OT professional practice knowledge. The strands I portrayed through my interpretation of practice knowledge are far from static: they are dynamic and changing in response to practice. In turn, they influence practice by providing links to past experience and practice knowledge. Shaping practice in the 'new community' of the 2000s was identified as a challenge for the profession. The process of consolidating professional practice knowledge to equip and support practice in community-based environments is ongoing.

The study identified challenges for future OT practice. There was an apparent reluctance to move into new environments, even those described as inherently occupational but which fall outside traditional medical models of service. The study identified some possible changes in occupational therapists' approaches to work in the community sector. More recently, occupational therapists have sought to develop a greater depth of understanding of the life experiences of people with mental illness, as a way to enrich professional practice knowledge,

although there are still problems with the incorporation of a client / consumer focus within practice. The adoption of intervention design and evaluation shared with clients remains a difficulty for the profession. My findings suggested that occupational therapists are moving toward a broader role, prepared to engage in debate about the role of occupation in promotion of mental health and wellbeing. Problems, however, are indicated by the absence of occupational therapists in diverse community settings. Further understanding of the reluctance to move into community-based psychosocial rehabilitation programs is warranted. Is the absence of OT in these settings, whether in management or practitioner roles, purely a symbol of wage and status issues, or are there tensions around the transfer of practice knowledge into these new settings?

During this study, I wrote with pride about the work of practitioners who have inspired my own practice. Occupational therapists have written somewhat modestly and cautiously about their professional practice knowledge, yet were strong in their desire to confront practice challenges and inspire future generations. It is clear that high stone walls, baskets and leather lacing have faded into the past. However, they leave links, strands of practice to guide action for what lies ahead. Even though future horizons are at times distant and hazy, there exists the core of professional practice knowledge as I have interpreted in this report. We work in the present, a somewhat blurry blend of past experiences and promises of what the future might hold. Health professions have a responsibility to work towards a future of effective and meaningful practice. Our professional responsibility to reflect on past practice creates the impetus to influence our work of today and that of the future we envision for the generations of practitioners following in our footsteps.

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Recruitment email: Understanding occupational therapy knowledge in mental health practice

Dear (occupational therapist)

This email is to invite you to take part in a research study, *Understanding occupational therapy knowledge in mental health practice*.

The aim of the study is to investigate the historical development of the profession within mental health services, and to propose issues and directions for future practice.

The study is being conducted by Lynne Adamson and will form the basis for the degree of PhD under the supervision of Joy Higgs at The University of Sydney. In the first two phases of the study, the development of mental health services has been investigated, with emphasis of early occupational therapy practice in Victoria. A further stage of the study aims for a 'critical professional forum' through which the input of experienced occupational therapists will be sought. Your involvement in this phase of the study would be very valuable and appreciated.

Participation in the study will involve either one or two interviews, by phone or in person, or participation in a small group discussion, for up to 2 hours. A participant information sheet and consent form are attached for your information.

If you are willing to participate, please contact Lynne Adamson at your convenience, and further arrangements will be made at a time and location to suit you.

Lynne Adamson, PhD candidate,  
Phone: 03 5227 8370  
mobile: 0418 441 652  
email: lynne.adamson@deakin.edu.au

**Any person with concerns or complaints about the conduct of a research study can contact the [Ethics Manager, Office of Ethics Administration, University of Sydney on \(02\) 8627 8175 \(Telephone\); \(02\) 8627 8180 \(Facsimile\) or \[gabriola@usyd.edu.au\]\(mailto:gabriola@usyd.edu.au\) \(Email\)](#).**



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**PARTICIPANT INFORMATION STATEMENT**

**Understanding occupational therapy knowledge in mental health practice**

- (1) **What is the study about?**  
 The aim of this study is to investigate historical developments of occupational therapy within mental health services, and to propose issues and directions for future practice. Following a review of historical and current practice contexts, the researchers will seek a 'critical professional forum' through which the input of experienced occupational therapists will be sought to review and discuss issues related to professional practice.
- (2) **Who is carrying out the study?**  
 The study is being conducted by Lynne Adamson and will form the basis for the degree of PhD under the supervision of Joy Higgs, Strategic Research Professor in Professional Practice at Charles Sturt University, and Professor, The University of Sydney.
- (3) **What does the study involve?**  
 If you agree to participate in this study, you will be invited to take part in one or two interviews or small group discussion, depending on your preference and availability. The arrangements for this will be negotiated. Interviews can be by phone, or in person. Small groups will be convened at either the Geelong or Melbourne campuses of Deakin University, depending on convenience of location for you. If necessary reimbursement for expenses related to attendance at an interview, for example fares or parking costs will be made. Your permission will be sought to record the interview for subsequent transcription. It is anticipated that you will not experience any discomfort, risk or inconvenience by participating in the study.
- (4) **How much time will the study take?**  
 Participation in this study will involve approximately two hours on one or two occasions.



- (5) **Can I withdraw from the study?**  
Participation in this study is entirely voluntary: you are not obliged to participate and - if you do participate - you can withdraw at any time. You may stop the interview at any time if you do not wish to continue, the audio recording will be erased and the information provided will not be included in the study.
- (6) **Will anyone else know the results?**  
All aspects of the study, including results, will be strictly confidential and only the investigators named above will have access to information on participants. Data will be stored in a secure manner, with access only to the researchers and a research assistant. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.
- (7) **Will the study benefit me?**  
While we intend that this research study furthers knowledge about occupational therapy, it may not be of direct benefit to you.
- (8) **Can I tell other people about the study?**  
Yes, you can tell others about the study. Your agreement will be sought not to disseminate any information or material distributed to you as part of the study until findings are published.
- (9) **What if I require further information?**  
When you have read this information, Lynne Adamson will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Lynne Adamson, PhD Student, 03 5227 8370 or 0418 441 652.
- (10) **What if I have a complaint or concerns about the study?**  
**Any person with concerns or complaints about the conduct of a research study can contact the Ethics Manager, Office of Ethics Administration, University of Sydney on (02) 8627 8175 (Telephone); (02) 8627 8180 (Facsimile) or [gbriody@usyd.edu.au](mailto:gbriody@usyd.edu.au) (Email).**

*This information sheet is for you to keep.*



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**Professor Joy Higgs**

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**PARTICIPANT CONSENT FORM**

I, .....[PRINT NAME], give consent to my participation in the research project

**TITLE: Understanding occupational therapy knowledge in mental health practice**

In giving my consent I acknowledge that:

1. The procedures required for the project and the time involved (including any inconvenience, risk, discomfort or side effects, and of their implications) have been explained to me, and any questions I have about the project have been answered to my satisfaction.
2. I have read the Participant Information Statement and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.
3. I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher(s) or the University of Sydney now or in the future.
4. I understand that my involvement is strictly confidential and no information about me will be used in any way that reveals my identity.
5. I understand that being in this study is completely voluntary – I am not under any obligation to consent.

6. I understand that I can stop the interview at any time if I do not wish to continue, the audio recording will be erased and the information provided will not be included in the study.

7. I understand that information or material distributed during the study will be the intellectual property of the researchers and will not be disseminated without the agreement of the researchers.

8. I consent to:

i) Audio-taping YES  NO

ii) Receiving Feedback YES  NO

If you answered YES to the "Receiving Feedback" Question, please provide your details i.e. mailing address, email address.

**Feedback Option**

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Email:** \_\_\_\_\_

**Signed:** .....

**Name:** .....

**Date:** .....

### Conversations with occupational therapist, excerpts from transcripts.

#### Excerpt 1:

- Researcher: I'm interested in the period 1950s, 1960s, when more occupational therapists were employed in the major psychiatric hospitals. I've read about the change in focus for OT, can you tell me about your experience in the OT role at this time?
- OT1: We each had responsibility for a ward, fifty or more patients, but we wanted to be able to treat according to individual needs. We developed this idea of an OT program ... we were still responsible for a ward, or wards, but we interviewed people on the wards, and we talked about their needs ... so the program would change, according to staff expertise and what we thought people needed. We had different sorts of groups ... so I ran a home management centre, and someone else had screen printing. There was a broad range of occupation, or activities that people would be going to, different periods during the day ... each person had an individual program "this was your program of the day" ... people went to groups according to what we thought their needs were and what their interests were. So we had carpentry, woodwork, ceramics, a person who did picture framing, a large industrial section, as well as other creative activities ...
- Researcher: So you were creating change, did other staff understand the purpose of OT?
- OT1: We were saying "we are occupational therapists, we are not just occupying people" ... previously [OT] was seen as socialisation, something like that ... [for us] it was "no, we're occupational therapist we know about occupation, we are skilled in this area, we are going to interview, assess people, and put them into a program occupational program that most suits their needs."
- Researcher: So, it wasn't that there had to be a doctor's referral - you made the decisions?
- OT1: We instituted a referral system, because we were interested in showing there was assessment involved, we were trying to reverse the previous system, which was that at 9 o'clock, [patients] were sent out of the ward, to come over to OT, so it was more like we were just looking after people for the day ... whereas this way, we wanted to establish OT, help people knowing what we actually were doing ... so we asked for referrals, not just from the doctors, they could be from nurses ...

#### Excerpt 2:

- Researcher: We've been talking about your work in the community rehab program, how did you think your role as an OT fitted with the program?
- OT2: I always thought this was one of the best jobs I had, it was just so OT, I could see how all the occupational pieces fitted into place for clients, they usually came [from the acute service] not really knowing what rehab was about and no one really knows how to explain OT, but I would just talk about their interests, maybe what had been interrupted by the hospitalisation ... sometimes this took many weeks, working together on a project that was already happening in the place, then slowly we came to what was important ... that's the part I waited for, then we could really talk about things ...
- Researcher: Now I know there is always turnover in OT positions, but how long did you stay with that program? Why did you leave?
- OT: I had really only intended this as a temporary job, sort of in transition, and not really sure that I wanted to stay in mental health, but I loved it, so down to earth, and at a distance from the hospital setting ... but somehow I think the lower pay, not really feeling people understood the OT role ... always a tendency to link us with more of the acute, clinical role ... then the opportunity to be part of a new program and also to do some part time teaching, I did want to influence where I saw the future ... I wanted students to see the options for working in the community ... but now I'm not so sure about this also ... during the 1990s we lost so many positions in community mental health ... with the transition from the hospitals, many OTs were disillusioned ...

**Journal notes: photos and artefacts**

25/01/10. Note from journal, visiting J ward Ararat (previously forensic mental health, now museum) .



I am struck by the severity of the dark high walls and the bland interiors of the corridor and sleeping cells. Our guide tells us about the threats from her childhood ... any sign of misbehaviour and they could be sent up to the institution on the hill ... and how as children she and her friends would wander past the garden to look at those strange people gardening ... and how they were in awe of the place on a night with full moon, that's when strange things might happen ...

The cells held a bed, grey blanket and bucket. A showering room was built adjacent to the sleeping quarters, meaning an early morning walk outside to the showers ... I think of the dark, cold air of winter ... there are no signs of comfort and warmth in the building ...



We hear the activities room was a popular place, and one in which patients would have choice of activity ... some of the work was so beautiful, fine embroidery, woodwork, and baskets, some of which were made for sale. Patients were known for their skills at their chosen craft ... or some were known for success in the garden ...

23/5/2010

Notes from field trip to Yarra Bend, site of first lunatic asylum in Melbourne, current site of Forensic Mental Health Service:

So close now to the bustle of the city, yet a quiet place ... it took me a while to find the imposing remains of the gate to the asylum, Victorian bluestone adds to the sense of awe, just as at Ararat ... stone that is equated with prison ...

Yet the new prison is quite different, unobtrusive, yet with a very solid, light coloured wall, hidden by groves of native bushes ...

I arrive with my 100 points of identification and wait for the eye scanning and metal detection ... inside the walls I am impressed by the sense of calm and the signs of activity – the garden plots, the gym, the woodwork workshop, the bikes for riding, people talking in the garden, small groups walking between buildings ... although I see the internal boundaries, the fences around the wards, allowing a two-way view, but no easy access in either direction ...



## Victorian Mental Health Service System

Clinical services			
Child & adolescent services	Adult services	Aged persons services	State-wide and specialist services
Intensive youth support	Crisis assessment and treatment	Aged persons mental health teams	Victorian Institute of Forensic Mental Health
Continuing care, clinical Day programs	Mobile support and treatment Continuing care teams	Acute inpatient services Aged persons mental health residential care	Personality disorder service Brain disorders service
Conduct disorder services	Primary mental health & early intervention teams Community care units  Acute inpatient services Secure/extended care inpatient services Homeless outreach services Consultation and liaison services Prevention and recovery care  Youth program - early psychosis services		Mother-baby services  Eating disorder services Koori services  Child inpatient unit  Dual disability service  Neuropsychiatric service Early Psychosis Prevention and Intervention Centre (EPPIC) statewide

Psychiatric disability rehabilitation and support services			
Mutual support/self help	Planned respite	Non-residential PDRSS	Residential PDRSS
	Day activities In-home respite Holiday/adventure activities Residential respite	Rehab. day program  Home-based outreach	

Source: Victorian Mental Health Service System, May 2005

Retrieved March 22, 2011, from  
<http://www.health.vic.gov.au/mentalhealth/services/mhsystem.pdf>

## **Standards and scope of practice related to OT practice in Australian mental health services.**

### **1. Australian Competency Standards for Occupational Therapists in Mental Health** (OT Australia, 1999). Retrieved May 25, 2011, from <http://www.ausot.com.au>

#### **Units of competency for occupational therapists, practising in mental health for two years.**

- Unit 1: Facilitate Occupational Development with Individuals, Groups, Organisations and Communities
- Unit 2: Work with Teams
- Unit 3: Develop and Maintain Collaborative Partnerships with Consumers and Carers
- Unit 4: Undertake and Support Systems Advocacy to Support Consumer and Carer Self Advocacy
- Unit 5: Undertake Evaluation and Research Activities
- Unit 6: Manage Professional Practice
- Unit 7: Maintain Professional Development

### **2. National practice standards for the Mental Health Workforce**

Retrieved May 25, 2011, from <http://www.health.gov.au>

- Standard 1: Rights, responsibilities, safety and privacy
- Standard 2: Consumer and carer participation
- Standard 3: Awareness of diversity
- Standard 4: Mental health problems and mental disorders
- Standard 5: Promotion and prevention
- Standard 6: Early detection and intervention
- Standard 7: Assessment, treatment, relapse prevention and support
- Standard 8: Integration and partnership
- Standard 9: Service planning, development and management
- Standard 10: Documentation and information systems
- Standard 11: Evaluation and research
- Standard 12: Ethical practice and professional responsibilities

### **3. Excerpt from OT Australia Position Statement: Occupational Therapy in Mental Health.**

(OT Australia, n.d.). Retrieved May 25, 2011, from <http://www.ausot.com.au>

Occupational therapists possess knowledge, skills and competencies to work with people with mental illness in the following ways:

- Assessment of functional independence, capacity to maintain family and community roles and ability to participate in vocational and leisure pursuits
- Interventions to assist clients to cope with or overcome the practical challenges of living with mental illness including independent life skills such as shopping and budgeting as well as social relationship skills and vocational rehabilitation included post work experience placement support
- Identification of risks factors within the client's usual environments and strategies for change, resolution of issues, or for healthy living are developed in collaboration with the client and relevant others
- Planning and advice regarding safe discharge, ongoing care options and referral to appropriate agencies and services for in-patients and outpatients
- Working alongside those with mental illness, other health professionals and the general community towards acceptance of mental illness

**Images and artefacts of occupational therapy practice**

The CD enclosed here contains a series of images collected during my study, which I have compiled as a short film.

Permission to use archival photos was granted:

*In the garden at the Red Cross Rockingham Convalescent Home, Kew, 1946.*  
Ref no: H99, 201.1388 Argus Newspaper.

*History of, and services provided by the Repatriation Commission and the Repatriation Department – Victoria – Occupational Therapy*  
National Archives of Australia, Series and image no: A7342 V 11.