AN EXAMINATION OF THE ROLE OF OCCUPATIONAL THERAPY OUTSIDE HOSPITALS

by

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C O N T E N T S

INTRODUCTION

This report discusses possible roles and functions of occupational therapists in the community - in its narrower sense of meaning "outside the hospital" rather than in the sense of a total community service. The report presents the results of my investigations into some of the present fields of work undertaken by occupational therapists in the community, the types and methods of work they employ and their conditions of service. It discusses some of the problems involved and the opinions of some occupational therapists and allied workers in the community.

My terms of reference were:-

1. To examine some existing community occupational therapy services in England.
2. To consider the role of occupational therapists in the community.
3. To identify problems encountered in community occupational therapy services.
4. To consider the relationship between community occupational therapy and occupational therapy in the hospital service.
5. To suggest possible future developments of occupational therapy outside the hospital.

After 18 years as an occupational therapist in the N.H.S., the last 11 as a Head Occupational Therapist, I was fortunate enough to be given the opportunity to undertake a 6 months' secondment to the Social Services Department (Physically Handicapped Unit) of the City of Canterbury. This assignment carried with it a commitment to devote one day weekly to beginning a study into "The Role of Occupational Therapy Outside the Hospital", in conjunction with the Health Services Research Unit at the University of Kent at Canterbury, under the direction of Professor Michael Warren. During my assignment it was necessary to return to my hospital group in Dartford one day a week to maintain contact in an advisory and managerial role of the hospitals' departments. The original administrative arrangements were to spend Monday, Tuesday, Thursday and Friday in Canterbury, returning to Dartford in the middle of the week on Wednesday, and using the equivalent of one of the four days on study. This, however, very quickly proved to be too fragmented to be efficient and proved wasteful of time, not only because of the extra travelling involved, but also because it was necessary to be

frequently re-orientating one's thoughts. Therefore, it was decided to devote 4 consecutive days, Monday to Thursday, to the Social Services Department, spend each Friday back at my hospital base, and accumulate the study days - except where visits were concerned - to form a block of about 3 weeks to be spent writing the project at the University of Kent towards the end of my secondment. This arrangement proved far more satisfactory in every way.

I am indebted to a large number of people who have helped in a number of ways and whose names are listed at the end of this report. I was particularly fortunate in having sufficient staff of enough experience at Dartford to enable me to be away for four days each week during the secondment. My thanks are due especially to them for their cheerful undertaking of extra duties and responsibilities during the 6 months.

THE PROFESSION

The first training school in occupational therapy in Britain was started in 1930, the Association of Occupational Therapists was formed in 1936 and the first public examinations held in 1938. In 1938 also, occupational therapy was first started as a community service in Surrey.

During the 1939-45 world war occupational therapy received a stimulus as being a realistic means of rehabilitation at a time when maximum and speedy recovery from injury was of paramount importance, and its potential as a remedial profession began to be more appreciated.

Since the end of the war the profession has developed as a recognised paramedical and remedial one with therapists trained and working in a variety of fields both within and outside the hospital service, e.g. in general, geriatric, paediatric, orthopaedic, psychiatric and subnormality hospitals, in day hospitals, rehabilitation centres, prisons, schools and with local authorities in a domiciliary capacity and in day centres and residential homes.

There is an acknowledged shortage of trained occupational therapists and owing to this shortage of manpower, it is important that the best use is made of available resources, and that occupational therapists are employed where their skills and knowledge can be used to the greatest advantage to the persons they serve in conjunction with medical, other paramedical and allied services.

In 1972 a survey carried out by the Association of Occupational Therapists showed that there were slightly more than 4,000 occupational therapists, 11,000 physiotherapists, and 300 remedial gymnasts registered in England and Wales. There were 1,369 'other staff' employed in occupational therapy departments, made up of 834 aides, 213 technical instructors, 91 craft instructors, 82 nurses, and 149 unclassified persons.

Despite these numbers of registered persons and the numbers employed, there is a serious shortage of staff. A study of the vacancies advertised in the July 1973 issue of the Journal 'Occupational Therapy', the official journal of the Association and the largest single source of advertised vacancies in the field showed the following:-

Senior and Head vacancies	- physical	- 100
Senior and Head vacancies	- psychiatric	- 65
Senior and Head vacancies	- local authority	- 37
Basic grade vacancies	- physical	- 117
Basic grade vacancies	- psychiatric	- 115
Basic grade vacancies	- local authority	- 15
	Total	449

There is no reason to assume that this was not a typical situation. It implies a much larger vacancy list, because many authorities have ceased to advertise their vacancies due to lack of response, and others use alternative media such as the 'Health and Social Service' Journal. In fact, the vacancy list is probably about 1,000.

DEFINITION OF OCCUPATIONAL THERAPY

Occupational therapy is defined by the Association of Occupational Therapists (now the British Association of Occupational Therapists) in its "Outline of the Syllabus of Course Leading to the Diploma", as "treatment by occupation. The treatment is medically prescribed, and may take the form of any activity, work or recreation, chosen specifically for the individual patient with a particular illness or injury to aid his recovery and resettlement and/or to help him to live with a permanent disability."

The aim of occupational therapy in the local authority service is "to restore to, or maintain a client in his normal place within the community, enjoying maximum independence in the physical, psychological, social and economic aspects of life." (B.A.O.T.).

A recent definition published in a supplement to "Practice Team" (February 1974) on The Professions Supplementary to Medicine, states that occupational therapy involves "The use of appropriate creative and work activities to achieve an improvement in the patient's physical and psychological state; the provision of work or domestic situations in which to assess and prepare the patient for resettlement."

The role of the occupational therapist as described in "Future Education and Training of Occupational Therapists, (published by the Council for Professions Supplementary to Medicine) is:-

" (i) At the initial stage to make a contribution through practical and social situations to the diagnosis and assessment of psychological and physical disabilities of patients of all ages.

(ii) At the continuous treatment stage of the patient to contribute to the development of functional ability to the maximum level of physical and psychological competence, through the use of the therapist-patient relationship and of appropriate activities in appropriate settings.

(iii) At the resettlement stage to prepare the patient for the home and the social and economic situation to which he will return.

These functions may be performed:-

(a) In hospitals, with short-term patients who may have long-term problems, and in special units calling for specialised care of longer-term patients.

(b) In the community where the therapist will continue to treat discharged hospital patients, and to care for the permanently handicapped, and the elderly, either in the patients' own homes, in treatment or work centres, day centres or residential homes for the permanently disabled or elderly."

Therefore, occupational therapy should be a continuous process starting with the patient in hospital and following him through, where necessary, back into the community and, in the case of the permanently disabled, keeping contact with him permanently or until resettlement in the community has occurred. This process may, of course, work in reverse order where a disabled person is admitted into hospital from the community either temporarily or permanently, owing to a deterioration in his condition or because it is no longer possible to care for him in his home situation.

THE HOSPITAL OCCUPATIONAL THERAPISTS AND THE OCCUPATIONAL THERAPISTS OUTSIDE THE HOSPITAL

Although the aims of occupational therapists inside and outside the hospital are basically the same (i.e. to enable the patient/client to achieve maximum independence in the physical, psychological, social and economic aspects of life), their methods of achieving this are necessarily very different. It has, in fact, been suggested that the community occupational therapist does not fulfil the same role as her hospital colleague, that her methods of work, her tools and equipment, working environment,and working knowledge are so different as to be almost unrecognisable as the same profession. There has for many years been a distinction within the National Health Service between the psychiatrically-orientated and the physically-orientated therapist but both have had the same basic training and are free to move from one specialty to the other if they so wish. The third element - the community occupational therapist - is a group that is gaining in strength both numerically and in importance. All community occupational therapists would probably agree that their basic training and any hospital experience they may have had has been of value to them in their present work, but that more training in the community services would have been an advantage. For example, it became apparent to me that comprehensive assessment forms, although excellent in themselves, can be an inhibiting factor to forming a good rapport between client and therapist. Similarly, it is not always right to activate people who have been disabled for many years; when it is right, it requires much time and tact to do so, over many years perhaps, without precipitating a family crisis. It also requires a very sound knowledge and understanding of the total situation.

It is interesting to note that some of the terminology used by the hospital therapist differs from that used by the community therapist. For example, a distinction is made between the individual receiving hospital occupational therapy - 'the patient', and the one receiving occupational therapy through a social service department where he becomes a 'client'. If he then attends a day centre, where occupational therapy is probably involved, he then becomes a 'member'. This leads to a certain amount of confusion, perhaps minor, but nevertheless apparent and at times embarrassing. Even the occupational therapists are given a variety of titles in their working situation, e.g. in Croydon, they are 'Specialist Services Officers' and, although they and the employing authorities know

that they are occupational therapists, this is not clear to anyone else. In Surrey the head occupational therapist, comparable to a group occupational therapist, is the 'Organiser of Rehabilitation Services', in Kent the 'Rehabilitation Officer', but in Buckinghamshire, the 'Head Occupational Therapist'. The reasons for these variations in these titles are usually related to scales of pay that it is possible to offer.

RANGE OF WORK OF THE OCCUPATIONAL THERAPIST IN THE COMMUNITY

The B.A.O.T. in their leaflet 'Occupational Therapy in the Local Authority Services' describes the range of work of the occupational therapist as follows:-

"1. To assess the client's needs in relation to his full participation in the community, taking in to consideration aspects of employment, social activities, and personal independence. This to be done in conjunction with other professional workers.

2. Following such assessment to make recommendations on means of furthering the client's independence including any necessary domestic adaptations and the use of personal aids to daily living.

3. To ensure that the recommendations are carried out, making use where necessary of workers with specialist skills and by cooperating with statutory and voluntary bodies.

4. To train the client and his relatives in the correct use of any aid or adaptation supplied.

5. To advise on suitable activities in Work Centres and Clubs for the physically handicapped or psychologically disturbed client and to supervise their practice.

6. To advise on occupational therapy and leisure activities for elderly and handicapped clients, both in residential care and in their own homes."

In carrying out my investigation, various local authority departments were visited where occupational therapy is carried out as a community service. Of these, four were counties (Surrey, East Sussex, Buckinghamshire and Kent), and one was a London Borough (Croydon). In three of the authorities occupational therapy was the responsibility of the social services departments, in one it was organised as a department in its own right within the framework of the social services department, and in one it was the responsibility of the health department. (This would appear to correspond fairly accurately with the results of a national survey carried out in 1971 (Kinnance and Chick, 1972) on occupational therapy services provided by county councils in England and Wales, where out of 41 counties providing occupational therapy, 34 were located in the social

services department, 6 in the health departments and one jointly. Opinions at that time as to the location of community occupational therapy after April 1st 1974 were almost equally divided between area health authorities and local authorities.) Of the five services I visited, two were long established - (Surrey and Buckinghamshire), two were established during the late '50s to '60s (Kent and Croydon), and one had been established for only about six months (East Sussex).

In at least three of the counties visited (Buckinghamshire, Surrey and Kent), occupational therapy had originally been started as an after-care service, or domiciliary service for homebound tuberculosis patients. (I remember doing a six-weeks' spell in 1956 as a finalist occupational therapy student with the T.B. After Care Committee in Maidstone when the work was purely domiciliary craft work.)

The trend has been for the longer established units to evolve as a rehabilitative service for chronically physically handicapped people, and later to include all grades of disability - physical, psychological, mentally subnormal, blind and deaf. This development has been given impetus by the Chronically Sick and Disabled Persons' Act (1970) in which local authorities were required to provide a comprehensive service for all the disabled in their area.

Therefore, since 1970, the scope for community occupational therapy has considerably increased, the demand has been made known and the movement of occupational therapists away from hospital to the community services has been apparent. In a recent survey conducted by the A.O.T. (February 1974) 20% of occupational therapists leaving hospital in the previous year did so to take up community posts; the next largest proportion leaving the hospital service was 15.6% because of pregnancy.

In some areas this development of occupational therapy led to problems of professional recognition and status, particularly where craft instructors (not trained in occupational therapy) had previously been employed for many years in isolation and without occupational therapy supervision, or where no distinction had been drawn between the two. Considerable effort has been required on the part of occupational therapists appointed to such situations to overcome this.

FIELDS OF WORK

An attempt has been made to identify and classify the work actually being done at present in the community by occupational therapists, or under their supervision, in the five areas visited. The results are presented in the table below:-

Service	Areas concerned
1. Assessment in activities of daily living	All 5
2. Provision of aids to daily living (frequently considerable overlap with social workers and health visitors), and instruction as to use	All 5
3. Assessment and advice for home adaptations and structural alterations	All 5
4. Provision of home occupations - craft or industrial outwork - usually supervised by an occupational therapist and carried out or maintained by a craft instructor.	4 Areas. Not Croydon where undertaken by an 'occupations officer'
5. Day Centres - provide facilities for one or more of the following:-	4 Areas - not yet established in East Sussex re occupational therapy.
work assessment ADL assessment and training industrial work creative work social and recreational activities maintenance of level of function	
for physically handicapped	Buckinghamshire, Croydon, Kent, Surrey.
for mentally handicapped	Buckinghamshire, Croydon, Surrey. (Kent not involving occupational therapy to any extent.)
for psychiatric disabilities	No centres specifically for psychiatric cases but are sometimes included with physically handicapped, e.g. Buckinghamshire, Kent.
Psycho-geriatric Day Centre	Croydon
Old People's Homes - residential	Buckinghamshire, Surrey (Croydon - coming)
Centres for Homebound Disabled	Surrey
Residential Home for Physically Handicapped	Surrey
Classes for physically handicapped (Working Groups)	Kent
Occupational and mobility training for the blind	Buckinghamshire, Surrey

Financial assessments	Croydon - mandatory East Sussex " Kent
Provision of telephones, holidays, vehicle badges	Croydon - mandatory
Child Guidance - Centre and domiciliary visiting	Kent - Occupational Therapists employed by Education Committee.
Paediatric Assessment - physical and mental handicap (Not strictly community occupational therapy as no provision made for domiciliary visiting and is still part of N.H.S.)	Kent - Occupational Therapist employed by N.H.S. on sessional basis.

It would appear that the suggested range of work is to a considerable extent being fulfilled in the areas visited, notably those that are well established. There seems to be little dispute that occupational therapists are the people best qualified to carry out ADL assessments, and to advise on and provide aids to daily living; to advise on home adaptations and structural alterations in conjunction with other staff, e.g. district nurses, health visitors, social workers, architects,and maintenance officials. There is, however, still a section of this work carried out by social workers and health visitors, notably the provision of aids; this, no doubt, has evolved from the days of the welfare officer. In many areas there are not enough occupational therapists and supporting staff to carry out their full role and, unless patients/clients are to be kept waiting for many months, it is sometiems unavoidable that aids are provided by others. This can lead to problems, many of which can be avoided if the occupational therapist acts in an advisory capacity to her colleauges.

It is important to draw the distinction between nursing aids and aids to personal independence. It is desirable that a district nurse should see to the provision of her own nursing aids where these are to be used to help her and the relatives in the nursing of a severely handicapped person as she will know from practical experience exactly what is required, although she may call in an occupational therapist to advise and assess where necessary. However, where an aid is required to enable an otherwise dependent person to become independent in a given activity, then the occupational therapist is the right person to undertake the provision of the correct equipment, and instruction as to its use.

The assessment of the client's needs in relation to full participation in the community, in conjunction with other professional workers, is usually carried out, but does give rise to difficulties and frustrations. A variety of comprehensive assessment forms are used for this purpose and these usually include sections on employment, social and recreational activities and interests. However, frequently - because of lack of local facilities and staff - it is difficult to meet all of the client's needs. Where there are no day centres, few clubs and few voluntary workers, this can be a very frustrating exercise as the need is recognised but there is no means of fulfilling it.

This latter point links with the role of occupational therapists in centres and clubs, in homes and at home to advise on activities. In many places this is admirably fulfilled with excellent assistance from supporting staff; most areas have firm plans laid down for the construction (the national economic situation permitting) of more day centres and clubs for the handicapped - physically and mentally - and for old people. Some occupational therapists are advising, in residential homes, on leisure activities. This tends to come at the bottom of the priority list and, quite rightly, is allocated where possible to a craft instructor or trained volunteer. It is not that the service is not needed, indeed it is important, but that the occupational therapist should not be wasting her skills in manning it herself.

There is a strong reaction here, and on leisure activities in the home, against the old image of occupational therapists being 'craft ladies' to help homebound people while away the hours. This reaction is understandable and surely no one would dispute that it is a waste of three years' paramedical training for an occupational therapist to devote herself to this type of work. However, there has in many cases been an over-reaction resulting in the exclusion in some cases of all creative work in centres and the home, with a concentration on industrial and remedial work only. The balance is now beginning to be restored and most occupational therapists and day centre staff realise the importance of creative, recreational and social activities to any individual to enable him to participate fully in his community, to such an extent that these are included in the day's programme as part of the routine. Perhaps we tend to forget the value of personal achievement in creative work today. It is important to maintain a really high standard of creative work especially where this is undertaken on a commercial basis (Surrey, Croydon).

In one division of East Sussex, particular emphasis is being placed on collaboration between hospital-based occupational therapy and the activities in the social service department. Agreement has been reached on the types of aids and the firms from which these should be ordered between the health district and the social service division so that the hospital is supplied with some aids by the social services division which can be given out directly to the patient after assessment (J.G. Sherwood, 1974, personal communication).

ADMINISTRATION

The community occupational therapy service appears to function efficiently and happily where there is a defined hierarchical structure laid down, and where occupational therapists know that there is a senior colleague of their own profession to whom they can turn for advice, whether or not this is in a social services or health department setting. Otherwise there tends to be a strong feeling of isolation, that there is no professional recognition, or opportunity for professional progress, or planned teamwork with colleagues of the same profession or others with whom the occupational therapist has contact during her work.

In social services departments, the head occupational therapist is ultimately responsible to the director of social services. However, in Surrey the occupational therapy team is recognised as such, and although part of the social services team, is a department in its own right with its own management structure and conditions of service. The occupational therapy team has been given professional recognition and not assimilated with the social services department. The occupational therapists are responsible through the occupational therapy hierarchy to the Organiser of Rehabilitation Services.

In Croydon the occupational therapists (Specialist Services Officers) are responsible to a Senior Specialist Services Officer (occupational therapist) who is responsible to the Principal Specialist Services Officer (Social Worker) within the Specialist Services Section of the Day Care Division team of the Social Services Department. Here the distinction between occupational therapists and social workers tends to be blurred and a more generic role is undertaken on both sides.

In Kent, the Rehabilitation Officer, is not officially managerially responsible for the occupational therapists in the area but is available for professional advice. In practice he does play a managerial role. He is responsible through the Assistant Director of Social Services (Domiciliary and Day Care) to the Director. The individual occupational therapist is responsible through the social services hierarchy.

In Buckinghamshire, the Head Occupational Therapist was responsible to the Medical Officer of Health and is now responsible to the Area Medical Officer. The individual occupational therapist is responsible to the head occupational therapist and to the medical officers appointed to the rehabilitation centres.

REFERRALS AND RELATIONSHIPS WITH DOCTORS

Referrals come from a number of sources and seem to be unaffected by the structure of the department. The chief sources are from:-

Social workers	District Nurses
General Practitioners	Relatives
Health Visitors	Hospital staff

If the referral is not from a medical person, departments have their own arrangements for referring back to the appropriate doctor for confirmation and advice. All those visited make every effort to have a close liaison with general practitioners using a variety of forms to do so in addition to personal contact. In the developing areas it is largely a matter of the occupational therapists making themselves known to general practitioners and other medical staff and creating a working relationship with them, informing them of the role and potential of the available occupational therapy service and thereby starting to build a truly comprehensive service. There would appear to be a need for more structured and informed medical supervision with perhaps one doctor who would be prepared to take a particular interest in the remedial services in the community and undertake overall supervision.

Where there is already a structured service, initial referrals to the occupational therapists are usually confirmed and recorded at Headquarters (Health Department or Social Services Department). Similarly, all the necessary documentation regarding particular services provided, the issue of aids, recommendations for adaptations, the services of technicians and costing, are processed and retained at headquarters. In all the departments visited, the policy was to inform the doctors of the patients helped and of the help given.

Well established departments have built up good working relationships with hospital occupational therapy departments and consultants. Community occupational therapists are able to attend ward rounds and clinics - physical medicine, orthopaedic or psychiatric, e.g. Croydon. Combined visits with the hospital occupational therapist are sometimes made to patients' homes prior to discharge, or a hospital occupational therapist may visit with a local authority 'technical instructor' (terminology variable) in order to assess for major home adaptations.

RESPONSIBILITY OF HEALTH AUTHORITIES AND SOCIAL SERVICES DEPARTMENTS

The question as to whether community occupational therapy should be a health department or social services responsibility is a controversial one. The argument would appear to stem from whether occupational therapy is considered basically a paramedical function or a social function.

The occupational therapists in those counties with established services were convinced they were fulfilling their role as occupational therapists in whatever setting they happened to be. Each quite firmly supported their own administrative structure but each had a clearly defined professional structure with lines of communication and responsibility laid down. This, in fact, would appear to be the crux of the matter, rather than the administrative base, i.e. the fact that occupational therapists are given professional recognition in their own right and not looked upon as additional social workers, and the fact that close medical liaison is available.

It is very difficult to define where the paramedical function ends and the social function begins in the community. All the occupational therapists consulted considered themselves to be providing a rehabilitative and remedial service - whether in the home or in various types of centres or residential homes - however, it surely cannot be denied that they perform a social function as well, particularly where patients/clients have attained their maximum level of performance and where functional and social maintenance is now being carried out.

The Department of Health and Social Security has the power to transfer personnel from local authorities to area health authorities but, where occupational therapists are concerned, these powers have been used selectively. Some area health and local authorities have an arrangement where occupational therapists are officially deployed between the two services on a

50:50 basis, i.e. hospital and community. This on the surface, would seem an ideal arrangement but is not a facet I have met or of which I have any experience in theory or practice.

USE OF ANCILLIARY STAFF

Established community occupational therapy departments utilise with much benefit both untrained staff, and staff trained in related skills and trades. These personnel augment and complement the work of the occupational therapist and would be needed even if there were ever a vast increase in the numbers of trained occupational therapists.

Terminology is again variable but 'technical instructors', 'technicians', and 'craft instructors' are widely employed. These are usually men with trade skills and/or industrial experience who, under the supervision of the occupational therapist, fulfil a teaching role or make and fit home adaptations and aids. Such fields as printing, chair caning, woodwork, metalwork, industrial outwork are covered apart from aids and adaptations.

Unqualified 'craft assistants' (Kent) are widely employed to assist, under supervision, in unskilled work and in maintaining supplies, supervision and records. In Surrey 'craft instructors' fulfil this role, and a considerable use is made of trained volunteers to instruct in craft work in day centres and clubs for the elderly.

In some counties (Surrey, Buckinghamshire) occupational and mobility instruction for the blind is undertaken, sometimes by occupational therapists who have taken the mobility instructors' course for the blind.

Secretarial and clerical help is available is most establishments, in some cases being on the occupational therapy staff, in some being on the social services staff and available to the occupational therapists.

In Surrey, apart from the professional staff there are also on the occupational therapy establishment an administrative officer, clerical officer, clerk/typist, telephonist, supplies and marketing officer, storekeeper, handyman/driver, domestic assistant, caretaker/groundsman, and a cleaner. Here, too, an occupational therapist (Head grade) is appointed as Training Officer within the occupational therapy service. A similar scheme is now operating in Croydon.

CONDITIONS OF SERVICE

There are two major problems here:-

(i) The frequent anomolies between salary scales within the N.H.S. and local authority services for occupational therapists.

(ii) The salary distinction between occupational therapists and social workers with the social services.

* All N.H.S. occupational therapists are on Whitley Council Scales, starting at £1,212 (basic grade), and rising to £2,820 (top of Grade V scale)(1973). This equates with the other remedial professions in the N.H.S. Some local authorities pay occupational therapists on Whitley Council Scales, e.g. Surrey - except for the top grade posts, i.e. Organiser of Rehabilitation Services and her deputy. However, a close inspection of advertisements for local authority occupational therapists shows that many are offering A/P Scales. These vary from AP 1/2 £1,353-£1,926, AP 2/3 £1,644-£2,235, AP 3 £1,926-£2,235 to AP 4 Special categories £1,644-£2,535 to £1,749-£2,640 in some London Boroughs (1973 salary scales). Sometimes these higher salaried posts are advertised as 'social workers' but requiring a qualified occupational therapist. At present the occupational therapy qualification is not given recognition in the 'Purple Book' of Conditions of Service in the Social Services, and the salary scales offered, although higher than in the N.H.S., do not equate with those given to qualified social workers. In fact, occupational therapists are often offered salaries on a scale comparable to unqualified social workers, or even below. In Kent, craft instructors are paid on scales parallel to unqualified social workers but subject to a bar at £2,040.

It can be seen, therefore, that there are many anomolies in salaries between the N.H.S. and local authority services, and within the local authority services; although in the case of the local authority services attempts are now being made to bring these scales into line. These discrepancies partly account for the drift away from the hospital service. They also create inequalities within the social services between professionals of comparable importance and qualifications. The occupational therapists are recognised as valuable and important members of the team but are not paid accordingly.

RECRUITMENT

None of the established departments visited expressed any undue concern over recruitment. All the head occupational therapists (or equivalents) held the view that it was comparatively easy, considering the overall short-

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* These figures were applicable at the time of writing. New salary scales are now in operation following the Halsbury Report.

age of qualified occupational therapists at present. One service claimed to have a permanent waiting list of prospective staff in spite of offering Whitley Council Scales.

By far the greater proportion of qualified occupational therapy staff (estimated at between 80% an' 90%) are married and many are working part-time. Many originally apply for these posts because the situation and hours are convenient and flexible enough to fit in with husbands' work and childrens' schooling.

It has become apparent that where local authorities are now setting up occupational therapy services for the first time, the preferable way of doing so is by making appointments from 'the top downwards'. Areas where occupational therapists of the same grading and responsibilities are employed in isolation in different localities tend to have extreme difficulties in becoming established whereas the appointment of a senior grade occupational therapist to a managerial post ensures the structured development of the service in the county or borough concerned.

JOB SATISFACTION AND WORKING RELATIONSHIPS

Most of the occupational therapists whom I met working in the community derived considerable satisfaction from their job as witnessed by the following statements, quoted from views expressed.

> "The work is broader, more fulfilling and rewarding than occupational therapy in the hospital service (opinion of several occupational therapists who had previously worked in hospital) - and it is largely up to the initiative of the occupational therapist herself what she makes of the job."

> "Freedom from the somewhat restrictive hospital routine with its limited spheres of work and opportunities."

> "Scope for development of the occupational therapist's own particular professional interests."

> "Appreciation of being valued as team members as occupational therapists in their own right."

> "A feeling of doing the job for which they were trained."

> "Satisfaction in being able to get to know the "patient" in his own environment as a person, rather than as an isolated case in hospital, leading to a practical and realistic assessment."

> "The chance to see realistic results."

> "A challenge to the occupational therapist to use her training and skills in solving problems of importance in the community, and in consequence a job of great responsibility."

> "Not a job for the girl who feels she requires the support and security of the hospital team."

However, where departments are only just beginning to be established there is a real danger of a feeling of isolation and frustration amongst occupational therapists who can feel they are not doing the job for which they are trained but are acting as advisors to social workers in order to enable them to carry out the occupational therapist's role, and only dealing with the difficult cases themselves.

Certainly adaptation is required on the part of the occupational therapist, and of the local authority staff, to integrate new professional colleagues into an already established situation. A certain amount of friction is inevitable and, for a successful outcome, much depends upon the personalities of the staff involved, and willingness to reconsider and adapt ideas and practises which have been long established and undisputed as the recognised method of work. Some authorities are finding this more painful than others and most have a long way to go to achieve working conditions as efficient, comprehensive, programmed and structured as, for example, either Buckinghamshire or Surrey.

Education, both formal and on-going, is of great importance here - an opinion expressed particularly by one area social worker in a developing authority, and confirmed by continual educational programmes already taking place in established departments. In Surrey, for example, in-service training is given to all occupational therapy staff, and the occupational therapists give lectures to groups of social workers, health visitors, district nurses, volunteers, etc. In this way, misunderstanding is avoided between professions and overlapping of roles minimised.

It is very important that the concept of TEAMWORK is always kept to the fore. Occupational therapists are a part of the team - in whatever administrative setting in the community - which united provides a comprehensive service for the 'patient'. No one member of this team can work in isolation and hope to provide a complete service - the 'patient' is the most important member, and the family too have an important contribution to make.

OTHER SPHERES OF OCCUPATIONAL THERAPY OUTSIDE THE HOSPITAL

1. Occupational therapists are employed in paediatric assessment units and child guidance clinics although the former are usually under the auspices of N.H.S. hospitals. However, there is, or should be, some overlap with community services here as, to be fully comprehensive, domiciliary visiting of the children and their families is essential. A system of

paediatric assessment units for physically and mentally handicapped children is in the process of being established throughout the country and it is to be hoped that they will have strong links with the community services and that occupational therapists and physiotherapists will have the right to visit and assess their patients at home. In the centre I visited (Canterbury) no provision had so far been made to enable physiotherapists or occupational therapists to carry out domiciliary visits.

2. The occupational therapist in the child guidance clinic I visited (Canterbury) was employed by the Education Committee and her salary based on Whitley Council Scales, but she expected to be transferred to the A.H.A. after April 1st, 1974. Her work involved the assessment of the emotional needs and the emotional age of children from 3 upwards who showed symptoms of emotional disorders or family disorders, i.e. 'pre-diagnostic investigations', utilising occupational therapy activities and combining them with psycho-therapeutic methods, on an individual or small group basis. She worked very closely with the child psychiatrist, psychologists, general practitioners, teachers, families and social workers. Domiciliary visiting and school visiting was considered an important part of her work.

Occupational therapists are also employed in borstals, prisons, special schools, and Spastic Society schools but these are outside the scope of this investigation.

MANAGERS OF DAY CENTRES

Some day centre managers and deputy managers are qualified occupational therapists and thus are using their training and experience to provide a comprehensive, structured, programmed training for their clients or trainees. They need to work very closely with industrial managers and it is often the case that where the manager is an occupational therapist the deputy will have an industrial background and vice versa.

Some day centres (e.g. Waylands at Croydon) have separate sections for the physically handicapped and the mentally handicapped. In this case it was stipulated that the appointed manager who was a qualified occupational therapist should take the one year's diploma course for teachers of the mentally handicapped in adult training centres. This she claimed was of

inestimable value and, together with her occupational therapy training, put her in a very strong position as manager of a centre providing training in its widest sense, i.e. ability to cope with daily life for varying grades of trainees. On the physically handicapped side, the aim was maintenance of the highest possible functional levels, and to provide as widely stimulating a day as possible - it did not claim to be rehabilitative.

TRAINING

From talking to senior occupational therapists with many years' experience in the community services, to occupational therapists who have recently joined the service and from my own experience, it is evident that the present occupational therapy training does not equip the student with sufficient knowledge and experience in this field. The wide range of work has been indicated in the previous pages and the table sets out the variety of patients treated by occupational therapists in the community.

SUMMARY OF TYPES OF PATIENTS RECEIVING OCCUPATIONAL THERAPY OUTSIDE THE HOSPITAL

Children	- physically handicapped especially spina bifida, cerebral palsy, congenital deformities, neuro-developmental disorders.
	- mentally handicapped - Down's syndrome, brain injuries, and a wide variety of subnormality conditions.
	- psychologically handicapped - battered babies, behaviour disorders, emotional disorders, autism, those lacking mental stimulation at home.
Adults	- physically handicapped - rheumatic diseases, neurological diseases (multiple sclerosis, Parkinsonism, poliomyelitis, paraplegia, head injuries, post-traumatic conditions, hemiplegia), and cardiac and pulmonary conditions.
	- blind and partially sighted.
	- mentally handicapped - ranging from limited ability to E.S.N.
	- psychologically handicapped - inadequate personalities for whatever psychological or psychiatric reason.
	- deaf (minimal service only).
Old People	- with or without a physical handicap, with or without mental handicap (psycho-geriatrics).

TABLE

It may not be appropriate to suggest dividing occupational therapy into two distinct factions so soon after the publication of the McMillan report and at a time when the remedial professions are advocating closer integration in working conditions and training. However, an additional period of training or a supervised period of secondment might help to give the occupational therapist a clearer knowledge of the work outside the hospital. Some authorities, e.g. Surrey, accept two students at a time for six weeks clinical experience, and those students who are lucky enough to have this experience, will obviously gain considerable benefit from it. However, the vast majority of students will obviously not have this opportunity.

The chief problems experienced by occupational therapists entering the local authority services are:-

1. an inadequate knowledge for dealing with the larger aids and major adaptations, of how and where these can be obtained and of their installation.
2. an inadequate knowledge of technical drawing regarding aids and adaptations.
3. insufficient knowledge of the functioning of local government departments and the social services in particular, and of the lines of communication.
4. insufficient knowledge of mental handicap (not always).

Most local authorities like to employ occupational therapists who have already had experience in the N.H.S. Only those authorities that have well-established departments and provide a structured in-service training (e.g. Surrey) welcome newly qualified occupational therapists and are prepared to train them accordingly. It is, in any case, probably wiser for the newly qualified therapist to consolidate her recently acquired knowledge in the hospital setting including experience in geriatric and psychiatric departments before branching out on such a demanding and all embracing field as occupational therapy in the community.

PERSONAL REACTIONS ON JOINING THE COMMUNITY OCCUPATIONAL THERAPY SERVICE

My initial reactions on joining the Social Services Department were of confusion and isolation. The confusion was partly due to being in a City new to me where the purely practical problem of finding my way around took time and thought; there was also the problem of learning the office routine and the City Council's methods of work and application, and of being suddenly separated from all the supporting services and the familiar routine of the hospital service.

It soon became clear that a fairly sound knowledge of the administration of the N.H.S. does not involve an automatic knowledge of the local government machinery and its hierarchy. It was necessary to consider on each occasion which department to contact - architect's, treasurer's, engineer's, etc. - before doing so, instead of it being an automatic reaction. This again took time.

There was also a surprising lack of know-how on my part on what facilities the department was able to provide and how, methods of costing, payment, financial assessment, registration, what allied services were available, etc. These problems again took more time than is normal and often involved several visits to a client where one or two should have been sufficient.

However, the strongest feeling was of isolation. There were no other occupational therapists at hand with whom to discuss practical difficulties, no medical staff - although general practitioners were accessible by 'phone - no medical referrals in the sense that I had been used to them, and no supporting hospital services, no facilities or equipment for assessment on a departmental basis. There was in fact a comprehensive stock of aids and literature available but there was no steady stream of patients appearing at appropriate times for specific treatment. It was necessary to be more self-motivating in order to make the effort to visit clients instead of waiting for them to appear.

This leads to another initial difficulty which is perhaps not always recognised, which was a feeling of diffidence at intruding into people's homes and investigating their domestic arrangements. This was only a temporary feeling and was, I feel, a reaction from the security of being on one's home ground in the hospital department and the reversal of the basic concept of guest and host.

As time wore on, most of these problems resolved themselves to a greater or lesser degree as knowledge and confidence increased with experience, and as adaptation and adjustment between myself and other members of the social service team took place and personal relationships began to be formed.

It became evident that the pattern of my work revolved round the assessment of the more severely disabled in their homes, the provision of aids and adaptations, and advice on structural alterations. With

the amount of administrative work involved in informing doctors, arranging and writing requisitions for alterations, ordering aids, keeping personal and departmental records and writing up file note reports, and following-up requests and orders, this was all there was time for. The majority of requests were concerned with mobility - ramps, rails, alterations to steps and doorways, stair lifts, with personal independence - toilet adaptations of various types including the provision of commodes and toilet annexes, bath aids including shower annexes, usually for people with heavy disabilities and in conjunction with social workers, health visitors, district nurses and the home help service. The majority of other aids delivered were walking frames and sticks, elastic laces, shoe horns, cutlery and kitchen aids of various types. This involved instruction and follow-up on the use of aids.

Time will be necessary for assimilation and consolidation of the experiences and knowledge gained and views formed over the 6 months of secondment to be able to evaluate the total scheme. However, at this moment, I feel that this was the sort of attachment which could benefit many occupational therapists and their patients - particularly those therapists who have been working for between 15 and 20 years and feel the need for a challenge, or a chance to reinforce their ideas or to question their current methods and practices with a view to future developments. A year, rather than 6 months, would perhaps be a more suitable length of time and allow for study and research in greater depth than it has been possible for me to undertake. About 20 days have been devoted to the project to allow for my other commitments and I feel this is barely enough. Other hospital authorities might consider seconding their senior occupational therapy staff on similar secondments, or local authorities sending theirs, to the mutual benefit of the reorganised health and local government services.

FURTHER DEVELOPMENTS

In addition to the need to develop orientation and training courses for occupational therapists wishing to work in the community, there are other problems that must be considered in relation to expanding and consolidating community occupational therapy services. The doubts about the status and career prospects of community occupational therapists have already been mentioned. Negotiations are now in hand between the B.A.O.T. and Social Services Directors "to obtain recognition of the professional

status of occupational therapists working in local authority social services departments". They are also "considering methods of improving the career and salary structure of occupational therapists working in this field" (A.O.T. Annual Report, 1973). Furthermore, following the McMillan Report (1973), it is hoped that added weight will be given to establishing a suitable career structure with direct representation at top management level within the social services. But such developments should be phased in with improvements in pay and career prospects for the hospital-based occupational therapists, if the present staff crisis in the hospitals is not to be exacerbated.

Another possible development may be a greater involvement of the physiotherapy service in the community. Although there have been physiotherapists working in schools for many years, it is unusual to find them in the community. There is, however, a community physiotherapy service in Southampton, as part of the Health Department (prior to April 1, 1974), where the physiotherapists are involved in an advisory and family teaching capacity which is proving successful. Physiotherapists and occupational therapists should be able to work together in the community to the greater benefit of the patient than is now possible, and with the proposed closer integration of the remedial professions (Tunbridge, Burt and McMillan Reports) this would seem a likely development and one to be welcomed. In my opinion, there is a need for a community physiotherapy service - to work very closely with the rest of the team and with emphasis on education and advice in the home to clients and relatives particularly on mobility, methods of lifting and transfer, home exercises and training methods for children as well as for those adults with permanent disabilities. It would be important for the physiotherapist and occupational therapist to work very closely together and the professional distinction between them would be necessarily blurred.

Although more day centres are planned for many parts of the country and these are undoubtedly needed as part of a complete service to handicapped people, perhaps the chief deficiency at the present time are day care facilities for the younger severely disabled on a social, recreational, creative, intellectual, and, as far as possible, remedial and maintenance basis. The need to provide occupational opportunities within the home was apparent in some cases but not so urgent as the need to get people out of their homes for some periods. This would involve the use of craft instructors and craft assistants as well as full supporting day care services and should involve facilities for domestic and ADL assessment.

Finally there is a need to involve occupational therapists much more in the education and training of nurses, social workers and doctors. The therapists are often dependent on these other professionals for the referral of their patients or clients and teamwork is meaningless if the members of the team do not understand the roles of their teammates. A feature of successful sports teams is that they learn and practice together.

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