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Occupational Therapy in the United Kingdom; Past Present and Future

Abstract

Introduction: The aim of this article was to consider the development of occupational therapy and its growth within the United Kingdom. It is an account of the professions' past, present and what we see as the opportunities of the future.

Objective: We describe the history of occupational therapy in the United Kingdom, from the historical events that facilitated the early development of the profession up until the present time.

Methods: This is a descriptive and historical overview of occupational therapy in the United Kingdom.

Findings: Through their influence within the social reform and arts and crafts movements. The integral work of John Ruskin (1819-1900), Octavia Hill (1838-1912) and Elizabeth Casson (1881-1954) are identified as the drivers of occupational therapy development in the UK.

Conclusion: We acknowledge the challenges and expectations of the profession within the National Health Service, and that occupational therapy practice is greatly dependent on government funding and the policy priorities for health and education. We advocate for the opportunity for creativity to craft the 'occupation' of the occupational therapist and propose a 'vision for crafting creative occupation'.

Keywords: History, Occupational Therapy, United Kingdom, Moral Treatment, Arts and Crafts, Occupation**,** Creativity.

Introduction

History shapes our personal and professional identity. To recognize our core assumptions, beliefs, values, and practices as occupational therapists, it is imperative to understand our history; to acknowledge how we as individuals, and the profession were, and are informed. This paper is not a detailed account of the complete history of occupational therapy in the UK (See Wilcock, 2001)., it is a reflective account of the profession's past present and future.

"Indolence has a natural tendency to weaken the mind and to induce ennui and discontent" (Tuke and Fowler 1880-1881)

PAST

Reform as an informant

Individualism, reason, skepticism, science and faith in human reason were foundational to the Age of Enlightenment (1715-1789). This stimulated the arts and crafts (1880-1920s) and moral treatment movements (1900s) and remains the foundation of the occupational therapy profession.

William Tuke (1732-1822) was a merchant and renowned philanthropist, who responded to the neglect and extreme cruelty that he witnessed at the Quaker Retreat Asylum for the care of Quaker members in England in 1796. The asylum was described as a prison where patients would at times be shackled and chained. Tuke, rejected medical theories and techniques, and viewed mental illness as a disruption of mind and spirit. Tuke cultivated rationality and moral strength in his treatment, where patients would engage in a balance of work and leisure time. This included, rest, talk, chores and manual occupations that enabled a sense of contribution and purposefulness (Tuke, 1964).

Bing (1981) commented that the ethos of moral treatment sprang from the fundamental attitudes of the day: a set of principles that govern humanity and society; faith in the ability of the human to reason; and the supreme belief in the individual' (p.152). The principles of the moral movement (Stoffel, Reed, and Brown, 2019) suggested that:

- The mind and body should be treated together.
- An individual's history and capabilities should be assessed.
- The context of the environment can be adapted to promote mental health.
- Individuals may have special or unique needs to be included in their intervention programs.
- Healthy aspects of the individual can be used to treat less healthy aspects.
- Occupations can be used to occupy, distract, or amuse the individual to counter the effects of less productive thinking.
- New habits can be developed to replace fewer desirable ones and,
- New learning can occur that may provide useful skills for dealing with everyday life.

As the enlightenment of society progressed, moral treatment shifted, theory evolved, and mental disease came to be seen as a legitimate concern for humanitarians and physicians (Reed, Hocking and Smythe, 2013). The development of moral treatment created an opportunity to enable the reason and rationality of meaningful occupation to influence the state of one's health.

Arts and Reform

Meanwhile, in England, social philanthropist, thinker and art critic John Ruskin (1834-1896) considered that there were many forms of social reformation. Ruskin noted that the industrial era lacked morals, social freedom and restoration, and added that the restoration of the human spirit through engagement in honest craftsmanship influxes one's state of wellbeing (Ruskin, 1884). Ruskin believed that society was healthier when people connected with their environment, their work and religious values

(Levine, 1987). He challenged the idea that all work was intrinsically good. For him, only work that was enjoyable to the person and not degrading was valuable. He advocated for the use of arts to release society from social restraint, to enable expression through one's hands, and proposed that schools teach artesian skills to stimulate the ‘art spirit’ (Ruskin, 1884). As a result, he educated the working class for free. It was through this movement that Ruskin met Octavia Hill (1838-1912).

Hill was recognized by Ruskin for her abilities and was employed by him to copy art and teach at the men's college, and later to manage houses for the poor. Hill did not believe in charity, she believed in enabling those who had lost hope, to build self-respect. She was innovative in the breadth of her interventions which began with the tenants housing needs. She also attended to questions of employment, leisure and education, socializing residents, refurbishing environments, and developing classes of projects with the vision ‘to enable one to build purpose’ (Smith, 2008).

Occupation as a freeing principle

Through the moral and arts and crafts movements, Ruskin, Hill and Casson identified the influence of occupational choice on health and wellbeing, and this informed the foundations of occupational therapy. The arts were determined as the freeing principle that enabled one’s hands to create meaning. Hill identified the environment as contributing to the meaning of a person's engagement in wellbeing. This concept later informed and influenced the work of Dr. Elizabeth Casson (1881-1954) in becoming a pioneer of occupational therapy (Wilcock, 1999).

Casson was able to observe the link between the resident's poverty and their ill health. It was then Casson decided to train as a doctor at the University of Bristol-UK, she [Casson] …had a moral and social conscience... she saw beyond the 'easy' to the 'difficult'. She looked for and saw what lay behind the poverty and disease' (Butler, 2004 p.287).

The intersection of occupation and healthcare

Facilitated by US orthopedic surgeon Joel Goldthwaite and Britain's Sir Robert Jones, occupational therapy has been recognized as being developed from the British model of rehabilitation, which included medical–mechanical treatment, physical therapy, massage therapy, vocational training, and engineering workshops (Pettigrew, Maloney & Robinson, 2017). The surgeons claimed that their medical knowledge of injury made them the most suitable to manage all aspects of reconstruction, including physiotherapy, bedside occupations, curative workshops and vocational re-education (Gutman, 1995). Their treatment demonstrated the intersection of the moral and the arts and craft movement being embraced by the medical model. Yet, whilst opportunities to engage in occupation were made available, it was prescribed occupation which lacked individual and meaningful purpose (Wilcock, 1993). The treatment did not appreciate the nature of the human person and that the mind and body should be treated together.

Following World War Two the occupational therapy profession continued to expand (Rosser, 1990) with the emphasis on enabling service men to return to vocational occupations, and it was during the 1950s that the focus on occupation began to broaden the scope of practice. Domestic tasks and the independence of persons with

long term disabilities were recognized. Nevertheless, the occupational therapy profession began to experience pressure from the medical model to “establish a theoretical rationale and empirical evidence for practice” (Kielhofner, 2004 p.44). The methodologies of the day did not provide an opportunity to measure restoration of the human, through craftwork. So, as a result of the early medical influence and assumptions about occupational therapy (Reed *et al*, 2013; Wilcock, 2002), the profession began to describe practice from a biomedical perspective. This included reductionist views of the body as a machine or single system, causing a shift of perspective known as the mechanistic paradigm (Reed *et al*, 2013). This stood in contrast to the views of the founders of occupational therapy, who considered mind-body synthesis to be fundamental to the therapeutic use of occupation (Reed *et al*, 2013). Consequently, the view of occupation and its connection to health appeared to be slowly eroding as its focus narrowed (Engelhardt, 1977).

In the mid 50’s, Casson and Foulds (1955) outlined modern trends in occupational therapy. They acknowledged that though physical or mental diagnoses were treated in different locations, occupational therapy remained the same, with ‘two definite components; its mental motivation and its physical expression’ (p. 113). They reported that ‘occupational therapy depends on the mental activity of the patient himself, stimulated by the therapist’ (p.113). They discussed the importance of individualized treatment and its application of occupation to disability, noting the essential components of the patient’s interests, span of attention and capacity to engage. The modern trend described in the 1955 paper concerned the need to combine the understanding of mental health, neurology, older people, surgery, psychology and the development of social services, and to recognize the variety of occupations ‘arbitrarily

grouped' as creative, social and recreational, educational, and prevocational, all used to meet the needs of the patient.

The development of professionalization in the UK

Occupational therapy in the U.K was first developed in Scotland following World War I. David Henderson a Scottish Psychiatrist (1884-1965) was influenced by his colleague Adolf Meyer (1866-1950) whilst working in New York and Baltimore. When he returned to Scotland, he employed Dorothea Robertson as the first instructress of occupational therapy (Henderson, 1925a). Robertson was a Cambridge graduate and although not trained in occupational therapy her approach was reported as having an impact on patient's self-esteem, and purposefulness. In 1924, Dr Elizabeth Casson attended a conference where Henderson (1925b) described occupational therapy at the Mental Health Hospital of Gartnavel in Glasgow. In a tribute to Elizabeth Casson's work Peto (1955) stated that, occupational therapy was initiated during the First World War by Sir Robert Jones, and then abandoned in the UK but developed in the US and brought back to the UK by Casson.

In 1929, Casson founded Dorset House in Clifton, Bristol, as a residential clinic for women with mental disorders. Here, she led occupational and artistic therapies for the promotion of psychological well-being, and health prevention. Interventions included activities such as dance, drama, and countryside excursions. A year later in 1930, Casson launched the UK's first school of occupational therapy at the same location. Due to the bombing of Bristol in the second world war, the School moved to Bromsgrove, and subsequently to Oxford after the war, initially to the grounds of the Churchill Hospital (Peto, 1955). Influenced by Ruskin and Hill's beliefs regarding social

reformation (Wilcock 1999), Dorset House was known for its communal nature where staff and students shared a range of daily occupations. Casson's schooling of occupational therapists still influences the education of practitioners today. In the same time period, the Scottish Association of Occupational Therapists (SAOT) was founded and the professionalization of Occupational Therapy was established within the U.K.

(insert Table 1 about here: for professional body development).

PRESENT

Education of Occupational Therapists

There are currently 53 Registered Programs within the UK (WFOT Accessed 22.11.2019). The Royal College of Occupational Therapists regulates standards of education (June 2019). Professional registration is via the UK Health and Care Professionals Council (HCPC). All of the programs in the UK are guided by the *World Federation of Occupational Therapists Revised minimum standards for the education of Occupational Therapists* (WFOT, 2016). There are approximately 48,000 occupational therapists in the UK employed in the public and private sector (Statista, 2019). As of 2019 there are a number of pathways to obtain eligibility (a license) to practice as an occupational therapist (source https://www.rcot.co.uk/) in the UK.

For *Pre-Registration Occupational Therapy Programs*

1. Bachelor of Science (BSc, Hons) degree program: 3 years (4 years in Scotland).
2. Post Graduate program (Masters or Postgraduate Diploma): 2 years
3. From 2018 - Degree level apprenticeships: 4 years (England Only).

and for Post- Registration Occupational Therapy Programs

1. Masters level advanced occupational therapy, professional doctorates and PhD routes are available within the UK.

Pre-registration programs contain academic study concerning: biological sciences, ergonomics, behavioral sciences, management and leadership, therapeutic interventions, environmental adaptations, research, occupational therapy knowledge and skills, core skills, humanities- the public health agenda, occupational science, theory and other relevant areas of study (see https://www.rcot.co.uk/ learning and development standards for full overview). In addition to academic study, practitioners are expected to undertake a minimum of 1,000 hours in practical placements (RCOT 2019).

Practice and guiding beliefs of Occupational Therapists

One guiding belief of occupational therapy is that time, place, and circumstance open paths to occupation (Peloquin, 1994). The 1980s saw a paradigmatic shift in occupational therapy from the mechanistic paradigm, which focused upon inner systems, to the contemporary paradigm of understanding that occupation has a central role in human life (Duncan, 2011). This shift in knowledge developed theory and evidence for the study of occupation, is known as occupational science. As appreciation for the study of occupation, and its influence upon wellbeing has developed, the breadth and scope of the profession has expanded.

Occupational therapy practice in the UK considers: rehabilitation, health promotion, health education and prevention. The profession can be found in multiple environments such as, but not limited to mental health settings, acute hospitals, social work, care homes, human resources, schools and prisons. Currently there are no defined physical parameters to the environments in which occupational therapists work, and no limit to the conditions and age span of our clients. Yet, despite overwhelming evidence that social factors are relative to one's function and engagement in occupation, and that the mind and body should be treated together (Bing 1981; Casson and Foulds, 1955), mental and physical rehabilitation continues to be divided, and rehabilitation lacks full appreciation.

Commissioning Rehabilitation

In 1948 the National Health Care Service (NHS) was born out of a long held ideal that healthcare should meet the needs of everyone, and be available to all regardless of wealth, on the premise that it is free at the point of delivery. The NHS is funded through payroll taxes. The government determines how much money the NHS receives and its healthcare priorities. Funding decisions are then referred to local commissioning groups who determine the priorities for the health population in their local areas.

Despite the 2015/2016 NHS forward view into action (NHS 2014) which supports the notion of preventative care, meaning; the care you receive to prevent illnesses or diseases (Ham and Murray, 2015), the healthcare system continues to be underfunded in comparison to the needs of the population. Demand is higher than the ability to supply medical attention and rehabilitation. The population is aging at an alarming rate, with complex health needs, and the NHS budget is failing to meet the

cost (NHS, 2016). In 2017 the British Red Cross speculated that the NHS was facing a humanitarian crisis, as demand continued to rise (Cambell, Morris and Marsh, 2017). As a result, of emergent health care needs and despite rehabilitation being identified as a priority (Ham and Murray, 2015), rehabilitation is not seen as an immediate financial priority for healthcare, and unfortunately, given the decision for Britain to exit the European Union, it is unclear what the future of the healthcare system will be.

From an occupational perspective, it is essential to understand the impact of the environment upon one's occupational form function and meaning. As an occupational therapist working in a stretched and pressured environment, scope of practice is determined by the services in which we work. Unfortunately, the priorities of the healthcare system overshadow the sense of what is rehabilitation, and what is occupation. In acute settings (namely hospitals) focused occupation concerns clients self-care, bathing, dressing and mobility, which may disregard the core value of the profession to enable clients ‘to do what they want, and need to do’ (Wilcock,1993) Therefore, rehabilitation may involve temporary compensatory support such as assistive devices that enable a safe and effective discharge from hospital for clients to be rehabilitated within their home. However, funding restricts access to therapists and social care within the communities, and waiting lists are long (Kings fund, 2018). This has the potential to reduce client’s occupational performance by relying on the compensatory methods impacting upon their daily roles and meaningful occupations.

Despite that it is increasingly acknowledged that effective rehabilitation delivers better outcomes, improved quality of life, has the potential to reduce health inequalities, and make significant cost savings across the health and care system (NHS 2016).

Occupational therapists are under constant pressure, and at times are at a loss as to how to challenge their environment, their position and the expectations forced upon the profession. Therefore, occupational therapists in order to remain commissioned, are once again under pressure to ensure that the demands and outcomes of the practice are justified. As a result, research and evidence remain a priority of the profession (RCOT, 2019).

This brief overview only provides a snapshot of the challenges experienced by some occupational therapists in the UK. There are occupational therapists carrying out occupation focused practices in many settings who are continuing to advocate for validation, and approval of occupation as a means to health and wellbeing. These include; the Allied health professions into action 2016-2017 / 2020-2021. However, the immediate impact upon occupational therapists in these settings should be addressed for the wellbeing of our profession.

FUTURE

Consequence, Creativity, Social Reform and Opportunity

Changes to the health and social care climate over recent years have had an impact on the daily practice of occupational therapists, and consequently occupational therapy practitioners are experiencing diminishing resources, increasing the demands of the role and workplace pressures. As a result, practitioners have reported a sense of burnout and loss of understanding of their professional values within practice and research (Perryman *et al*, 2019).

As occupational therapists, and human beings we have the innate need to make and create. Thompson and Blair (1998 p.54) discuss how humans are continually divided by their inner world and their external reality, and that this tension compels humans to engage in imaginative processes… 'that can for the brief moments give us a sense of balance and our deepest consolation of our greatest glories' p.54. So here we pose a question to you, the reader; if occupational therapists do not have the opportunity to create their occupation and interventions for practice, what are the consequences for the wellbeing of our clients and the profession alike?

The Royal College of Occupational Therapists (COT, 2015) emphasize that occupational therapists "view people as occupational beings. People are intrinsically active and *creative,* needing to engage in a balanced range of activities in their daily lives in order to sustain health and wellbeing. People shape, and are shaped by, their experiences and interactions with their environments. They *create* identity, purpose and meaning through what they do and have the capacity to transform themselves through conscious and autonomous action" (P.1). However, the terms, 'art', *'creativity'*, *'crafting' and* '*create'* are not clearly defined as skills for the profession and remain absent from the guidelines for practice and education (RCOT 2019). Therefore, these skills can be determined as merely implicit as opposed to explicit. By enabling occupational therapists to extend their *creative* practice to use the language and actions that are imbedded in our roots, a sense of the profession is cultivated, where our communication and interactions will be a catalyst for health and social care reform to enable sustainable practice.

It is acknowledged that that as a profession the use of crafts are stigmatized amongst other professionals (Williams *et al*, 1987) and that we have had difficulty justifying interventions that use physical crafts (Bissell and Mailloux, 1981). However, in this paper the term *craft* does not just mean creating art alongside the client for therapeutic benefit, it relates to the *craft* of occupational therapy practice. The emphasis is placed upon the process of *how,* and *why* the occupational therapist facilitates the client to engage in occupation, and this takes precedence over both the outcome and the product. We, therefore, must consider the strength of the *craft* of occupational therapy practice. Having said this, craft activities are not always included within academic curricula. Barris *et al*, (1986) and Creek (1996) highlighted that specifying the importance of occupational therapist's understanding of how to modify occupations, is to know it themselves, which provides an opportunity to see the therapeutic power in the findings.

In recent publications Bathje (2012) and Fortuna (2018) have identified the essentiality of the arts and crafts movements within current occupational therapy practice. These authors recognize the importance of being clear in our approach as *creative* beings and as professionals, and to be open and explicit in our use of language in order to state our position. However, does the arts and crafts movement remain an underground practice of occupational therapy? Schmid (2004) found that occupational therapists understood creativity in their practice to include adaptation, innovation, change, first insight, going with the flow, and risk taking. This exploratory study also recognized that practitioners identified creativity as "part of everyday practice" (p. 83) and that the use of arts and crafts activities in treatment encouraged the patient to think creatively (Schmid, 2004). So, what happens if we return to using this explicitly

in our education and everyday practice? By evidencing this opportunity, it will have added benefits to not only the profession, but more importantly the clients we serve (Hasselkus and Dickie, 1994). Consequently, we propose, “a vision for crafting creative occupation”. It is envisioned that the opportunity will allow our roots to inform our practice, to promote social reform, expression, individuality and the interconnected practice of the occupational therapist, and the occupational therapy practice, philosophy and intentions.

It is acknowledged that to craft is a skill, but to be creative, is something that we believe can be taught. This can be described as – *“to craft”*, to develop the creativity of occupational therapists. It is proposed that this will enable us to understand the relationships between interconnected components, to see barriers in interventions within the occupational therapy process, and to be able to manipulate environments to create opportunities to take action. We advocate that, to enable, to do, to be, and to become, is all to be found within the process of *creating*, and occupational therapy practice is to craft the “vision for crafting creative occupation”.

Conclusion

This paper has accounted for the profession’s past, present and future. It recognizes the integral work of John Ruskin (1819-1900), Octavia Hill (1838-1912) and Elizabeth Casson (1881-1954) who are identified as the drivers of occupational therapy development in the UK. We acknowledge the challenges and expectations of the occupational therapy profession in the National Health Service. We specify that our practice is greatly dependent on the planning and execution of government funding and policies that prioritize health and education. Yet, we advocate for the opportunity

for *creativity* and the *craft* of carrying out the 'occupation' of the occupational therapist

and propose a 'vision for crafting creative occupation'.

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Table 1: The History of the Associations of Occupational Therapy in the UK from https://www.rcot.co.uk/about-us/our-history(accessed 5th March 2019)

Date	Activity
1932	The Scottish Association of Occupational Therapists (SAOT) is founded.
1937	The Association of Occupational Therapists (AOT) is founded for England, Wales, Northern Ireland.
1938	AOT offers the first diploma examinations for occupational therapy in England the AOT journal "Occupational Therapy" is launched.
1945	AOT sets up its first office in Brompton Road, London.
1948	The NHS is established and AOT and SAOT appoint representatives to the Whitley Council to negotiate national pay and conditions for NHS occupational therapists.
1954	SAOT establishes its first office in George Street, Edinburgh.
1969	A referendum shows the membership of AOT and SAOT in favour of a merger.
1974	The British Association of Occupational Therapists (BAOT) is formed from a merger of AOT and SAOT. The British Journal of Occupational Therapy is launched.
1978	BAOT becomes a registered trade union in line with members' wishes and sets up the College of Occupational Therapists (COT), a registered charity, to deal with the professional, educational and research business of the organisation.
1986	HRH The Princess Royal becomes Patron of the College of Occupational Therapists.
1993	BAOT members vote to contract with UNISON for trade union services.
1998	BAOT/COT moves into its current headquarters building in Borough High Street, London.
1999	Devolution leads to the establishment of Country Boards for the four countries and Policy Officer roles for Northern Ireland, Scotland and Wales.
2007	The United Kingdom Occupational Therapy Research Foundation (UKOTRF) launched
2011	The “official” opening of the refurbished College of Occupational Therapists’ headquarters in the presence of HRH The Princess Royal, Patron of the College of Occupational Therapists
2016	COT celebrates: 40th Annual Conference and Exhibition, 30 years of HRH The Princess Royal as COT Patron, 10 years of Julia Scott as CEO.

2017	HM The Queen grants COT a Royal charter to become the Royal College of Occupational Therapists (RCOT).