E. M. Macdonald.

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BOARD OF CONTROL

# MEMORANDUM ON OCCUPATION THERAPY FOR MENTAL PATIENTS



LONDON
PUBLISHED BY HIS MAJESTY'S STATIONERY OFFICE
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1933

(*Reprinted* 1935)

70—301

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## CONTENTS.

### PART I.



### PART II.

## PART I.

### CHAPTER I.

**1. Definition.**

Occupation Therapy is the treatment, under medical direction, of physical or mental disorders by the application of occupation and recreation with the object of promoting recovery, of creating new habits, and of preventing deterioration.

**2. Purpose.**

Rest may be essential in acute states, but, if unduly prolonged, it is attended with no less undesirable results in cases of mental disorder than in physical disorders. At the earliest possible moment, therefore, the use of the mind should be promoted by the mildest measures of occupation or by encouraging the patient to take interest in things external to himself.

**3. Some of the advantages of Occupation Therapy.**

(i) *The patient's mental attitude is favourably influenced.*

Occupation therapy provides at least a means whereby he may escape from the boredom of inactivity, and from depression. It offers new outlets, with the chances of an increase of interest, a lessening of concentration on immediate mental troubles and a reduction of emotional disturbance. Moreover, it induces a hopeful attitude not only towards the benefits to be derived from occupation therapy itself, but to other forms of therapy which may at the same time be applied for the amelioration or cure of the illness.

(ii) *Good habits are induced and maintained.*

The treatment can be regarded as a medium for the establishment of controlled behaviour; it promotes regulation of habits to the advantage of the work of mass nursing. It maintains not only the habit of occupation, but the equally important capacity for co-operation, in patients who may otherwise sink into mental isolation, and it helps also to maintain a sense of responsibility. All this may be curative, but where cure is not possible, deterioration and degradation are retarded.

(iii) *Physical health is promoted.*

The result directly of exercise and change of posture and indirectly of increased interest will be improved physical health.

(iv) *The whole atmosphere of the hospital is improved.*

Monotony is the bane of institutional life; occupation is a form of treatment especially calculated to counteract it.

Occupation therapy breaks up the routine institutional life of the hospital and relieves monotony, and induces a busy activity with resulting cheerfulness and hope of recovery. It allows social contact between mental patients in circumstances of common interest to those under treatment.

The economic value of occupation need not be stressed. But if the result of the treatment is to raise the general level of social behaviour, it follows that misuse and destruction of clothing and property will be a less prominent feature of the activities of those undergoing treatment and their capacity for useful work will be greater.

We consider, too, that the stabilisation of conduct resulting from the treatment will, in many cases, enable patients to be boarded out with their friends and relatives.

Occupational treatment, continued into the convalescent phase of the illness, will often make the re-adjustment to a working world a more agreeable task, and must inevitably lessen the anxiety and dread with which the recovered patient takes up again the burden of life.

In conclusion, we think that the value of the proper application of the treatment as a socialising factor can hardly be over-estimated, not only from the point of view of the patient, who will more readily come for early treatment, but also from the effect created upon the public mind. We believe, indeed, that the introduction of a well-organised system of occupation therapy will mean a considerable step forward towards the time when mental hospitals will cease to be regarded as closed units within our social system.

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PART I.

## CHAPTER II.

### Classification and Scope of Occupation Therapy.

**1. Classification.**

The following is a brief outline of some of the means of applying occupation therapy in a mental hospital.

(i) *Occupational.*

(*a*) By using the existing utility departments of the hospital.

*For women.*—Employment in the kitchen, laundry, sewing room, and in the more homely household duties in the wards and departments.

*For men.*—Employment on the farm and garden, and in the making and repair of clothing, footwear, bedding and furniture, and in the maintenance of building and engineering services.

(*b*) By means of handicrafts and other less strictly utilitarian activities.

*For women.*—Indoor occupations: Sewing, embroidery, lace-making, tapestry, knitting, crochet-work, raffia-work, quilting, netting, weaving, rug-making, paper folding, bead-making, toy-making, ornamental wood work, hat-making and bag-making, drawing and painting, and many arts and crafts requiring varying degrees of attention and skill.

Outdoor occupations: Gardening, poultry-keeping.

*For men.*—Woodwork, ornamental metal-work, painting, french polishing, weaving, basketry, concrete and mosaic slab and tile work, printing and bookbinding, mat and brush-making.

The above list is not intended to be exhaustive, but gives some indication of the type and variety of occupation which may be utilised.

Much can be done by the use of waste material, *e.g.*, burlap, old stockings, etc., in the making of hooked rugs; packing cases for making wooden toys; and string for making belts and bags.

(ii) *Recreational.*

Under this heading are included many activities which may be purely educational in both the mental and physical sense; others are purely recreational, while many can be regarded as amusements. Several of them contain elements of all three.

(*a*) Physical drill and re-education, with combined exercises, both indoor and outdoor.
(*b*) Walks and country rambles, shopping expeditions.
(*c*) Dancing, including ballroom dances, country dances, Morris dances and eurhythmics.
(*d*) Music, vocal and instrumental, including community singing.
(*e*) Concerts, dramatic performances, combined indoor games and competitions, wireless, cinema shows.
(*f*) Reading and study circles, classes and clubs.
(*g*) Use of libraries and reading centres.
(*h*) Outdoor activities—football, hockey, cricket, croquet, net-ball, stool-ball, tennis and many other organised games.

(iii) *Social.*

We want not only social contact between patients under conditions favourable to the enjoyment of it, but desire also to encourage, for the benefit of the patients, frequent visits by friends and voluntary visitors.

Arrangements can often be made for patients to spend the short hour of a visit alone with friends either within or beyond the grounds of the hospital. Such an arrangement is keenly appreciated by the patient, and friends should be encouraged to do this.

**2. Scope of Occupation Therapy in the Mental Hospital.**

The activities falling under the heading of occupation therapy are so many and diverse that no difficulty should be found in bringing into the scheme all patients who are not actually infirm or seriously ill, or who, for mental reasons, are temporarily unfit to associate with the patients undergoing group or individual treatment. On the figures available, more than 80 per cent. of the patients in a mental hospital should come within the scope of the method.

The following indicate the possibilities of occupation therapy in a mental hospital :—

(*a*) Bed occupations for patients who are not prescribed absolute rest.

(*b*) Habit training in the wards with deteriorated and disturbed patients.

By the simplest methods and devices, and with very little cost in material, it is possible to undertake in small groups in the wards the preliminary steps in the rehabilitation of good habits and stabilisation of conduct of the worse patients. Many doctors who have applied the system to the most diverse types of patients say that occupational treatment, more than any other single factor, is instrumental in preventing much of the deterioration of mind and habit occurring in dementia.

(*c*) Occupation therapy in the wards for patients who, though disturbed and active, are able to respond to the appeal of craft work.

There are many patients in a mental hospital who, though still unfit for various reasons to leave the wards, are nevertheless in a condition to respond to the appeal of craft work. It might be thought that the restless, disturbed and violent patients do not come within the scope of the method, but it is the fact that restlessness with noisy and violent behaviour as an observable element in ward life tends to disappear under treatment.

(*d*) Handicrafts and industries in Occupation Centres.

Here will be treated many of the quieter patients who are able to work outside the wards and need more advanced and attractive occupations.

(*e*) Industries forming part of the normal services of the hospital.

Domestic work in the wards, kitchen and laundry and work in the sewing rooms and shops, together with outdoor work on the farm and gardens, can be utilised to provide for a number of the quieter and more tractable patients occupations of therapeutic value without interfering with the efficiency of the service.

(*f*) Recreational and social activities throughout the hospital.

It has long been recognised in our mental hospitals that games and other recreational activities are especially valuable for mental

patients on account of their re-socialising influence, and also from a diversional point of view. We believe, however, that more patients would be found well able to take part in associated physical and mental activities if they were well organised under a competent instructor. These activities have more than an entertainment value if they are the means of encouraging patients to take part.

Dramatic performances, choral societies, etc., will also be found to appeal, while patients of sedentary habits, due to age or infirmity, can be directed to activities requiring the minimum of movement.

Again, the infinite gradings of physical exertion in gymnastic exercises, and the stimulating effect of rhythmic movements to music, bring within this form of treatment a considerable proportion of the hospital population.

The patient coming into a mental hospital has to make many adjustments; the most important is that from the family to the community life of a hospital ward. The extreme difficulty with which this is accomplished is evident; so many patients retire into a pseudo privacy involving an intense dislike of their surroundings. But in group activities, each regulated to the desires and the needs of the group, we may find influences far more potent than any that can be applied to the individual.

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PART I.

## CHAPTER III.

### Occupation Therapy in relation to the utility services of the Hospital.

The object of occupation is primarily therapeutic, and it is of the utmost importance that it should be regarded as such and not as a means of providing commodities for use in the hospital at a low cost compared with that of ordinary supplies from commercial sources. A sharp distinction between therapy and mere occupation, of whatever kind, should be maintained, though it is recognised that any form of occupation may have a therapeutic value if applied under the direction of the physician and in the hands of staff who are specially trained in this branch of medical therapy.

The utility services, the kitchen, laundry and sewing room, with the household departments in which women work, and the various shops with the farm and garden for men, are centres where occupation has been provided over almost the whole period during which mental hospitals have existed. In these places are employed only the more stable and industrious inmates.

Again, other work, for the purpose of providing some of the articles and garments used or worn in the hospital, is often not

done within the hospital because it is believed to be more economical to buy in the open market. We suggest, however, that the therapeutic value of the occupation which would be provided for patients needing just this kind of work by the making of these same articles in the hospital may be such as to outweigh the small monetary gain obtained by purchasing them from outside sources.

The primary factor is the therapeutic value to the patient, so that too much stress should not be laid on output and finish.

But if the work in the utility shops and departments is to be used as a means of treatment, the medical officer must have the same freedom to move patients from and to them, and to change the occupations of patients working in them, as he will have in the case of those occupied in the handicraft centres.

We do not dispute that the utility shops and departments of the hospital may often fittingly be regarded as the proper sphere of occupation for patients who have undergone treatment to secure stabilisation, but whose cure is found to be no longer likely. They may quite well maintain the standard of skill and output, and thus themselves, by making the shop a useful centre to the hospital, facilitate the treatment of other curable patients who may come there for continued therapeutic treatment, but the need of the individual patient must be the determining factor in every case.

It may be, especially on the male side, that these shops and departments may provide the finishing treatment of convalescent patients who are soon to resume their social activities in the outside world. If these departments of the hospital are to serve as treatment centres as well as providing material service, it may be necessary to make some modification in the present method of using them.

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PART I.

## CHAPTER IV.

### Present Position in Mental Hospitals.

The following accounts of visits to mental hospitals abroad and at home will give an idea of the existing position in regard to occupation therapy.

**1. Germany.**

Dr. Simon of the mental hospital at Gutersloh recognised the value of occupational treatment as early as 1905 and began to re-organise his hospital accordingly. The hospital provides accommodation for 1,240 patients, and the estate covers over 447 acres, of which 125 are forest. There are six villas for men and eight for women.

It appears that the keystone of Dr. Simon's principles is the elimination of maniacal activity from the patient's environment.

Dr. Simon, therefore, takes sure steps to prevent one disturbed patient from exciting others to turbulent behaviour; these steps consist in the prompt isolation of any patient at the earliest sign of uncontrolled conduct to prevent the spread of disturbance, and to give the isolated patient the best chance of speedily re-gaining the similitude of a balanced mind, and of returning to his occupation.

When visited on the 27th April, 1932, out of a total of 1,032 patients, 47 were on leave, 952 were occupied in the hospital, 21 were unoccupied on account of physical illness, and 12 because of their mental state. Of those who were physically fit for employment, therefore, and not on leave, 98·7 per cent. were occupied.

The following facts emerge from this brief visit :—

(i) The means of occupation are in the main provided by the ordinary work necessary to the institution; very little in the way of fancy crafts is undertaken.

(ii) No special occupation therapy officers are employed.

(iii) Apart from the workshops there are no special occupation therapy rooms; the work treatment is carried on in the wards which themselves largely serve as work-rooms.

(iv) The proportion of staff to patients is large where it is required, but in the quiet or chronic wards it is probably less than in England and Wales. Owing to the manner in which Dr. Simon's principles are carried out, the energies of the staff are not absorbed in dealing with the excessive motor activity of unoccupied patients.

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Later, similar work was undertaken at the Constanz mental hospital in South Germany by Dr. Thum, with good results. In consequence the method came to be regarded as applicable to any mental hospital, so that the practice spread to other parts of Germany and to the neighbouring countries.

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**2. Holland.**

In 1926, Dr. Van der Scheer sent 60 of his nurses from Santpoort Mental Hospital, near Amsterdam, to Dr. Simon, for training. As a result the work progressed rapidly. It is now being carried on by Dr. Kraus, who succeeded Dr. Van der Scheer as Medical Director.

At Santpoort the work is done almost entirely by the nursing staff. They began that way, and it seems that only more recently has it been necessary to introduce into the work staff who have not previously undergone training as nurses.

The following tables shows the disposition of patients from two sections in the different centres on the day of our visit.

SANTPOORT MENTAL HOSPITAL.

*Patients' Employment List (Dr. Mees' Section).*

Number of Patients .. .. 309.

*Female.*

| *Central Shops.* | | *Ward Employment.* | |
|---|---|---|---|
| Central Sewing Room .. | 39 | Ward duties (5 wards) .. | 37 |
| Weaving .. .. .. | 4 | Ward Therapy Shop .. | 44 |
| Mat-making .. .. | 8 | ,, ,, ,, .. | 50 |
| Vegetable-room .. .. | 6 | ,, ,, ,, .. | 33 |
| Garden .. .. .. | 2 | ,, ,, ,, .. | 32 |
| Land work .. .. .. | 8 | | |
| ,, .. .. .. | 13 | | |
| Brush-making .. .. | 3 | | |
| Division garden .. .. | 6 | | |
| Working with special nurse | 1 | | |
| Total .. .. | 90 | Total .. .. | 196 |

*Ill and Infirm.*

| | |
|---|---|
| Senile and Sick .. .. | 17 |
| Katatonia .. .. .. | 1 |
| Schizophrenia .. .. | 1 |
| Negativistic .. .. .. | 1 |
| Idiot .. .. .. .. | 1 |
| Diabetes .. .. .. | 1 |
| In continuous bath .. .. | 1 |
| Total .. .. | 23 |

*Note.*—The small number of women shown as working in the "Central Shops" is due to the fact that in this particular section a considerable proportion of the ward day-room space is utilised for central workshops, and not for the performance of work done by patients who still require training in the wards.

*Patients' Employment List (Dr. Rambout's Section).*

Number of Patients .. .. 305.

*Male.*

*Central Shops.*

| | |
|---|---|
| Messenger | 1 |
| Coal Porter | 1 |
| Poultry | 3 |
| Park (paper-picking) | 0 |
| Garden | 2 |
| Coffee House | 1 |
| Waste and Swill | 1 |
| Kitchen garden | 4 |
| Porter | 1 |
| Destructor | 0 |
| Fencing | 6 |
| Gardening | 13 |
| Tree pruning | 1 |
| Grinding (knives, etc) | 2 |
| Whitewashing | 1 |
| Concrete work | 1 |
| Metal work | 1 |
| Painting | 7 |
| Potato party | 6 |
| Vegetable garden | 2 |
| Stone breaking | 8 |

*Central Shops (contd).*

| | |
|---|---|
| Land work | 12 |
| ,, | 12 |
| ,, | 11 |
| ,, | 17 |
| Clerk | 2 |
| Library | 1 |
| Hairdresser | 1 |
| Kitchen | 1 |
| Laboratory | 1 |
| Stores | 5 |
| Tailor | 2 |
| Baskets | 2 |
| Mattress work | 8 |
| Mat-making | 15 |
| Mat and fence work | 5 |
| Potato paring | 9 |
| Shoe-making | 5 |
| Smithy | 4 |
| Carpenter | 7 |
| Laundry | 5 |
| Food wagons, etc | 7 |
| Total | 194 |

*Ward Employment.*
*Ward Duties.*

| | |
|---|---|
| Ward A | 9 |
| ,, B | 10 |
| ,, I | 9 |
| ,, II | 10 |

*Therapy Room.*

| | |
|---|---|
| A | 4 |
| B | 15 |
| I | 13 |
| II | 12 |
| Total | 82 |

*Sick or Infirm.*

| | |
|---|---|
| Malarial treatment | 2 |
| Sick | 11 |
| Invalids | 16 |
| Total | 29 |

From the figures shown in the above tables it will be seen that on the day of our visit the proportion of patients from the two sections in question undergoing occupational treatment was 91·3 per cent. If the ward workers are excluded, the proportion is still nearly 80 per cent. The period during which the patients were under treatment was 5½ to 6½ hours a day.

The medical officers were responsible specially for their own divisions and were expected to give a great deal of their time to the application of occupation therapy.

The training of the nurses in occupational work is a special feature; by means of lectures, demonstrations and handicraft training, probationers are taught the principles and practice of what is called in Holland "active therapy."

The more recent introduction into the central workshops of technicians, who are not nurses, illustrates one of the weaknesses of the original method While it had been possible to train the nursing staff to a certain extent in the various craft occupations, the Director in his progress has found it necessary to raise the technical standard. Arrangements have now been made for the nurses to receive assistance in training from these technicians.

Many of the ward occupations are of the simplest kind, teasing material, sewing, knitting, and mat-making, but in the central workshops there is an ever-increasing standard of skill.

There are two other features—the employment of turbulent men and women on the land and garden, and the use in some centres of men to train women patients.

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**8. United States of America.**

The following notes refer to the organisation of occupation therapy in the mental hospitals in the States of New York and Massachusetts and in Philadelphia.

(i) *Occupation Therapists employed.*

Wards Island—over 6,000 patients. Chief Occupation Therapist. Nine trained assistants.

Psychopathic Institute—210 patients. Chief Occupation Therapist. Four trained assistants. One physical trainer.

Friends Hospital (private) 150 patients. Chief Occupation Therapist. Four trained assistants.

All the nurses in the New York State Hospitals are given training with the object of enabling them to co-operate in occupational treatment; they attend six lectures in the course of their training, are taught simple handcrafts and have a minimum of one month's practice in the Occupation Therapy department.

(ii) *Methods of treatment.*

A distinction is drawn between occupational therapy departments and industries.

Patients who are not well enough to be employed in less protected surroundings and those who continue to benefit from occupational treatment, work with occupation therapists under medical prescription. When they are fit to work for the community they are either transferred to service departments or are discharged or sent out on parole.

In the hospitals seen, about 25 per cent. of the patients were under occupational treatment in this sense.

**4. England and Wales.**

Occupation therapy is making steady progress in our own mental hospitals, notably at Barming Heath, Cardiff, Severalls, Exminster, Chester and Clifton (North Riding, Yorks).

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## PART II.

### CHAPTER I.

### Outline of method and its application.

From the concluding section of Part I it will be seen that, while the lines upon which occupation therapy is conducted in Germany, Holland and America, are to some extent similar, there is a divergence of view as to the personnel required to ensure the best results.

The Americans apparently hold that the addition to the ordinary hospital staff of a number of what are known as occupation therapists, who have had two years' training in various crafts and the therapeutic application of them, is necessary, while the Dutch and Germans take the view that this form of treatment can best be carried on by the ordinary staff of the hospital. It appears, however, that the Dutch have recently found it necessary to include in their personnel technicians in special crafts, who are not nurses, and the Americans use them in their industrial shops, farm, garden and laundry which are regarded as being outside the domain of the occupation therapist.

There are thus three ways in which occupation therapy may be carried on under medical control :—

(i) Existing nurses and staff are trained and utilised.
(ii) Technicians, who have not undergone training as nurses, are added to the existing nurses and staff.
(iii) Occupation therapists are employed, in addition to nurses and technicians.

(i) *Utilisation of existing nursing staff.*

While attaching due weight to the important part which the nurse must obviously play in the scheme of occupation therapy, and whilst agreeing that he or she will need to acquire a working knowledge of the simpler occupations and crafts by attendance at classes within the hospital, or technical classes held locally, we believe that, in order to make full use of some of the more advanced occupations and crafts which will be required for a number of the

patients, it will be necessary to add to the staff a few persons with special knowledge of such occupations and crafts, and ability to hand on their knowledge to the patient.

(ii) *Utilisation of existing nurses and staff with the addition of technicians.*

It is quite possible to give a nurse a course of training extending over a few weeks or even a month or two, but a course of that length could never be sufficient to enable her (or him) to acquire a really thorough and detailed knowledge of even a few of the simpler arts and crafts. Many of the crafts forming even the more commonplace occupations are so difficult that a prolonged apprenticeship is necessary to the mastering of them, *e.g.*, weaving, gardening (real horticulture), carpentry, cabinet making, art needlecraft, etc.

For this reason, it is proposed to employ technicians in addition to nurses.

It would no doubt be of advantage to have the technician trained as a nurse or to have a nurse who turned out to be a technician, but it is only occasionally that the latter happens. Usually the technician is too well paid to allow of his being tempted to take the work and pay of a probationer nurse. So he joins the staff as a technician simply ; and, to give him the necessary help until he is experienced in the treatment of patients, a nurse is included in his class.

Already in some departments of our hospitals the employment of persons with technical knowledge has been found necessary, to ensure economy and efficiency in the service, *e.g.*, kitchen, laundry, etc.

It must be remembered that many patients are persons possessed of considerable intelligence and manual skill. If the instructor is to be in a position to attract the interest of such patients, and command their attention, it will be necessary for him to possess expert knowledge of his craft, and ability to impart his skill and thus ensure a high standard for the work.

The technician is therefore introduced in order to widen the scope of the occupational and industrial work, for the additional interest he arouses, and for the higher degree of satisfaction the well finished article produces in the patient.

(iii) *Utilisation of existing medical and nursing staff with the addition of technicians and occupation therapists.*

It would appear that with the doctor prescribing and keeping in touch with the work his patients are doing, with the technician providing the higher technique in many branches, and the nurse with a working knowledge of the simpler arts and crafts, we need no further complication, but there are still some defects in the system.

Somebody is needed in the hospital who knows how to do the handicrafts, how to teach them to mental patients, and how to instruct the nurses in the application to the patient of all the wide training, including habit training, which occupation therapy comprises.

While giving the nurse help in her (or his) handicrafts by appointing someone who is able to teach six or seven handicrafts, it may be convenient to combine in this person a number of other qualities necessary for our purpose.

The doctor having no knowledge of crafts or experience in teaching them is, in our opinion, unsuited to be the occupation therapist. He is already the director of the work, prescribing the treatment and generally supervising its application.

Similar arguments apply to the cases of the matron and the chief male nurse. We do not believe that their existing duties would permit of their giving the necessary time to such tasks. In the case of the matron, the existence of the post of sister tutor in the majority of hospitals of any size points to the fact that she has already been found to have insufficient time to devote to her existing duty of instructing the nurses in practical nursing, and affords evidence that no further substantial burden can now be placed on her.

For these reasons we advocate the adoption of method (iii) and the introduction of the occupation therapist as a new grade of staff in the mental hospital, who, working with but independently of the matron or chief male nurse, will carry on therapeutic treatment by occupation under the doctors. We are also of opinion that technicians, who have not undergone training as nurses, will be necessary in certain of the special crafts and in the industrial shops.

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PART II.

## CHAPTER II.

### Role of the Medical Superintendent and other officers.

#### 1. The Medical Superintendent and Medical Officers.

Occupation can be used throughout the hospital as a socialising factor or as a method of cure only if it is organised with this object in view. The treatment should, therefore, be in the hands of the doctors, with the Medical Superintendent himself organising the arrangements and seeing that each officer is given a place in the scheme.

The difficulties that arise and the new relations entailed between members of the staff make the task of the Superintendent a difficult one unless he has studied the subject and made himself acquainted

with the details of the type of organisation which experience has indicated to be necessary.

The medical officers should be allotted the task of administering the details of their own sections, *i.e.*, teaching and encouraging the nurses, studying the effect of the treatment on the different types of patients, preparing prescriptions to guide the staff and ensuring that every occupation and recreation is used therapeutically.

In short, the medical officer should direct the course of occupational treatment in every phase. It is not enough for him to visit his wards ; he should see the patients in the various classes, in the occupation centres, in the gardens, in the recreation hall, and, in fact, wherever they may be.

**2. The Occupation Therapist.**

Here is a new class of officer who has to be fitted into an organisation designed in the first place without any thought of the intrusion ; we assume that a woman will occupy this post on the female side and on the male side a man.

The occupation therapists will, under the medical officer of the section, be responsible for initiating and giving general direction to the therapeutic work.

Their knowledge of many handicrafts will enable them to train the nurses in this field, and, during the progress of the work, to deal with difficulties in technique and therapeutic application. Though their work at first may be confined to the training of the nurses in the occupation centres, as soon as a few of the latter have been trained, the sphere of the therapists will be enlarged to include the whole of their respective sides of the hospital. We suggest, also, that in order to ensure that recreational activities will assume their proper place in the scheme, it may be well to make the occupation therapists responsible for all recreational as well as occupational treatment. For such a responsible post, we must have somebody who has considerable knowledge of the theory and practice of occupation therapy, and who has the education and mentality to interpret the doctors' instructions in the widest therapeutic sense.

**3. Technicians.**

In certain crafts, and in the industries, a small number of additional skilled artisans, as instructors, will be necessary. Their role will be to instruct the patients in the special and more difficult occupations and crafts.

Often they will not have had experience in the wards, and will, in consequence, be unused to dealing with patients suffering from mental disorders ; at first, therefore, it may be necessary for them to have a nurse to assist them with their class, but they will in time assimilate the therapeutic atmosphere of the hospital.

We envisage also under this heading the officers in charge of the various industries in the hospital. If, as we suggest, these industries come within the sphere of occupation and therapy, there will be many such officers who must serve two masters—the matron, the clerk and steward or the chief attendant on the one hand, and the occupation therapist on the other.

This is one of the difficulties to be faced. We believe, however, that the heads of the laundry, kitchen, etc., can carry on their utility services under the matron, or clerk and steward, without in any way excluding the patients in these departments from the attentions of the doctor and the occupation therapist.

The technicians in charge of the various utility shops on the male side can quite well be brought under the occupation therapists. The works and engineering departments are exceptions, but here again co-operation between the occupation therapist and the heads of those departments should be arranged.

**4. Nursing Staff.**

(i) *Matron and Chief Male Nurse.*

It will be seen that the occupation therapists will be new appointments, and that they will not be responsible on the women's side to the matron or on the men's side to the chief male nurse.

In special circumstances, however, it may be possible for the matron to undertake the duties of occupation therapist, or to delegate the task to one of her assistant matrons. This could possibly be done in a small hospital, but we consider that it would not normally be proper to add this work to the matron's very heavy burden.

(ii) *Nurses.*

All nurses should be trained to regard the application of occupational and recreational treatment as an important part of their daily work. The training carried out in the wards, occupation centres or shops, must be continued during the hours of rest and recreation. It would be useless, for example, to instruct patients in habit training for a few hours during the day, and to allow degradation full play during the remainder of the 24 hours.

Thus to maintain continuity of training and to get good results, the help of the nurses is essential; but first of all they will require thorough training. How this should be obtained is discussed in the next chapter, and is therefore mentioned here only to stress its absolute necessity. The role of the nurses will be to take part in every activity in the hospital, as nurses who have been trained to understand the part they have to play and to realise that occupation and recreation therapeutically applied are part of their nursing duties.

We think it is clear that the occupation therapists will need some assistance in their work in the occupation centres and in

supervising the ward therapy groups and training new staff. We suggest, therefore, that the system of employing a small group of assistants, who could be called " craft workers," might be developed. This system has been tried and found to work well in one hospital (Severalls).

Usually they will be nurses who possess considerable experience with patients, and who have worked for some time at handicrafts, either in the hospital or in outside centres; they will receive instructions in the object and methods of the treatment from the doctors and the occupation therapists. The craft workers will not have any purely nursing duties and will not have charge of wards; they will be few in number.

It appears to us that it should be possible for each craft worker to specialise in one or more departments of their work, *e.g.*, handicrafts, recreations (including physical exercises and dancing), teaching deteriorated patients, etc., and thus prove of considerable assistance in maintaining the all-round standard of therapy at a high level. As their proficiency increases, the occupation therapist should be able to depute to them a considerable part of the practical training of the nurses in the subjects in which they have specialised.

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PART II.

## CHAPTER III.

### How to begin the work and how to proceed.

Occupation therapy can be applied in a mental hospital only if the medical superintendent has previously studied the methods successfully used in other hospitals, and his views and knowledge are shared by his medical officers. It is essential also that the medical staff should make the method adopted their own concern as much as they do the medical treatment and nursing of their patients.

The training of the nurses is the foundation upon which the entire system depends. The first step, then, before any thought is given to the application of therapy to the patients, is the training of the nurses. In the beginning the occupation therapists should devote themselves, in co-operation with the doctors, to this subject. A small occupation centre, together with a ward class, should be established for the purpose, to be used as a training rather than a treatment centre.

Though it may be possible, and even desirable, to give the nurses training by classes held in other hospitals or in technical

school centres, there is no substitute for the training and demonstration given in the hospital itself; it must be remembered that the nurse takes her cue and enthusiasm from those with whom she must work.

For teaching purposes it is necessary to begin with the most modest plan, leading on both the patients and the staff very slowly to a wider understanding of the aims and practice of the treatment.

As soon as thoroughly trained staff are available, a start can be made in applying the treatment to the patients. In Chapter II of Part I we have endeavoured to indicate some of the means available for this purpose; we now propose to describe briefly the methods which should be adopted in relation to the patients according to the various classifications.

A few general principles can, we think, be laid down :—

1. No patient should be sent out to take part in occupations outside the wards if his conduct or habits are likely to have a disturbing influence upon the other patients. It is, therefore, necessary to institute a system whereby a considerable number of patients can receive training in groups in the wards. As soon as a patient's conduct has been stabilised in this way he should be promoted, whenever possible, to some centre of occupation outside the wards.

2. In order to maintain the therapy at the highest possible level, it will be necessary to secure careful grouping of patients and progressive grading of occupations.

3. New admissions should receive special attention and should, if possible, be dealt with separately from the older patients in order to prevent them from picking up the habits of the latter.

4. Care should be taken that patients are given occupations which are suitable to their mental and physical condition.

5. Outdoor occupations should be made use of wherever possible for both sexes.

6. Recreational training including physical drill, etc., should be combined with the occupational treatment, not only during the hours of leisure, but also as part of the general scheme. This method will be found especially useful in the case of deteriorated patients.

For our purpose we will divide the patients into the following classes :—

(*a*) Recent
(*b*) Quiet.
(*c*) Observation.
(*d*) Restless.
(*e*) Turbulent.
(*f*) Deteriorated and demented.

No classification of this kind is absolute, but it will generally be possible to divide up into groups within these classes even if two types must at one time use the same room.

(*a*) *Recent cases.*

Though not forming a definite psychological type, such patients may be classed together on administrative grounds, *i.e.*, where there is an admission and convalescent unit, where some of the milder psychoses are retained for special treatment, it may be found convenient to make special arrangements for them within the unit. Treatment in bed, in ward groups and occupation centre groups, will be the common practice. Outdoor treatment, *e.g.*, work in the garden, may be used for those for whom it is prescribed as suitable.

No rule can be laid down, but it may be advisable to treat within such a unit only those who are more easily amenable to treatment. Patients who will require prolonged treatment should be dealt with in classes where special methods adapted to their needs are in use.

(*b*) *Quiet types.*

The quiet patient who has sufficient control and sense of responsibility to live an ordinary life within the institution is our simplest problem.

This is the class of patient who will be fit for treatment outside the wards, in the occupation centres and shops, and in the utility departments. They should be allowed change of occupation as frequently as their best interests may demand.

(*c*) *Patients requiring close observation.*

In dealing with a group of patients who need close observation, it may be advisable to hold the class for them in the ward in which they live.

We are insistent that this class of patient shall not be allowed to remain idle unless rest is definitely prescribed by the doctor. It is safe to say that these patients improve to an immeasurable degree under occupational treatment.

For the more difficult classes of patients a prolonged course of training in the wards may be necessary, for the purpose of stabilising their conduct and fitting them to work elsewhere.

At the outset, at all events, for the majority of them, the simpler forms of occupations, combined with conduct training, will be made use of ; no elaborate equipment will be necessary.

Generally it will be desirable to split them up into small groups in bays or other easily separated portions of the day-room, and to carry on the training by work demanding progressively graduated effort and attention.

In beginning the treatment in wards containing these more difficult types, it will probably be found desirable to make a start

by forming a small group of the quieter patients first, under selected nurses, and adding to it very slowly as experience is gained.

The types of difficult patients will be :—

(*d*) *Restless.*

Where the mental condition has as its consequent symptom physical activity by way of relief of mental strain, there can be no greater boon than the means to direct this activity into the normal habit-retaining channels of daily life and occupation.

Though most of this class of patient will enjoy out-of-door activities, or work in centres and shops entailing large joint movements, many of them will at first be suitable only for the application of therapy in the ward groups. Training carried on thoroughly, slowly and progressively, will bring these latter patients on sufficiently for transfer, one by one, into the quieter groups under treatment outside the wards.

(*e*) *Turbulent.*

It is because of the extreme difficulty of dealing with this type that it may be advisable to make a beginning with some other type.

The variations, however, between one hospital and another, and the evidence of the results of treatment, have convinced us that excitement and mere noisiness are not, in chronic mental disorders, an essential sign of the condition. They are over-growths, arising in the excitement of the acute phases of the illness, which have been allowed to develop into obtrusive noisiness and hostility, and remain as such ; under proper treatment the patient almost invariably would retain a firm enough hold of reality to prevent these obnoxious characteristics from becoming quasi-permanent in character.

There are two ways of tackling our problem, prevention and cure. Prevention is relatively easy, it occurs in the course of early application of occupational treatment, and habit and interest training activities.

The cure of existing cases is not so easy. Outdoor activities and graded interest development may cope with some. With the others, we should form very small occupation groups in the ward, preferably in rooms where they will not be distracted from the task to which they are set ; usually the group will be free from the presence of any but the nurses actually carrying on the class. The onset of even the mildest excitement is the signal for removal to a quiet room or to bed near by, until the attack has subsided.

It is essential that during the progress of work no noisiness or talkativeness likely to disturb the other patients should be tolerated.

Sometimes it is necessary to commence work with one or two patients and an equal number of nurses, introducing additional

patients only after a successful beginning, but usually a group of five or six patients is enough for a class. With this group, conduct training must be maintained at all times.

(*f*) *Demented and deteriorated type.*

This type of patient requires rather more special teaching which will, of course, be carried out in the ward groups. Useful lessons in method and variety of approach might be learnt by visiting a colony of defectives, but it must be clearly understood that considerable modifications of the system there in force will be necessary. The many variations of the simplest occupations should be used at first, combined with habit training and recreational activities; here, as with the turbulent type, habit and conduct training must be continued through all the waking hours.

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PART II.

## CHAPTER IV.

### Administration.

(*a*) **Staff required.**

The suggestions in the foregoing chapters indicate that there will be some re-arrangement of the staff of the mental hospital.

The extent of the changes is a matter of considerable importance, as the impression is very firm that in Continental hospitals where occupation therapy has a vogue the proportion of staff to patients is much higher than in this country. This has been advanced as a reason why similar treatment in this country is impracticable. In this connection the following table referring to some Dutch, English and German hospitals will be of interest.

| Hospitals. | Patients. | Staff on Pay Roll. | Proportion of staff to Patients. |
|---|---|---|---|
| Utrecht (Holland) .. | 1,215 | 508 | 1 to 2·38 |
| Santpoort (Holland) .. | 1,508 | 565 | 1 to 2·68 |
| Napsbury (Middlesex) .. | 2,246 | 605 | 1 to 3·7 |
| Long Grove (London County) .. .. | 2,235 | 563 | 1 to 4 |
| Parkside (Cheshire) .. | 1,305 | 289 | 1 to 4·5 |
| Bedburg-Hau (Germany) | 2,700 | 544 | 1 to 5 |
| Gutersloh (Germany) .. | 1,032 | 196 | 1 to 5·25 |

The hospitals on the Continent standing out as examples of places where occupational (but not recreational) treatment is fully carried out are Gutersloh and Santpoort.

It is very interesting to find such a wide difference between the proportions of staff to patients in Gutersloh in Germany and Santpoort in Holland, and it is clear to us that it existed before the introduction of occupation therapy in Holland, and is, therefore, due to longer standing differences of practice in the two countries. We are assured, however, that since the introduction of the method at Santpoort in 1926, there has been no increase in the number of staff relative to patients; in fact, between 1921 and 1932 the total staff employed was reduced by 136, though the numbers of patients increased by 134. These two hospitals have, in comparison with our own hospitals, a high proportion of doctors to patients. Whereas in Gutersloh, with 1,032 patients, there are seven doctors, a similar hospital in England would have four or at most five medical officers on the staff.

(i) *Medical Officers.*—We have insisted that in England and Wales the burden of directing work should be borne by the medical officer, and we have said that without his help occupational treatment in its main purpose must fail.

(ii) *Occupation Therapists.*—The fact must be faced that one occupation therapist will be required on each side of a hospital of 1,000 beds. We suggest that the scale of pay be £200-£300 per annum, and that it might be well for them to be non-resident.

(iii) *Technicians.*—By utilising the staff of the existing shops and service departments of the hospital, treatment can be provided for a good proportion of our patients and only a very small additional number of technicians as instructors will be required.

(iv) *Craft Workers.*—The craft workers will be needed to help the occupation therapist in the occupation centres, in the ward therapy groups, and in out-door and recreational work. In a hospital of 1,000 beds, two or three on each side will be required. As they will be required to do much supervision, and should be nurses with considerable experience and some craft training, we agree that the grading is a proper one.

(v) *Nursing Staff.*—As to the ordinary nursing staff, we think from the examples before us that no increase in numbers will result from the gradual introduction into the hospital of occupation therapy. On the female side, especially, some of the nurses who do duty in the wards will go to the occupation centre with their patients. In any event, wherever the patients are there must be nurses, and, if the patients are not occupied they will require just as much, if not more, attention. Thus, what is gained in improved behaviour amongst the patients may ensure that the nurses, who formerly devoted their energies to the control and supervision of their charges, will have the application of occupation therapy as an alternate and much more agreeable task The system imposes on the nurse not so much added duty as a change of work.

(*b*) **Buildings and recreation grounds.**

It will be desirable to use all the existing departments and shops as centres for the application of occupation therapy.

Many of the patients, both men and women, will be given treatment in the ward groups

The recreation hall cannot be used as an occupation centre, because the hall should be in use for the recreational, musical and literary activities of patients throughout the day and early evening.

We must, therefore, provide some additional space for the fuller occupational treatment of the patients.

After the most careful consideration of the space normally available in a mental hospital, and of the numbers of patients who can be treated in the departments, wards and existing shops, we consider that it will be necessary ultimately to provide occupation centres for something like 15 to 20 per cent. of the patients.

In a hospital of a thousand beds, this need will be met by five huts, each giving twelve hundred square feet of floor space (each 20 ft. by 60 ft.). They could be grouped as most convenient to make two or more occupation centres, and might be of temporary or permanent construction.

If in permanent but light construction, each containing one W.C. and a lavatory basin, and warmed by two independent stoves, the average cost would be for each about £700, or total cost for five units £3,500. We are advised that some reduction in cost would be obtained by the erection of buildings of a temporary type.

In the above calculations we have not taken into consideration the possibility that in some of the older hospitals there may be buildings which are no longer used for their original purpose and which may well be adapted for use in this mode of therapy.

For indoor recreational work there is sufficient room—in the recreation hall, the wards and the library. For church choral work the chapel could appropriately be used.

Out-door recreation should form a considerable part of the programme, and we would like to see the practice, adopted in colonies for defectives, followed in mental hospitals, whereby all patients who are fit to play games are encouraged to do so. In a hospital of one thousand beds two or three football grounds, two hockey grounds and several cricket pitches would be required; with, too, space allotted for other field and ball games. Naturally the summer and winter pitches would overlap.

The necessary grounds could be provided on a field of suitable shape having an area of nine to ten acres.

(*c*) **Cost of materials.**

It is impossible within the limits of this memorandum to discuss this matter in full, but there are several important points to be considered.

We do not postulate that all the patients should be occupied in producing articles of high artistic merit or of commercial value; but we do wish to provide for infinitely graduated treatment.

The best work can often be done with the simplest and cheapest materials.

Therefore no great outlay is necessary on the materials to be used in the ward therapy rooms. Many hundreds of varieties of useful articles can be made from condemned materials and from the waste from the sewing room; a little ingenuity in this direction solves many problems.

For handicrafts considerable purchases have to be made, but the cost of materials is usually covered by sales.

In the shops much of the work done is in the service of the hospital, *e.g.*, the making and mending of clothes or of boots. Here the question may arise whether it is not more economical to buy the new articles for use in the hospital from outside sources, rather than to have them made by the patients. In detail, the answer will depend on the article under discussion; for one it will be dearer, for another an economy. Either way, the difference is a small one, and, if the advantages to the patient are set out and tested as indicated in the earlier chapters, it should be apparent that the case for the retention and the extension of this shop system is a very strong one.

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PART II.

## CHAPTER V.

### Propaganda and Training.

#### 1. Medical Superintendents and Medical Officers.

Much has been done to encourage superintendents and medical officers of mental hospitals to visit the Continent (Germany and Holland) to see the excellent work being done there.

Unfortunately, there is no hospital in this country where the treatment has been fully developed; but an interchange of visits between superintendents who have begun the work and who are interested would be useful.

#### 2. Occupation Therapist—Training.

The following arrangements for training in occupational work may be mentioned:—

(i) The College of Nursing, in conjunction with the Maudsley Hospital, hold a course of six months open only to State registered nurses.

Handicrafts are taken at the Goldsmith College on three and a half days per week, and on three days graduated practical work with patients is done at the Maudsley Hospital.

Twenty-four lectures are given at the College of Nursing by a doctor, followed by clinical demonstrations of cases at the Maudsley.

(ii) School of Occupation Therapy, Dorset House, Clifton Down, Bristol.

This house is a nursing home for 20 patients, approved under the Mental Treatment Act, and is under the direction of Dr. Elizabeth Casson.

The course in the theory and practice of Occupation Therapy extends over two years; if the student has already a thorough knowledge of crafts the course may be completed in one year. The reception here of private patients under the Mental Treatment Act enables students to obtain a certain amount of actual practical experience of the work.

We understand that Dr. Casson now endeavours to arrange for her pupils to spend three months in a mental hospital during their course.

As we see it at the moment we think an occupation therapist should undergo a course of training extending over something like two years to include :—

(*a*) Nine months to one year devoted to the learning of crafts in an approved training school.

(*b*) A series of lectures on basic subjects, with clinical demonstrations of cases suffering from physical and mental illness.

(*c*) A period of training in a mental hospital where occupational work is being done—possibly six months would be sufficient.

(*d*) A short course in a large colony for defectives. This will be valuable as an introduction to the methods of training of low grade defectives which, with the necessary modifications, can be applied to deteriorated patients in mental hospitals, until training in the application of the treatment to such patients can be obtained in the mental hospitals of this country.

(*e*) Three months training in recreational activities, including indoor and outdoor games, dancing, drill, music, dramatics, etc.

Some of the above courses could probably be fitted in to run concurrently.

**3. Nurses—Training.**

We have assumed that the nurses will be trained in the hospital by the medical officers, assisted by the occupation therapists and craft workers. Training will be given by means of lectures and demonstrations by the medical staff and occupation therapists, and through practical experience in the application of the treatment in the therapy classes. It is the most important link in the whole chain and unless it is properly carried out the entire scheme will fail.

The training in the hospital could be supplemented, if found desirable, by attendance at classes held in central schools for Arts and Crafts, or by training in these subjects arranged through the Women's Institutes of the district in which the hospital is situated. Use might also be made for similar purposes of institutions for defectives where a good system of training is in being.

Every nurse in the hospital should be trained.

A nurse might quite properly, we think, be required, as part of her course of training, to do six months' work in occupation therapy in the occupation centre or in the therapy classes in the wards, just as she is now required to devote a similar period to training in general nursing in the sick wards of the hospital. It is important that the subject should be treated as a part of the ordinary course, and not as an optional or special subject.

The nurses' course in occupation therapy should be a general one, and until qualified as a nurse she should not be encouraged to specialise in any particular branch to the exclusion of the remainder.

**4. Craft Workers.**

The craft workers may be certificated nurses who have merited promotion on account of their general experience and their knowledge of crafts. Alternatively, they may be persons from outside who have already received training in crafts, but who desire to obtain practical experience in the therapeutic application of the treatment to patients in a mental hospital, with a view to qualifying as occupation therapists. We suggest that in either case the period spent in the hospital as a craft worker should count as part of the course of training necessary to qualify as an occupation therapist.

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