

1 What have we been ‘doing’?

A historical review of occupational therapy

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Personal narrative

Before I address the question of how occupational therapists got here, I will answer the question: how did I get here? What has influenced my knowledge and practice to bring me to my current work and research interests, and why this book?

I grew up in a working-class family living in a large Glasgow housing estate. My father worked and my mother kept the house. I was the eldest daughter with two older brothers and two younger sisters. It was an interesting position to inhabit. It was not until I was in my teens that my mother felt able to return to work. I am sure this was because I was now deemed able to take on board some of the household tasks that she left behind, for example, preparing evening meals. I believed at the time that my elder brothers were as capable as I was of cooking and serving up this meal but the task became mine. We were, after all, a traditional working-class household with easily identifiable women's tasks and men's jobs. It took me a while to realise things could be different.

I also grew up near one of Glasgow's largest mental hospitals. This meant that I had knowledge of psychiatry from a young age. At a superficial level, I was aware that the people that I often saw at my local shops looked different in their dress and general presentation. They were patients from the hospital. I had further opportunities to observe the inside of the mental hospital on my visits with local church groups to celebrate the main Christian festivities of Christmas and Easter. These visits were always interesting: I had a close-up view of the environment and of the patients, who seemed surprisingly ordinary. We were, of course, reminded on these occasions to be on our best behaviour. I later returned to this same hospital as I prepared for my interview at the Glasgow School of Occupational Therapy. On that occasion, I was allowed access to the patients within occupational therapy settings. Although my interest was stimulated, at this stage, I had decided my career in occupational therapy would be within physical settings. Perhaps, I was drawn to the uniform, its status and its power.

However, this decision changed on my first practice placement. I found myself, in 1983, in another mental hospital, this time in Dundee. This hospital upheld the Victorian ideal of asylum, being well away from the town; indeed, special transport arrangements existed to get staff to and from their place of work. I began to

read about mental illness, not about the psychiatric conditions I witnessed but from a sociological perspective. I realised that psychiatry was an area that was little understood and that society preferred it to be out of sight. Nonetheless, during this placement, I was fortunate to be working in a setting that provided treatment to a range of patients who had acute and enduring mental health problems. I was fascinated by the lives of the people I met there. I was intrigued by the turns in their lives that had brought them into the psychiatric system. Some patients were on their first, frightening admission, and others had spent a lifetime (or so it seemed to me) in this hospital. I tried to understand the pressures and the inequalities that had resulted in people having mental illness.

It was against this background that I decided mental health would be my future area of practice. In my first post as an occupational therapist I worked in the long-stay wards of the Royal Edinburgh Hospital. Here were women who had been admitted to the psychiatric services for not adhering to society's norms of previous generations, for example, having an illegitimate child. The result was a lifetime spent in an institution. I often wondered about these women, their experiences and the child from whom they had been separated. Similarly, within acute wards, I found that women were often labelled manipulative or attention seeking, and that their role as main carers of children and others was hardly considered. The focus was on stabilising the woman's mental status and on discharging her back to her community, with little or no follow-up. The development of my interest in women with enduring mental illness grew from these experiences. How was it that women found themselves in these situations? How did the profession in which I worked, which was and continues to be largely dominated by women, contribute to the maintenance of the system?

It was not until I began to study women with enduring mental illness for my doctoral thesis, to read of women's own experiences and to explore women writing about women that I became interested in the women's movement and feminism. I came to this body of literature rather late in the day: it certainly was not part of my occupational therapy education, nor had it been an aspect of my other education. This literature helped me to reconsider and gain understanding of my own experiences and to further consider the role of women in society and, specifically, the inequalities and oppression experienced by women with mental illness. This summary, I hope, makes the influences on my life, practice and research more transparent.

Occupational therapy development

Returning to the question, how did occupational therapists get here? As we settle into the new century, it is perhaps timely to review occupational therapy over the past century. This chapter will consider the growth of occupational therapy and its unique relationship with the early development of psychiatry. It will briefly examine the parallel historical development of psychiatry and occupational therapy. It will also demonstrate that occupational therapy's development in the UK

was, and still is, significantly influenced by American and Canadian perspectives on contemporary occupational therapy theory and research. The chapter will conclude with consideration of the influences impacting on mental health practice internationally.

In the UK, from medieval times until the eighteenth century, mentally ill people relied on the charity of the church for care. In the eighteenth century, the affluent mentally ill could be looked after in a variety of ways, 'in the homes of physicians or clergymen, or they could be confined to private madhouses' (Hume & Pullen, 1986, p. 3). However, for the poor, these choices were not available. It was not until the latter half of the eighteenth century and throughout the nineteenth century that changes began to take place in the psychiatric field.

At this time, Busfield asserts that 'value was placed on reason, and unreason in all its forms – madness, crime and poverty was banished in a great confinement' (1996, p. 70). As a result, from the 1760s onwards institutions such as workhouses, prisons and hospitals were purpose-built, but few hospitals were opened for the mentally ill. The eventual overcrowding and abuse of these individuals led to the first legislation for the mentally ill in 1774 (Hume & Pullen, 1986). The mad, it was felt, needed to be cared for in special places. The result was the creation of the asylums: these buildings, often located in rural settings, were to be the mainstay for managing the mentally ill for over a century. This legislation introduced 'certification, no person could be detained without the signature of a physician, a surgeon or an apothecary' (Hume & Pullen, 1986, p. 5). In the field of mental illness, this resulted in the power of the medical profession, at this time, a male domain, being enshrined in law.

The impact of moral treatment

The emerging philosophy of this time drew on the humanistic principles of the age of enlightenment that proposed that 'all men were made equal and governed by universal laws' (Kielhofner, 1983, p. 11). There was an emphasis on the humanity of individuals and the importance of the arts to humanity. Moral treatment, as an approach to the mentally ill, led Philippe Pinel to introduce work to the Bicetre Asylum for the Insane, Paris. He further prescribed physical activity and manual work, with the aim of reducing the use of external physical coercion. This regime led to the freeing of inmates from their restraints in 1793. His reforms were widely recognised and followed across Europe and North America (Paterson, 1997).

In the UK, William and Samuel Tuke, Quakers, founded and developed the York Retreat, a private hospital based on moral treatment. They believed that by treating patients as rational individuals, they could be re-educated. Re-education was hoped for by structuring the environment physically, socially and temporally. Engagement in normal daily activities, work-related activities and play created a total daily programme of organised occupations that minimised the disorganised behaviour of the mentally ill. Occupation as therapy was created – the forerunner of occupational therapy (Wilcock, 2001).

Although, Pinel and the Tukes are held in esteem as the liberators of the mentally ill, there are some dissenters, notably Foucault (1967), the French philosopher, who argued that the constraints of the new moral treatment were just as tight as the chains that had held the people before.

Nonetheless, there was a growing emphasis in the nineteenth century on the use of occupations concentrated within the mental health field (Paterson, 1997). Early examples exist from a variety of locations in the UK. In Scotland, at the Montrose Asylum and later at the Crichton Institution, Dr W. A. F. Browne was the 'foremost of the moral psychiatrists in Scotland' (Paterson, 1997, p. 181). He understood the role of motivation in the therapeutic use of occupation. Moral treatment was seen to be a success – if only in a few locations. As Corrigan (2001, p. 203) highlighted, 'moral treatment was unable to challenge its appropriation of the governance of the insane'.

The early proponents of moral treatment in the USA were also psychiatrists. They included Rush, Dutton and Meyer, all of whom played a major role in the formation of the profession of occupational therapy (Hopkins & Smith, 1993). Benjamin Rush, considered to be the father of American psychiatry, was the first to use the concepts of moral treatment and occupation. He, like the Tukes, was a Quaker. Towards the end of the nineteenth century, Meyer reiterated the importance of occupation and treatment. His work has had a significant impact on the development of the philosophy of occupational therapy in the USA (Meyer, 1997). It was Meyer who employed Eleanor Clarke Slagle as the director of occupational therapy at his hospital. She set up the first professional school for occupational therapists in Chicago in 1915, and is acknowledged annually by the American Occupational Therapy Association (AOTA) in the keynote lecture named after her.

Rush's nephew, William Rush Dutton, another psychiatrist, also advocated the use of occupations. In 1911, he conducted a series of classes on the use of recreation and occupation for nurses at his hospital. In 1915, Dutton published the first complete text on occupational therapy. He later became editor of the *Archives of Occupational Therapy* which eventually became the *American Journal of Occupational Therapy* in 1947.

At the start of the twentieth century in the UK, asylum standards had fallen, as staff shortages and overcrowding grew and maltreatment existed. Moral treatment could not be sustained against this background, with the result that most asylums provided only custodial care (Paterson, 1997). Rollin (2003, p. 297) in his retrospective 'Psychiatry in Britain one hundred years ago' argues that the early reformers' dreams were shattered and that 'the idealised asylums had become grossly overcrowded, under valued and under funded'. He concludes that restraint in the form of strait jackets and padded cells continued well into the twentieth century. Nonetheless, work activities were still used with patients, but more for the maintenance of the institution rather than for the benefit of those who were mentally ill. Exploitation was rife. Nonetheless, some smaller institutions continued to provide treatment regimes that held true to the value of occupation both for the individual's own productivity and for their personal satisfaction (Jackson, 1993). What is clear is that the reforming moral psychiatrists shared with the new

profession of occupational therapy a belief in the efficacy of meaningful occupation as useful treatment in psychiatry. However, other world events also influenced the development of the profession.

Twentieth-century developments

A significant factor in the development of occupational therapy was the First World War. This saw rehabilitation centres set up throughout the UK to treat both physically and mentally injured soldiers, through the use of occupation. Other factors and international influences were also impacting and shaping the mental health field in 1920s. A Royal Commission (1924–1926) recommended that a special officer be appointed to each psychiatric hospital to direct patients' activities. In 1925, the first trained occupational therapist, Margaret Fulton, was employed at the Royal Cornhill Hospital, Aberdeen, Scotland. She had been educated in Philadelphia, America.

Dr D. K. Henderson introduced occupation into Gartnavel Royal Mental Hospital. In 1924, he presented a paper on occupational therapy to a meeting of the Royal Medico-Psychological Society of Mental Science. Dr Elizabeth Casson, the first woman doctor to graduate from Bristol University, heard him speak. She specialised in psychiatry, and this meeting prompted her to visit the USA and to later introduce occupational therapy to her psychiatric nursing home, Dorset House. She later sponsored the education of Constance Tebbit also at the Philadelphia School of Occupational Therapy. Tebbit along with Casson in 1930 founded Dorset House, the first occupational therapy school in the UK (Creek, 1990, p. 10). Elizabeth Casson today still influences contemporary occupational therapy through the provision of her trust fund, which supports education for occupational therapists and the Casson Memorial Lecture, which is the keynote address of the College of Occupational Therapists' annual conference.

In Scotland, the first school at the Astley Ainslie Hospital in Edinburgh was staffed by Canadian occupational therapists. In 1932, a group of 11 Scottish occupational therapists, mostly from psychiatric hospitals, formed the Scottish Association of Occupational Therapists. This became the first professional association in the UK. The influence of moral treatment, the growth of psychiatry as a medical specialism and both American and Canadian involvement have all influenced occupational therapy, and these aspects cannot be understated when reviewing the profession's development in the UK (Schemm, 1993).

External influences

There are many milestones in the development of psychiatric care in the UK from the 1930s onwards, including legislation, the founding of the National Health Service (NHS – 1948), the development of new drug treatments, especially major tranquillisers, and the move towards community care (Paterson, 1998). The work of Barton (1959) and Goffman (1961) highlighted the dehumanising ways in which patients

were often treated in institutions, resulting in dependent and passive individuals. This added considerable weight to the demand for community-based services.

Mental health legislation and policy documents, for example, the Mental Treatment Act (1930), Hospital Services for the Mentally Ill (1971), the Mental Health Act (1983) and Caring for People (1989), show how consecutive governments aimed to improve mental health services. Most recently, governments have reinforced the refocusing of care to the community. The NHS Plan (Department of Health, 2000), the National Service Framework (NSF) for Mental Health (Department of Health, 1999) and the Scottish equivalent, the Framework for Mental Health Services (The Scottish Office, 1997), all advocate the further development of community care. Integration of health and social care agencies to provide effective care for people with enduring mental illness is embedded in these policies. Feaver (2000) stressed that to meet the aims of the NSF there must be a drive towards collaborative, continued professional development. These developments in the UK are mirrored in other countries.

The combined effects of these external factors have had a lasting impact on the shape of occupational therapy. The closure of large mental hospitals and the consequent reduction in bed numbers have resulted in many individuals with enduring mental health problems living in the community. Occupational therapists continue to work with individuals with a range of mental health problems, in many contexts. Some therapists still work in in-patient areas, some bridge the gap between hospital and community and others work solely in the community. Some are employed by the NHS, others by the Social Services and still others by non-statutory organisations. A growth area within mental health services has been the development of forensic occupational therapy services within the specialist State Mental Hospitals (Duncan *et al.*, 2003).

Internal influences

Internal pressures within the profession have also contributed to changing practice. The 1960s and 1970s saw the influence of a range of theories impacting occupational therapy in mental health, including analytical psychotherapy, behaviourism and cognitive theories (Kielhofner, 1983). The profession was in a time of crisis. The integration of such theories led to the loss of professional confidence and commitment to occupation. Reitz (1992) found that occupational therapy abandoned its earlier philosophy of occupation and health. Therapists had lost their appreciation of the importance of occupation and its significance to human life (Kielhofner, 1983; Whiteford, 2000).

These pressures were experienced not only in the UK but also in North America and Australia. The profession identified a growing need among therapists for a unifying concept. In the 1980s, the refocus on humans as occupational beings with occupation and occupational performance being identified as core concepts of the profession led to the development of practice models: for example, Reed and Sanderson (1980), Model of Human Occupation (Kielhofner, 1985) and The Canadian

Model of Occupational Performance (CAOT, 1997). These models have strengthened therapists' belief in their profession and in the health-giving benefits of the occupation. They have enabled most therapists to articulate the complexity of occupational therapy and the significance of the person–environment–occupation relationship.

Within the UK, occupational therapy in mental health is still a significant area of practice, with approximately one-third of therapists being employed (Walker & Lynham, 1999). However, this is not the case in other Western countries. In the recent Canadian Association of Occupational Therapists Membership Statistics (CAOT, 2005) 12.3 % of occupational therapists reported their main practice setting as mental health. In a recent workforce survey by AOTA of 8998 occupational therapists and occupational therapy assistants; 3195 responded. Of these respondents, 3.6% indicated that their primary work setting was in mental health and a further 3.5% indicated that their secondary work setting was mental health. (personal communication, AOTA, 2006). Australia traditionally had fewer therapists employed in mental health practice; recent figures from the OT Australia indicate that, of their total membership of 4592, only 602 (15%) therapists are listed as working in mental health (personal communication, OT Australia, 2006). Ireland, too, has traditionally had a smaller number of occupational therapists working in the mental health arena; the Association of Occupational Therapists Ireland (personal communication, AOTI) indicates that approximately 120 therapists (10%) work in mental health settings in Ireland.

Given that occupational therapy has its roots in mental health, the small proportion of therapists working in this area has been a matter of concern. There is an ongoing debate about the specific contribution of occupational therapy in mental health. In an attempt to address these issues, in the 1990s, the College of Occupational Therapists, in the UK, established a Mental Health Project Working Group to produce a position paper on the way ahead for research, education and practice in mental health. It identified little research literature relating to the practice and management of occupational therapy in mental health (Craik, 1998; Craik *et al.*, 1999). As a result, two surveys were undertaken to profile practitioners and managers working in mental health.

The first survey, by Craik *et al.* (1998), explored the views of practitioners. This work identified that issues existed around role definition, the need for a unifying theory and research, and the value of the profession. Nevertheless, the respondents were committed and enthusiastic about occupational therapy in mental health. Although few of the respondents had direct involvement in research, most were aware of the need for research and evidence-based practice.

The second survey examined the perspectives of occupational therapy managers in mental health. It revealed that the majority of managers were women. In the main, similar findings to the practitioners' survey were found. These findings included the need for clarification of the core skills, roles and approaches of occupational therapists (Craik *et al.*, 1999).

Building on the work by Craik *et al.* (1999), Fowler-Davis and Bannigan (2000) explored the priorities for mental health research in the UK. They identified the

three areas most needing research to be occupation, group work and occupational performance skills. They further identified that the core skills of the profession, professional status, effectiveness issues and finally, client-centredness, were all worthy of further research. An update of the mental health research priorities by Fowler-Davis and Hyde (2002) indicated that occupation remained the number-one research priority area; however, occupational performance and users' perspectives were ranked second (3 in 1999) and third (8 in 1999), respectively. The position of users' perspective marked the greatest change from the 1999 priorities, reflecting the need to involve service users in research, service design and provision. The message of these surveys was clear: occupational therapists were questioning their unique contribution and their status within mental health services.

Duncan (1999) emphasises that one way to silence the continued call for clarification of the profession's contribution is evidence-based research into the efficacy of occupational therapy and occupation. Wilcock (1999) takes this further advocating for research and intervention at policy and population levels focusing on enabling occupation, health and well-being. Whatever form the research takes, it requires involving service users in its development, implementation and evaluation. Only such collaborative research can create a firm evidence base for occupational therapy to provide effective services to its users in both health and social care settings.

Building the evidence base

Recently, there has been some movement towards bridging the research gap in UK mental health practice. Studies conducted across a range of topics include:

- The role of primary mental health care in meeting the needs of people with enduring mental health problems (Cook, 1997; Cook & Howe, 2003).
- The quality-of-life priorities for people with enduring mental health problems (Mayers, 2000).
- Support groups for people who have experienced psychosis (Hyde, 2001).
- Clinical effectiveness and the Canadian Occupational Performance Measure (Chesworth *et al.*, 2002).

Significantly, over the last decade, occupational science has developed as an academic discipline to generate knowledge about the form, function and meaning of human occupation (Zemke & Clarke, 1996). Occupational science is a multi-professional discipline, initially developed at the University of Southern California. It built on the work of Meyer, Riley, Ayres and others, and the ideas put forward have generated worldwide interest and research (Yerxa *et al.*, 1989). It is argued that occupational therapy's unique contribution to health lies in the relationship between health and occupation (Wilcock, 1998). Wilcock and others have argued that there is a human biological need for occupation (Wilcock, 1993; Wood, 1998).

Wilcock (1998) stressed that occupational therapy has latterly concentrated on ill health and that the profession has negated the potential of occupation to influence

the public health agenda. She has worked to explore this perspective and, in the process, has repositioned occupational therapy beyond its traditional health and social care borders. Occupational science as a theory has offered occupational therapists' new ways of thinking and new ideas to broaden the profession's horizon (Wilcock, 2001).

Occupational science proposes that individuals should be studied in their interactions with their occupations and environment in everyday situations (Yerxa *et al.*, 1989). It draws upon a multi-professional background and recognises the need for a variety of research methods that enable the illumination of our understanding of how people ascribe meaning to occupation and their lives. Methods to achieve these aims have focused on using qualitative methods, including narrative inquiry, to access and present diverse accounts (Polkinghorne, 1995; Frank, 1996). These methods are consistent with the central tenets of post-modernism, with its emphasis on different perspectives, situatedness, temporality and contexts. Occupational science has unified a focus on occupation and facilitated alternative research to be undertaken.

In a review of 6 years of *British Journal of Occupational Therapy* from January 2000 to September 2006, the influence of occupational science is readily evident. There has been an increase in mental-health-related publications with authors responding to the call for research involving users of mental health services to explore occupation and the relationship between health, well-being and engagement in occupation. Time-use (Shimitras *et al.*, 2003; Farnworth *et al.*, 2004; Bejerholm *et al.*, 2006), the value of occupation (Mee *et al.*, 2004), barriers to occupational engagement (Chugg & Craik, 2002) and the meanings engagement in occupation adds to their lives have all been researched. Furthermore, the occupations explored took place in a variety of contexts; in-patient and forensic units, day services and community settings. These studies encompass a range of occupations including adult education (Westwood, 2003), horticulture (Fieldhouse, 2003), leisure and outdoor recreation (Heasman & Atwal, 2004; Craik & Pieris, 2006; Frances, 2006), skills acquisition, life skills training (Mairs & Bradshaw, 2004), woodworking (Mee & Summison, 2001), cooking (Hayley & McKay, 2004) and support groups (Hyde, 2001).

These studies demonstrate the importance of occupation to the lives of people with mental health problems. Although all are based on relatively small samples, they contribute to a growing body of research that explores the perspectives of mental health users. They begin to address the significance of occupation to maintaining mental health and they further explore, in some depth, the meaning that individuals ascribe to their lives through occupation. The body of work makes a valuable contribution to evidence-based mental health practice, revealing the importance of positive and successful experiences through participating in occupations leading to a sense of meaning, increased self-esteem, skill acquisition and an improved sense of identity. The importance of supportive environments, opportunities for social networking, facilitating people to make their own choices and, importantly, enabling them to take control of their lives were to the fore.

The work to date goes some way to address the earlier calls for relevant research and it reflects the research priorities identified by Fowler-Davis and Bannigan (2000). This research offers a sound foundation on which the College of Occupational

Therapy can move forward with its 10-year Mental Health Strategy for Occupational Therapists (2006). The strategy highlights five key themes: occupation focused, person centred, accessible, available and relevant (COT, 2006).

Current influences on occupational therapists working in mental health

The international influences on therapists practising in mental health currently include the recovery movement, users' perspectives and participation, social inclusion, vocational rehabilitation and cultural sensitivity. Practice contexts that continue to challenge occupational therapists are acute care, crisis intervention and forensic settings. The chapters of this book follow a broadly similar format of a personal narrative through which the scene is set for the author's journey in mental health, exploration of the evidence for their practice and examples of advanced practice. However, contributors have adopted different approaches to fulfil their remit of writing a chapter, reflecting the diversity of mental health practice. Some have shared a very personal narrative that has influenced practice while others have shared their research or research careers. Each chapter concludes with a number of key questions to assist readers in thinking about the chapter content in relation to advancing their practice.

A brief glance at the list of authors and their current affiliation gives some indication of their international background, but closer examination reveals even more diverse experience. Authors currently work in occupational therapy in practice, education and research in the UK, Ireland, Canada and New Zealand. But if their country of origin is noted, other countries are represented: South Africa, Singapore, Australia and Hong Kong. Several authors received their occupational therapy education and practised in one country before moving to another; so, Carla van Heerden from South Africa is now practising in London; Kee Hean Lim from Singapore is now teaching in London and Samson Tse from Hong Kong is now living and researching in New Zealand as is Caroline Doughty. Thelma Sumsion was educated in Canada and practised and taught there before moving to England, where she taught and undertook her PhD in London before returning to Canada. The authors represent a truly international perspective on the current influences and practice.

Anthony (2000) considers that 'recovery is a process...a belief which infuses a system...which providers can hold for service users...grounded on the idea that people can recover from mental illness and that the delivery system must be constructed on this knowledge' (p. 159). Recovery highlights practice based on restoring hope, making meaning, experiencing success, taking control and maintaining and developing supportive relationships (Repper & Perkins, 2003). In the last 15 years there has been an increased interest in incorporating recovery philosophy into services particularly in New Zealand, Canada, the US, the UK and Ireland. Recovery and occupational therapy are considered in depth by Karen Rebeiro in Chapter 8.

Social inclusion and its relationship to mental health problems is well recognised and complex. Users of mental health services can be excluded in multiple

ways and experience stigma and discrimination in their daily lives. Occupational engagement and community participation are highlighted as ways of reducing both stigma and discrimination. Wendy Bryant offers a stimulating discussion on occupational alienation and inclusion within the community in Chapter 7.

The importance of work to increase engagement and social inclusion is discussed by Carla van Heerdan in Chapter 10 as she merges her South African and UK experiences of vocational rehabilitation. The use of creative activities in community settings offers a possible way forward to enhance social inclusion and reduce alienation in the community. In Chapter 9, Jacqueline Ede illustrates innovative partnerships to achieve inclusion.

In Chapter 2 Gabrielle Richards provides an overview of the impact of policy on occupational therapy practice. Cultural sensitivity and multiculturalism pose challenges for services worldwide, and in Chapter 3, Kee Hean Lim reviews the significance of cultural sensitivity in practice.

In Chapters 4 and 5, Samantha Dewis and Michelle Harrison discuss the importance of occupational therapy in acute care and crisis intervention teams. Elaine Hunter shares her experiences of developing a forensic service aligned to the best evidence in Chapter 6. Graeme Smith in Chapter 11 reinforces the significance of narrative to change the dominant discourses prevalent in mental health.

The need for users to be active participants, collaborators and consultants in service provision, development and research is well established. In Chapter 12, Dr Samson Tse and Dr Carolyn Doughty present the results of a systematic review examining user participation in service delivery. In Chapters 13 and 14 Dr Edward Duncan and Dr Thelma Sumsion, respectively, share their personal journeys as researchers. To conclude, in Chapter 15 Christine Craik reflects on the past and offer insights into possible futures for occupational therapy in mental health.

Questioning your practice

1. Reflect on your career to date how you have got to where you are?
2. How has your practice changed in the past 2 years?
3. How do you imagine your future practice developing?

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