



## City Research Online

### City, University of London Institutional Repository

---

**Citation:** Simpson, A., Bowers, L., Alexander, J., Ridley, C. & Warren, J. (2005). Occupational Therapy and Multidisciplinary Working on Acute Psychiatric Wards: The Tompkins Acute Ward Study. *British Journal of Occupational Therapy*, 68(12), pp. 545-552. doi: 10.1177/030802260506801203

This is the accepted version of the paper.

This version of the publication may differ from the final published version.

---

**Permanent repository link:** <https://openaccess.city.ac.uk/id/eprint/8073/>

**Link to published version:** <https://doi.org/10.1177/030802260506801203>

**Copyright:** City Research Online aims to make research outputs of City, University of London available to a wider audience. Copyright and Moral Rights remain with the author(s) and/or copyright holders. URLs from City Research Online may be freely distributed and linked to.

**Reuse:** Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge. Provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way.



## **Occupational Therapy and Multidisciplinary Working on Acute Psychiatric Wards: The Tompkins Acute Ward Study**

Category: Scholarly paper: Clinical: Adult Psychosocial

Words: 5,000

## **Occupational Therapy and Multidisciplinary Working on Acute Psychiatric Wards: The Tompkins Acute Ward Study**

### **ABSTRACT**

There is a limited research into occupational therapy and interprofessional working on acute psychiatric wards. This research aimed to explore relations between occupational therapists and other members of the multidisciplinary team through structured interviews with 47 staff on 13 acute psychiatric wards. The study found that occupational therapists provided assessments, group activities and individual therapeutic work, with the assessment and development of activities of daily living central. Linking patients with community resources in preparation for discharge was also important. Severity of illness amongst patients and speed of discharge were barriers to effective input. Nurses and psychiatrists appreciated occupational therapy input but rarely the breadth of the role. Multidisciplinary relations were generally positive though some ward teams were disinclined to include occupational therapists in communications and decision-making. Occupational therapists appreciated their professional knowledge and opinion being respected and considered. The study concluded that occupational therapists play an important and often misunderstood role on acute psychiatric wards but their involvement could be significantly increased through the employment of more experienced occupational therapists and the provision of interprofessional education. Further research is required to explore the facilities, resources and support required to maximise occupational therapy input and identify areas for increased interprofessional working.

## **INTRODUCTION**

Occupational therapists still have a role in acute inpatient mental health care settings despite the shift of focus from hospital to community care (Craik 1998, Christian-Edwards 2004, Duffy and Nolan 2005). However, there may be some confusion or disagreement about the contribution of occupational therapists in psychiatry (Lieberman et al 2001, Auerbach, 2001, Rebeiro, 2001, Tsang, 2001) and of the occupational therapist role generally (Creek 2003). Despite resistance amongst some occupational therapists to more generic mental health roles (Lloyd et al 2004), they are reported to have adapted well in community multidisciplinary teams but may be less sure of their role in inpatient mental health settings (Greaves et al 2002). The need for occupational therapists to clarify their role and relationships with other mental health professionals has been recognized, particularly in light of the increasing emphasis on interprofessional working (Craik et al 1998, Duffy and Nolan, 2005). This study explores multidisciplinary teamwork on acute psychiatric wards, with a particular focus on relations between occupational therapists and other professions.

## **MULTIDISCIPLINARY TEAMS AND TEAMWORK**

The development of multidisciplinary teams (MDTs) lies at the heart of modern health and social care in which collaboration between agencies and professional disciplines is intended to replace divisions and demarcations in order to improve the quality of service provision (Department of Health 1997). Research evidence suggests that more integrated teams produce better patient outcomes including reduced mortality, greater continuity of care, consistent communications with patients and family, and shared team knowledge and skills (West 1999, Miller et al 2001, West et al 2002). In a comprehensive study of over 400 healthcare teams in England and

Scotland, those with clear, shared objectives and higher levels of communication and participation were judged to operate more effectively on self-report and external measures. Quality of meetings, communication and integration was also associated with the introduction of new and innovative ways of delivering patient care and improved mental well-being amongst staff (Borrill et al 2000).

Following concerns expressed by service users about poor interprofessional communication and the lack of multidisciplinary input into treatment programmes, the policy implementation guide for acute psychiatric care in England identified the need for an increased MDT approach on wards and for occupational therapists to be more involved in the provision of activities and treatment planning (Department of Health 2002). Greater involvement of occupational therapists in joint training on wards has also been advocated (Clarke 2004). A recent UK survey of occupational therapists registered with the Association of Occupational Therapists in Mental Health and working with adult mental health inpatients found that whilst all 63 respondents considered MDT working important, just a third were part of a team whose members came from several disciplines; occupational therapists more commonly worked alongside nurses and doctors only (Duffy and Nolan 2005). It has been suggested that working as part of a team can significantly shape what occupational therapists accomplish, as they are required to adapt to the unit philosophy and management style (Creek 2003) and tensions can arise over the level of involvement in various aspects of patient and ward management (Christian Edwards 2004). Working constructively with colleagues and managing interprofessional conflicts have been identified as key factors in providing effective mental health care (Hope 2004). However, the authors found little research literature in the UK or elsewhere concerning relationships

between occupational therapists and other members of the MDT, a finding echoed by an earlier comprehensive review of key journals in the UK, USA, Canada and Australia (Craik 1998).

The data reported in this paper were gathered as part of the Tompkins Acute Ward Study, a longitudinal research project investigating care on acute psychiatric wards using qualitative and quantitative methods. The study builds on a programme of research that has identified teamworking skills (cohesion, consistency and mutual support within and across disciplinary boundaries) as a possible key factor in creating calmer, more therapeutic wards with lower levels of conflict (Bowers 2002, Bowers et al 2003a, Bowers et al 2003b, Simpson and Bowers 2004). The interviews described in this paper were collected at the outset of the study in order to characterize the approaches of different psychiatric wards.

## **AIM**

This paper aims to explore and describe relations between occupational therapists and other members of the multidisciplinary team on acute psychiatric wards.

## **METHODS**

### **DESIGN**

## Occupational Therapy and Multidisciplinary working on acute psychiatric wards

The study was a cross-sectional interview survey of multidisciplinary staff working on acute psychiatric wards.

### SAMPLE

Multidisciplinary staff (n = 47) from 14 acute psychiatric wards in one NHS Trust in London composed of occupational therapists (n = 11, [3]), ward managers (n = 13 [0]), F grade (senior) mental health nurses (n = 14 [0]), and consultant psychiatrists (n = 9, [15]). Numbers in the square brackets are of those who declined to participate, or did not respond to invitations to do so. All ward managers, occupational therapists and consultant psychiatrists were approached and asked to participate. Where there was more than one F grade nurse on a ward, the person first contacted was asked to participate. The interviews were conducted from October to December 2003.

### INSTRUMENT

The Operational Philosophy and Policy Interview (OPPI) was developed for this study. This semi-structured interview schedule covers the general care philosophy of the subject, their concept of the purpose of acute inpatient psychiatry, interdisciplinary relationships, team strengths and weaknesses, ward structure, and plans for changes in practice. The interview framework was created by the principal investigator (LB) and derived from current knowledge of the field plus previous research work in the area. It was piloted and reviewed twice by the research team. There were 12 questions in the schedule, each with suggested prompts for the



interviewer to encourage more detailed exploration of topics. Sample questions and prompts by participants included:

Q7. Are there any other professions involved in the treatment of patients on your ward? If so, what is their contribution?

Prompt: Are there any professions/workers you would like to see working on the ward?

Q9. How would you describe the relationship between the different professions on the ward?

Prompts: What aspects of multi-disciplinary collaboration work well? Any particular difficulties?

Only occupational therapists were asked *explicitly* about the role of occupational therapists. All other questions to participants were identical, including several about the contributions of and relationships between different professions.

## PROCEDURE

The study received ethical approval from the local research ethics committee. Prospective interviewees were contacted by phone and asked if they would participate. Subject to their agreement, a mutually convenient appointment was made. At that time one of two researchers (psychologist and mental health nurse researchers) explained the study in more detail, gave the subject an information sheet, and asked for their signed consent. Interviews were conducted on the wards or in adjacent offices. All interviews were tape recorded and transcribed except one, where notes were taken. Following transcription, the accuracy was checked against the initial recordings and corrections made.

## DATA ANALYSIS

Interview transcripts were imported into qualitative data analysis software (QSR N6) and basic factual coding completed (e.g. ward, profession, etc.). All interviews were read by three researchers, who met to collate ideas on analytic categories and agreed a strategy for coding following discussion. As a preliminary step, interviews were coded to the broad topic areas of the structured interview questions. Coded topic areas were then read and re-read and coded to emergent themes and concepts. Preliminary findings were reviewed following discussion with members of the department's research and clinical development team. Additionally, frequent contacts with ward staff by members of the research team allowed continuous informal discussion and feedback of findings. Findings were also presented, discussed and included in interim reports to each ward and presented at Trust conferences, to ensure credibility and trustworthiness (Krefting 1991). This paper focuses on interviewees' responses about interprofessional relations, multidisciplinary working and the role and contributions of occupational therapists. Other papers incorporate findings on the purpose and aims of acute wards, types of teamworking, and ward management and leadership.

## **FINDINGS**

Interviews were conducted across 13 acute inpatient wards with 47 staff members. Table 1 provides summary demographics of the participants. It is evident that the occupational therapists held junior positions in terms of their age, length of time since qualifying, time in current role and time spent working on the ward. For the majority,

this was their first post following qualification. They were also more likely to be female, white and British.

INSERT TABLE 1 HERE

Findings will be presented under five themes identified during analysis: ‘the role of the occupational therapist’; ‘barriers to involvement with patients’; ‘multi-disciplinary working: listening and respecting’; ‘multi-disciplinary working: participation’; and ‘interprofessional training’. Anonymous quotations from participants are used to illustrate themes.

### **The role of occupational therapists**

Occupational therapists identified several core functions to their role: continuous assessment of patients, organising and facilitating group work, individual therapeutic work and liaison with other staff and agencies. These functions were frequently explained by occupational therapists to be interrelated, something not always recognised by other members of the MDT. Assessment activities included evaluating independence in activities of daily living (ADL):

*Basically, we do assessments and evaluations involving activities of daily living. It's about how a person can cope once they are out there and not under this protective environment. If they are able to manage a household, do shopping, take care of themselves, socialise, access resources, access the community, budgeting. It's all life skills that we take for granted. Occupational Therapist.*

Assessments included planning aftercare arrangements and determining the facilities and resources required to maximise successful community living following discharge.

Some occupational therapists described linking people into community resources in preparation for discharge as their priority.

Participants reported that demands made for more activities for patients on acute wards (Department of Health 2002, Commission for Health Improvement 2003) had led to occupational therapists providing more therapeutic and activity groups. These included health promotion, education and discussion groups, music appreciation, relaxation, creative art and writing, pottery, cookery, healthy living and physical activities. Some occupational therapists facilitated patient community groups and involved people from community services. Participation by patients in group activities provided occupational therapists with opportunities to assess concentration and social skills and to help patients develop these through therapeutic interactions in groups and individual therapy as outlined in treatment plans. Observations and assessments conducted by the occupational therapists were fed back to the rest of the MDT to inform treatment decisions. It was suggested that their perspective might contain a unique element, not possible for other ward staff in light of their particular roles:

*I often see a different side of people because I'm not seen as the custodial person. I'm not the person that does sectioning. I'm not the person that gives out medication. I'm not the person that restrains people. So sometimes I will get more of a rapport with people just for that reason alone. Occupational Therapist.*

On some wards, nurses, ward managers and psychiatrists saw the occupational therapist role and contribution largely in terms of their providing and facilitating group activities. Often these were seen as predominantly diversionary or 'time-filling' activities with more explicitly therapeutic functions, such as ongoing assessment of activities of daily living, rarely acknowledged:

*...there's a perception sometimes that we are there to make people do things just so that they, keep them busy, keep them, stop them being idle. That sort of devil makes work for, you know, that sort of philosophy rather than anything we do having any meaning or purpose to people. Just keep them, you know, we could as well be just taking them to run round and round the hospital. Occupational Therapist.*

Elsewhere, occupational therapists were considered key components of the multidisciplinary team (MDT) in all aspects of patient care from initial and ongoing assessment, through treatment planning to aftercare arrangements.

Occupational therapists were keen to see more involvement of nurses in the running of groups, with some feeling that the groups remained separate from the rest of the ward staff. However, a few expressed concerns over the level of understanding and skills some nurses had in relation to group work:

*...there has been times when I've had nurses saying, I want to do this group, I want to do this group and they've actually set up a group without thinking about, you know, continuity, without thinking about whether their shift pattern allows the continuity, without any thought about boundaries, so the group's starting at three, and they turn up at quarter to three, without any assessment of person's needs or skills or whether that person can tolerate being in that group and I think that's dangerous. Occupational Therapist.*

Despite these concerns, there existed recognition of the value of nurses becoming involved in group therapies and of opportunities for different professions to advise and support each other, to learn from one another and become more integrated. Many of the nurses interviewed were highly complimentary of the occupational therapists and positive about their input on the wards:

*We have a very good occupational therapist and occupational therapy support which is great, and [this] has even improved over the last week where they've recently started a programme where there's a lot more group work on the ward and so that's a very vital part of our assessment [procedure]. Nurse.*

Some ward managers were very keen for their nursing staff to become more involved in group work on the wards, seeing opportunities for them to develop important skills. One nurse recognised how involvement in group activities also allowed a greater continuity of care in the care and treatment of patients:

*And also the good thing about it [is] that the staff is involved in even the OT things because it, to help us to understand what's happening really, so and the added strength that it gives you an idea about what he is doing and then how you can utilise what is done by the OT on a continuous basis. Nurse.*

### **Barriers to involvement with patients**

Severe mental disorder amongst patients sometimes limited the involvement of the occupational therapists, with patients too unwell to participate in therapeutic and group activities or unable to comprehend the objective of occupational therapy:

*In this specific city sometimes we work with clients while they're very, very, very, very much acutely ill that sometimes makes it difficult for me, for instance to work, to have the input that I would like to have. Occupational Therapist.*

Occupational therapists could feel frustrated when the patient was too ill or, due to the pressure on acute inpatient beds, would be discharged just as they were beginning to fully participate in therapeutic activities. Some occupational therapists wanted to be able to follow patients into the community to provide continuous contact and involvement to further rehabilitation. Several occupational therapists identified situations where they felt their skills and expertise were not being fully appreciated or made use of in the planning of treatment and aftercare. The speed with which patients were often discharged tended to preclude consideration of information obtained through ongoing assessments, made available by the occupational therapists. Some patients were being discharged despite suggestions they were not capable of coping in

the community in terms of their safety or ability to provide for themselves, as was born out by speedy relapse and readmission.

*I think that we could have a bigger role in saying whether or not we feel people are sort of safe to go home and quite often assessments are requested of us but they are not always read. Occupational Therapist.*

Despite providing information about occupational therapy, occupational therapists were still receiving referrals requesting input for patients 'because they are bored'. They wanted to see staff develop a greater understanding of occupational therapy and to view it as a core part of treatment. Several said they were happy to explain the purpose and philosophy of occupational therapy to other disciplines. One occupational therapist suggested the need for at least two occupational therapists and an assistant on each ward, which would ensure a range of activities could be provided regularly at different times of the day. When there were urgent demands for ADL assessments in order for a patient to be discharged, groups had been cancelled as assessments were considered a priority. She also wanted group activities available at weekends, a dedicated group room on wards and a larger budget for ward activities that would allow for the provision of materials for patients.

### **Multi-disciplinary working: 'Listening and respecting'**

Although there was recognition that various other personnel were involved on wards, the occupational therapists in this study worked primarily alongside mental health nurses, nurse ward managers and psychiatrists. Occupational therapists described generally positive relationships, especially between themselves and nursing staff. Being listened to and respected as a fellow professional was a key issue, as it was for the nurses and ward managers interviewed. Having one's professional expertise and views acknowledged and considered, contributed to the existence of a team ethos:

*...particularly with one of [the consultants], I do feel hugely valued and you know, my opinion's always asked on a situation and you know, the work that I do is appreciated so I do feel like I'm part of the team in that and, you know it's quite good coming out of ward rounds feeling that [...] your input's been recognised. Occupational Therapist.*

Many occupational therapists saw this as a crucial issue for all staff and some spoke with concern of medical and nursing colleagues having a 'lack of mutual respect'. Perceived insensitive attitudes of some consultant psychiatrists towards their colleagues and patients were also remarked upon and were seen to impair interprofessional relationships:

*... the way he approaches clients or the family, and for that matter I think other staff, other multi-disciplinary team members, it seems like he listens to you very briefly but in the end it's his own decision. So I wouldn't say that there is much sort of respect and consideration unfortunately. Occupational Therapist.*

A few occupational therapists suggested that it could take time for interprofessional relationships to become integral to day-to-day working, although the benefits were considerable when this was achieved.

*The consultant I've known for over a year now and it's taken me a long time to find a working relationship with her, but I have done now. She has got a very different style of communicating to me, and it's very medically model based, and it's taken a long time for me to promote what I do to her, so that she understands and appreciates what I do. She's now got to the point that she wants to do a research project with me around activities of daily living assessments, so we've got there... Occupational Therapist.*

The need for each profession to have an awareness of the different pressures each faced and an understanding of the philosophy that underpinned what each was doing was recognised to minimise confusion and misunderstanding.



### **Multi-disciplinary working: 'Participation'**

There was wide variation between wards as to the level of involvement the occupational therapists felt they had within the MDT. Some spoke very positively of ward managers and consultants who ensured they were fully involved in discussions and decision-making:

*I'm really impressed with the medical team because they, it's not kind of dictatorial, they're not like well you know, we're going to do this, this and this, when they sit down and it's a team decision ultimately they ask the nursing team and the OT team and I do feel like I have a voice in the ward round and their role is essentially to I think gather and collate all that information through all the different sources... so ultimately, I mean they kind of collate, they gather all the information that's like handed over to them in ward rounds and as a result of that, work out together with the team a good treatment plan, a care plan... Occupational Therapist.*

But others spoke of feeling on the periphery of the team and of being excluded from team communications:

*Yeah I think the communications seems to be quite good... but I think I'm kind of seeing it on the sort of periphery, I'm not seen as necessarily part of the team. I'm kind of on the outskirts... Occupational Therapist.*

One occupational therapist spoke of being 'out of the loop' and another described situations where key information, including violent incidents concerning patients she was involved with, had not been passed on to her. Others spoke of difficulties experienced in trying to participate in MDT meetings and ward rounds. One spoke of meetings being dominated by a consultant who left her feeling 'intimidated', with the result that her input to the team and patient care was 'very limited'. On some wards, management meetings were arranged for times when occupational therapists were required to attend meetings elsewhere thereby limiting opportunities for joint discussion and planning. At other times ward rounds overran due to poor time management, clashing with occupational therapy groups on the ward. Communication

and joint decision-making were clearly improved on wards that had introduced joint planning meetings to which occupational therapists were invited:

*... we decided to have the morning handover, so everybody goes to morning handover, so there's a nursing shift handover at change of shift but then there's a nine o'clock handover as well which is for all the other members of the team who don't work to a shift pattern, so I'll go, the OT assistant will go, there'll be the two Senior House Officers will go to it, there'll be the psychologist there. That's a daily thing. And I think it really does make a difference. Occupational Therapist.*

Occupational therapists were also affected by their time being divided between the ward and the occupational therapy department. Consultants, other doctors and nurses were more established as part of the ward team, which allowed them to dictate timing of meetings and to fit things around their schedules. Developments such as information boards where articles of shared interest were posted were identified as helping develop a team ethos. On some wards, whilst the input of occupational therapists was valued, their involvement was seen by others to be limited by them 'keeping a distance' from the rest of the team and having limited knowledge of the management of the ward, which was still primarily a nursing responsibility. Some staff, though, were aware that the full value of the occupational therapists' knowledge and skills was not fully appreciated or exploited:

*With the occupational therapists I think it's good, but they don't come into any of the ward rounds and their opinion is never valued in that sense and they can pass on a bit in the morning hand over, but I feel they are not treated as full professionals even though they've been to university for three years, because they don't have that sort of high profile in the ward round, so no one's there to listen to their opinions. Nurse.*

There appeared to be different policies concerning referral to occupational therapists by other ward staff. On some wards referrals to the occupational therapy department were still required whilst on others, occupational therapists saw themselves as part of the MDT, available to all patients. This allowed the occupational therapists autonomy

in deciding which patients would most benefit from their input. Similarly, occupational therapists appreciated having autonomy in developing the group work programmes in consultation with the rest of the team.

### **Interprofessional training**

All interviewees were asked about training they had attended or that had made an impact on the operation of the ward. It was apparent that there was little in the way of joint training or development. Occupational therapists attended courses organized by the occupational therapy department that addressed their individual professional development. Some occupational therapists spoke of attending a risk management course that they had found very helpful but it did not appear that other professions had attended the same course. Nurses were required to attend a vast array of mandatory and other training and some nurses and ward managers attended leadership or management courses. Consultant psychiatrists rarely mentioned any training. Each profession appeared to know little or nothing about training undertaken by other staff. One occupational therapist initiated discussions with the modern matron, which led to nurse training programmes being made available to occupational therapists, in order to '*model collaborative and multi-disciplinary working*'. This had enabled useful joint discussions to take place.

### **DISCUSSION**

The occupational therapists in this study identified activities of daily living as their primary type of group and individual intervention, alongside a broad range of groups and therapeutic activities similar to those described in the UK survey of occupational therapists working in inpatient mental health services (Duffy and Nolan 2005). There

was some resistance to the idea that groups existed to provide patients with relief from boredom, but given patients frequently identify boredom as a major concern on wards (Baker 2000), the importance of such a role should perhaps be reconsidered. The occupational therapists appeared to place greater stress on their involvement in assessment activities on the ward than did those surveyed across the UK and to also regard their role in preparing patients for life outside the hospital environment as a priority, in line with Brenneman Baron (1994). This may reflect the need for discharge planning to start as soon as patients are admitted under the Care Programme Approach (CPA) in England (Department of Health 1999), coupled with the need to discharge patients urgently in London due to bed pressures (Audini et al 1999).

Difficulties in providing occupational therapy to a client group that was often seriously mentally disturbed or swiftly discharged were reported and regrets that interventions could not be continued post-discharge expressed. Dutton (2004) has suggested that the occupational therapists' role and skills equips them to engage 'revolving door' patients whilst on inpatient wards, even when faced with limited time, and to provide psychosocial interventions aimed at re-evaluating and managing distressing symptoms. Ensuring similar work continues following discharge is a key aspect of that role, he argues. Short inpatient admissions are now integral to modern psychiatric care, with the majority of patients preferring home-based treatment and support whenever possible; a factor reflected in the rapid development of an array of home and community treatment teams (Appleby 2004). Inpatient occupational therapists perhaps need to consider how they can best adapt in order to do their best for the population and circumstance they have, rather than hope for less ill patients and longer hospital stays for their input to be effective. Occupational therapy input on

acute wards can only ever be very partial and will rarely see the recovery process through. It can however be specialised, intensive and vital to assessment, decision-making and future planning within the inpatient team.

Although some occupational therapists experienced frustration in having to constantly explain the occupational therapy role and interventions to professional colleagues, many appeared positively inclined towards educating their colleagues. In line with the national picture, the occupational therapists worked predominantly alongside nurses and doctors with the level of integration highly variable, reflecting MDTs in many other healthcare settings (Miller et al 2001). Whilst most occupational therapists described reasonable or good working relationships with nurses and sometimes doctors, they often felt themselves and were often seen by others to be on the periphery of the core ward team. This may in part reflect their relatively junior status in terms of age, experience and length of time on the ward, which are likely to inhibit their contribution to the team and discussions of patient care. All occupational therapists spoke of communicating information to nursing and medical members of the ward team with most attending MDT meetings, although some clearly experienced tensions in this area. Difficulties participating in teams and meetings are a cause for concern as member participation is a key determinant of effective, healthy teams (Borrill et al 2000). The employment of additional and more senior occupational therapists on acute wards may help provide the confident and assertive input and leadership necessary to ensure that the voice and skills of occupational therapists are seen as an essential component of MDT working. Another suggestion is that occupational therapists are freed from wider commitments and encouraged to 'muck in' with ward duties to win increased friendship, trust and respect within the ward

Occupational Therapy and Multidisciplinary working on acute psychiatric wards team. It may also be worth exploring the pros and cons of occupational therapists being involved in some of the more containing or controlling aspects of patient management mentioned in this study and by Dutton (2005). Greater involvement in the everyday management of acute wards by other members of the MDT might enable all staff to provide more of the therapeutic interactions service users value (Standing Nursing and Midwifery Advisory Committee 1999). The activities and processes amenable to greater occupational therapist and MDT involvement require further investigation.

An interprofessional focus on education and training in assessment skills, risk management, care/aftercare planning and group work may also encourage the development of interprofessional solutions to many of the issues facing ward staff and a greater understanding of occupational therapy. A systematic review of the impact of interprofessional education (IPE), in which two or more professions take part in interactive learning, demonstrated that IPE can improve interprofessional collaboration and enhance the delivery of patient care (Reeves 2001).

## **LIMITATIONS**

Participants were not explicitly asked to describe examples of collaborative working so these may be under-represented in the interviews. Only occupational therapists were specifically asked about their role on the wards and further questioning of other disciplines may have elicited a wider range of views. The study took place in one NHS Trust in an inner city area and the involvement and integration of disciplines on

acute wards may be different elsewhere. Transferability of the findings may be restricted given these limitations and the relatively small sample size.

## **CONCLUSIONS**

Occupational therapists play an important and often misunderstood role on acute psychiatric wards. The facilities, resources, support and learning opportunities required to maximise their input in the assessment, treatment and aftercare of acutely mentally disturbed people should be explored. Occupational therapists have much to offer their professional colleagues and service users in acute inpatient psychiatry and further research into the opportunities for and barriers to interprofessional working and learning are required.

## **ACKNOWLEDGEMENTS**

Funding from the Tompkins Foundation and the Department of Health supported the research upon which this publication is based. However the views expressed in this publication are those of the authors and not necessarily those of the funding bodies. The comments of two anonymous reviewers helped improve this paper.

## **REFERENCES**

- Appleby L (2004) *The National Service Framework for Mental Health - Five Years On*. London: Department of Health.
- Audini B, Duffett R, Lelliott P, Pearce A, Ayres C (1999) Over-occupancy in London's acute psychiatric units - fact or fiction? *Psychiatric Bulletin*, 23, 590-594.
- Auerbach E (2001) Occupational therapy and the multidisciplinary team. *Psychiatric Services*, 53(6), 767-8.
- Baker S (2000) *EnvironMentally Friendly?* London: MIND Publications.
- Borrill C, West M, Shapiro D, Rees A (2000) Team working and effectiveness in health care. *British Journal of Health Care Management*, 6(8), 354-371.
- Bowers L (2002) *Dangerous and Severe Personality Disorder: Response and Role of the Psychiatric Team*. London: Routledge.
- Bowers L, Alexander J, Gaskell C (2003a) A trial of an anti-absconding intervention in acute psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*, 10: 410-416.
- Bowers L, Simpson A, Alexander J (2003b) Patient-staff conflict: results of a survey on acute psychiatric wards. *Social Psychiatry and Psychiatric Epidemiology*, 38: 402-408.
- Brenneman Baron K (1994) Clinical interpretation of 'The Assessment of Motor and Process Skills of Persons with Psychotic Disorders'. *The American Journal of Occupational Therapy*, 48(9), 781-782.
- Brown B, Crawford P, Darongkamas J (2000) Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health. *Health and Social Care in the Community*, 8(6), 425-435.



Commission for Health Improvement (2003) *Emerging themes from mental health trust reviews*. London: Commission for Health Improvement.

Christian-Edwards R (2004) Integrated teams on acute inpatient wards can work. *Mental Health Occupational Therapy*, 9(3), 103-104.

Clarke S (2004) *Acute Inpatient Mental Health Care: Education, Training and Continuing Professional Development for All*. London: NIMHE/SCMH.

Craik C (1998) Occupational therapy in mental health: A review of the literature. *British Journal of Occupational Therapy*, 61(5), 186-192.

Craik C, Austin C, Chacksfield J, Richards G (1998) College of occupational therapists: Position paper on the way ahead for research, education and practice in mental health. *British Journal of Occupational Therapy*, 61(9), 390-392.

Creek J (2003) *Occupational therapy defined as a complex intervention*. London: College of Occupational Therapists.

Department of Health (1999) *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach*. London: Department of Health.

Department of Health (2002) *Mental Health Policy Implementation Guide. Adult Acute Inpatient Care Provision*. London: Department of Health.

Department of Health (1997) *The New NHS: Modern – Dependable*. London: Department of Health.

Duffy R, Nolan P (2005) A survey of the work of occupational therapists in inpatient mental health services. *Mental Health Practice*, 8(6), 36-41.

Dutton N (2004) On the role of the occupational therapist in the engagement of patients with acute psychotic conditions in an in-patient setting. *Mental Health Occupational Therapy*, 9(3), 85-87.

Greaves A, King R, Yellowlees P, Spence S, Lloyd C (2002) The competence of mental health occupational therapists. *British Journal of Occupational Therapy*, 65(8), 381-386.

Hope R (2004) *The Ten Essential Shared Capabilities: A framework for the whole of the Mental Health Workforce*. London, Department of Health.

Krefting L (1991) Rigor in Qualitative Research: The assessment of trustworthiness. *The American Journal of Occupational Therapy*, 45(3), 214-222.

Liberman R, Hilty D, Drake R, Tsang H (2001) Requirements for multi-disciplinary teamwork in psychiatric rehabilitation. *Psychiatric Services*, 52, 1331-1342.

Lloyd C, King R, McKenna K (2004) Actual and preferred work activities of mental health occupational therapists: Congruence or discrepancy? *The British Journal of Occupational Therapy*, 67(4), 167-175.

Miller C, Freeman M, Ross N (2001) *Interprofessional Practice in Health and Social Care: Challenging the shared learning agenda*. London: Arnold.

Rebeiro K (2001) Occupational therapy and the multidisciplinary team. *Psychiatric Services*, 53(6), 767.

Reeves S (2001) A review of the effects of interprofessional education on staff involved in the care of adults with mental health problems. *Journal of Psychiatric and Mental Health Nursing*, 8, 533-542.

Simpson A, Bowers L (2004) Runaway Success. *Nursing Standard*, 21 (18): 18-19.

Standing Nursing and Midwifery Advisory Committee (1999) *Mental Health Nursing: Addressing Acute Concerns*. London: Department of Health.

Tsang H (2001) Occupational therapy and the multidisciplinary team. *Psychiatric Services*, 53(6), 768-9.

West M (1999) Communication and teamworking in healthcare. *NTrresearch*, 4(1), 8-17.

West M, Borrill C, Dawson J, Scully J, Carter M, Anelay S, Patterson M, Waring J (2002) The link between the management of employees and patient mortality in acute hospitals. *International Journal of Human Resource Management*, 13(8): 1299-1310.

<b>Table 1: Age, gender, ethnicity and experience of participants</b>							
<b>Profession</b>	<b>Number</b>	<b>Mean Age</b>	<b>Gender Male/Female</b>	<b>Ethnicity</b>	<b>Mean Years Qualified</b>	<b>Mean Years in Current Role</b>	<b>Mean Years on Current Ward</b>
<b>Occupational Therapist</b>	11	33.4	2/9	8 White British, 3 African/Indian	2.9	1.3	1.4
<b>Nurse</b>	14	35.7	10/4	4 White British 1 Black British 5 Black African/ Caribbean, 3 Other	9.5	3.1	3.1
<b>Ward Manager</b>	13	39.8	8/5	4 White British, 5 European/Indian	15.4	6.6	6.2
<b>Consultant Psychiatrist</b>	9	43.8	7/2	4 White British, 5 European/Indian	16.2	6.9	6.6
<b>Total</b>	47	38.2	27/20	20 White British 27 Other	11	4.5	4.3