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Occupational Therapy Commentary – Lisa J Ward

This commentary is based upon my reflections as a service user of occupational therapy following a serious post natal illness, and my subsequent role as an educator.

Suffering from a mental illness is an incredibly bewildering experience. Your belief systems change and you can lack insight. Important personal relationships are put under strain. Mania gives you the energy to realise that there is nothing you can't achieve; depression makes you feel worthless.

Two weeks after having a baby, I was approached on a ward by occupational therapists (OT) asking if I wanted to play badminton. Along with another patient, I was taken to a sports centre. It was empowering to be away from the ward setting. Even more so to know that the sports centre staff thought I was the carer rather than the patient. This demonstrated all 3 OT threshold concepts: person centred practice - I was asked if this was something that might interest me and taken in a very small group. Professional identity: the OT staff explained that their role is to help us develop confidence, and practice in the real world: safety assessment, parking regulations, ensuring users benefit from the activity.

Whilst in the grips of mania, my mind was constantly overflowing with ideas. These were coming so thick and fast that I struggled to remember and categorise them. Relationships with my family were tense; we didn't seem to be able to communicate in the normal way. The hospital was my sanctuary. My relationship with the other patients was good and with OT staff even better. At school I had always regarded my useless at art. Yet under mania you will try anything. I was invited to art classes, and was surprised that I enjoyed it and able to express myself in ways I did not expect, it became therapeutic.

Like virtually all in-patients, I was quickly medicated. Within a fortnight I went from mania to 'zombification' a state where I was unable to function or stay awake. I had every side effect of medication: severe sunburn, aching joints, lack of facial movement, swollen tongue, and 'jet-lag'. Again OT helped, unable to move my arms and hold a paint brush, lacking the concentration to make quills to stick onto cards. Simple alternatives were always suggested to me. I was allowed to do whatever I was able. If I wanted to rest this was my choice.

As a patient on a psychiatric ward little is of your own choice. OT activities gave me a sense of control.

Several years later, I met a university involvement facilitator and was invited to speak to students about my experiences. Gaining insight in what it feels like to be a service user is an important part of student learning. I hope that students will be able to ask me the questions that may not be appropriate in a clinical setting.

I observed that students from other health and social care disciplines do not understand what OT is. They have a vague idea that it might be something to do with rehabilitation. In my workshops I have made time for OTs to discuss their roles with other health professionals. There is a gap in the education of the other health professionals relating to OT. This is one of the areas that institutions really need to improve. OT educators need to ensure that knowledge of their subject area is embedded in the core curriculum for other health professionals. Without this basic knowledge of how professionals can work as partners, strong working relationships cannot be developed.

I developed my own teaching practice from monologue to 'service user facilitated inter-disciplinary leaning' (Ward and Padgett, 2012). I don't think health care fits into neat little boxes and specialisms. Professionals need as the author suggests 'to think critically to prepare them for tomorrow's challenges'.

I now recount a portion of my story, pause to ask the class what they would do, from the point of view of the health professional. This is normally greeted by stunned silence. Students tell me they haven't been asked to think from the perspective of other health professionals and find this an alien concept. I ask them to start a conversation on what they might do. Normally conversations start off quietly, building to full discussions. Then I ask the students to pause, and tell me their ideas. I make comments from my perspective. This can often raise challenging issues; occasionally my perspective is the opposite of the established 'best practice' as demeaned by professional and auditing authorities. For example, I was not directly told that of my hospital admission. This was exactly the right approach; I trusted my husband and family GP who arranged the admission. To understand why I was going to hospital would have meant that I would have to have accepted that I was ill. This was something that I did not do for several weeks or even months. This led to challenging discussions. What do students do if the legislation and procedures tell you one thing and the patient perspective another? When I co-facilitate with an academic we can also discuss this, and it is something which can be followed up in subsequent lectures.

Thibeau (2006) discussed the author wants institutions to be at the forefront of the action, wake up their students and communications, and plan strategies to bring about rapid change.' This is what I hope to do with my teaching practice.

As I left hospital my named nurse said to me, 'we can only guess at what's it's like for you. You know, you have precious knowledge'

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