OCCUPATIONAL THERAPY and OLD AGE.

The role of occupational therapy in the rehabilitation of the aged and chronic sick.

by

Morag L. Insley.

"The best medicine for old age is occupation."

- Dr. Matthew Fyfe, Medical Officer of Health, Fife.
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2. The particular conditions to which this study was applied.

3. Occupational therapy - the weapon chosen to attack the problem.

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SECTION I. - INTRODUCTION.

1. The Problem.

The increasing proportion of older persons in the community provides a social problem which is not confined to Great Britain. Within the last few years however, the problem has become increasingly acute here, and the present position has made it urgently necessary to utilise as efficiently as possible the facilities available for the care of the aged.

The problem is a twofold one; firstly, the provision of suitable care for those older persons who are not ill, but who become the responsibility of the community for reasons of finance or because their relatives will not or cannot provide a home for them; and secondly, the correct use of available nursing and hospital facilities in order to decrease the number of aged persons who have been, and in some places are still being, allowed to qualify for inclusion in the category of "the chronic sick".

In an article in the Lancet of June 8th., 1946, Dr. M. Warren quotes figures to show the increase in the numbers in the old age group during the last half century. In this country, the number of over 60s in the population has risen from 2½ million in 1901 to 6½ million in 1944. (Figures in America suggest that a similar rise may be expected to be revealed in 1980 compared with the 1940 figures.)

The expectation of life in this country has risen
by almost fifteen years during the same period; for the male, from 48.5 years in 1901 to 61.7 years in 1942, and for the female, from 52.4 years in 1901 to 67.4 years in 1942.

The Beveridge Plan pointed out that, according to present trends, in 1971 something over 20% of the population of this country will be males over the age of 65 or females over the age of 60. It is therefore obvious that the principal medico-social problem of the near future will be concerned with persons showing an increasing infirmity due only to the biological processes of aging, and it is generally accepted that the ideal is to enable these people to lead an independent existence in their own homes as far as possible.

At the moment, however, it is a matter of much greater urgency to ensure that no such person is permitted to become unnecessarily incapacitated by disease or infirmity following disease. In the past, the influence of the aging processes on acute disease in the elderly has not been appreciated, and much research is still required to allow of accurate assessment of its full effect in the future. If the patient did not recover immediately from the acute incident, he or she was very liable to become classed as "chronic" which was frequently regarded as synonymous with "incurable" and often even "hopeless", which he or she rapidly became.

Large numbers of these found their way eventually into poor law institutions, lethargic, bedfast, incontinent, and forgotten by all but the well-meaning
I, 3.

attendants. The rest were looked after as well as possible by their relatives in their homes, where they soon became an overwhelming burden.

It has now become obvious that a fresh approach to these so-called chronic cases can frequently result in recovery of much of their ability to lead an independent existence. The true chronic diseases (disseminated sclerosis, paralysis agitans, etc.,) do not as a rule affect the aged in the first instance, although sufferers from them may eventually qualify for inclusion in an age grouping as aged.

An article in the transatlantic publication, "Occupational Therapy and Rehabilitation", in August, 1944, quoted American figures for chronic disease then as 1% of the total population of the States, and its proportion to acute disease as 1 chronic patient to 310 others. BUT of these chronic cases, 50% were under 50 years of age.

By means of an intensive three-pronged attack, using medicine, physiotherapy, and occupational therapy, such workers as Warren, Howell, and Cosin have shown that the problem of hospitalisation for the aged sick can be reduced at least to manageable proportions. At Orsett Lodge, Essex, Dr. Cosin had over a few years reduced his bed-fast cases to 3.5% of his total inmates, which is a very close approximation to the 2.5% bedridden that Dr. Sheldon found among the old people in his random sample of the population of Wolverhampton.
2. The conditions of the present study.

On July 5th., 1942, Cowley Road Hospital, Oxford, became the geriatric unit of the United Oxford Hospitals. Previously it had been the Public Assistance institution, housing aged fit inmates as well as "chronic sick". In the three months preceding the appointed day, these fit inmates were transferred to another hospital in the area, which was to become a home for the aged, and the bedfast cases from this other institution were transferred to us. (Both these institutions had till then been run by the same Master and Matron.)

This made Cowley Road Hospital a 250-bedded unit (96 male and 154 female), and at the beginning of June 1942, 51.9% of our cases were bedfast, and many more got out of bed, under protest, only for bedmaking or to use the commode. The description of a typical chronic case by M. W. Warren in the Lancet of June 8th, 1946, was all too accurate for 75% of our patients.

At this juncture, modern geriatrics methods were introduced and an Occupational Therapy department was opened. There had been no organised occupational therapy before this, although there was a physiotherapy department, staffed by one part-time therapist and equipped with a minimum of old-fashioned and totally inadequate gear.

Our review of the situation therefore led us to believe that occupational therapy could be used as a very potent weapon against the inertia and hopeless
attitude of so many of our old patients, and that it might usefully be made the spearhead of our attack.

3. The weapon.

Occupational therapy has been defined as:-
"Any activity, mental or physical, definitely prescribed and guided, for the specific purpose of contributing to or hastening recovery from disease or injury."

It is best known for its use in the treatment of mental disease. In the form of music and games, we know that the ancient Egyptians used it to treat mental patients, while the Greeks were much in favour of the use of occupations in educational training.

In A.D. 172, Galen laid down that: "Employment is Nature's best physician and is essential to human happiness." This edict is accepted as the basis for all occupational therapy, and its truth is recognised more widely at the present time than ever before.

The use of prescribed occupations as an essential part of the treatment of mental disease was introduced to European schools of medical thought by Dr. Philippe Pinel of France, who published an account of results in some of his cases in 1741 in the form of a "Traité".

The idea spread to America, and in 1798 we find Dr. Benjamin Rush of Pennsylvania advocating it in writing to the managers of the Pennsylvania hospital concerning the treatment of mental disease.

In Britain, its practice developed side by side
with the more humane treatment of the insane, and the
Quaker, Tuke, who founded the Retreat, York, was one
of its strongest supporters.

During the 1914-1918 war, it was found that
handicraft work could be employed with advantage in
the rehabilitation of certain types of war wounded.
It was then that the idea began to be recognised
under the name of "Occupational Therapy", and courses
for training teachers began to be organised.

It was welcomed more enthusiastically on the
other side of the Atlantic (both in Canada and in
U.S.A.) than in this country, but between the wars
it continued to develop slowly, until the second
world war produced more rehabilitation problems
which showed the wide application of this form of
treatment to the physical as well as to the mental
aspects of injury.

It has also been adapted for the treatment of
long term tuberculosis cases, and its value here is
widely known and generally accepted as a mental
stimulant and as a test of increasing capacity for
activity, as well as pre-vocational training to fit
the patient to earn a living after his discharge
from the sanatorium.

With reference to chronic disease especially,
one Dr. Thomas Salmon is quoted as saying in 1918 that
"Occupational therapy will some day rank with anaes-
thesics in taking the suffering out of sickness, and
with anti-toxins in shortening its duration. The
greater part of the distress in chronic disease is
mental, and occupational therapy is, thus far, our only means of dealing with this factor."

The guiding principles of rehabilitation for all age groups were laid down by Lord Horder when he wrote for the Chartered Society of Massage and Medical Gymnastics that:

"No amount of massage, and no amount of electrical stimulation has the same physiological value as the natural movement carried out by the patient under supervision and guidance.

"The keynote to rehabilitation is self-activity.

"Activation of the body has its counterpart in activation of the mind, and to activate the mind is to take the first step in the return to mental health."

4. The method of its application.

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The Dorset House School of Occupational Therapy undertook to supply a trained therapist to run our department at Cowley Road Hospital, and was then allowed to use it to train their students. Because the introduction of the department was before July 5th., 1948, the institution which became the home for fit old people was included in the department. After July 5th., the work proceeded in the same way, the one therapist dividing her time between the two institutions, assisted by a number of students.

By courtesy of Dr. Warin, the M.O.H. for Oxford City, who is responsible for this home, I was given access to the department there to see the work done, though I had nothing to do with the prescribing
of it as the home was attended by a visiting general practitioner.

Thus we had a series of fit cases receiving occupational therapy from the same therapist as our sick ones, and this afforded me unexpected material for comparison of results.

In Cowley Road Hospital, all the occupational therapy was prescribed by myself, and every patient's progress was checked and noted. In every case of refusal to co-operate, an attempt was made to analyse the reason. Such refusals were rare, however, principally because the work was regarded as treatment from the start by the medical staff as well as by the therapists. This attitude incidentally ensured the full co-operation of the nursing staff, which was undoubtedly an important factor.

In the first instance, 10 patients were selected and their progress was so marked and their enthusiasm so infectious that other patients clamoured to be allowed to "do something too". We tried not to refuse any such request, as we were most anxious to avoid any sense of frustration in connection with the new treatment.

Our low percentage of refusals to try anything was in marked contrast to the experience of therapists in other hospitals for the aged, who are commonly confronted with a categorical statement to the effect that the patient has worked hard all his life and refuses to work now! In some cases the management even resorted to bribing the patient with the...
finished article, with disastrous results on the financial side of the department in consequence.

We never allowed attention to become focussed on the handicrafts concerned, but paid attention only to the improvement in the patient's condition that was the result of the craftwork. It was all the more interesting, therefore, to discover, when we held an exhibition of the patients' work after eight months of the experiment, that the standard of craftwork was remarkably high, and indeed was easily comparable with the work of younger patients in acute hospitals in the same hospital group (the United Oxford Hospitals).

There are three main groups of patients under consideration here. The first and largest group is of patients in the Cowley Road Hospital who had a physical defect which might benefit from occupational therapy, or whose physical condition was not responding as well as it might because of the marked lowering of general morale, so typical of elderly ill people.

The second group is made up of the inmates of "The Laurels", who were able to be up most of the time and who are therefore not given a diagnosis.

The third group consists of those cases in Cowley Road hospital whose mental condition was so poor that their occupational therapy was given by a therapist specially trained to deal with mental patients; and who for the purposes of this work are classified loosely as "senile dementias". The approach and results in this group are considered separately.
The work done by all patients in Cowley Road Hospital for whom occupational therapy was prescribed is shown in the form of a table. No special order has been chosen for this, as age and diagnosis alike are unreliable yardsticks as to the response likely to this form of treatment. Sex and age differences and certain groups of patients suffering from diseases commonly encountered in a geriatric hospital are discussed in more detail in the commentary which follows the table, under the following headings:

1. General
2. Refusals
3. Rheumatoid arthritis
4. Hemiplegia
5. Paralysis agitans
6. Cardiac cases
7. Fractures of the neck of femur
8. New growths.

Note 1.
In the fourth column of the table, "ambulant" represents the opposite of "bedfast", and includes all those cases who were "chair-borne" (i.e. permanent wheel-chair cases.). The majority of these were permanent patients.

Note 2.
A common complaint met with by occupational
therapists who work with elderly people is poor eyesight. In our group, all patients were seen regularly by an ophthalmologist, and where it was thought that spectacles would improve the sight these had been prescribed, and in many cases delivered, by the end of the first six months of the period under review. The rest arrived within the following weeks, and so we were able to give complaints of poor sight their proper value.
<table>
<thead>
<tr>
<th>CASE NUMBER</th>
<th>AGE</th>
<th>DIAGNOSIS</th>
<th>Condition at end of year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>59</td>
<td>Paralysis agitans</td>
<td>Ambulant</td>
</tr>
<tr>
<td>2</td>
<td>74</td>
<td>Rheumatoid arthritis</td>
<td>Ambulant</td>
</tr>
<tr>
<td>3</td>
<td>56</td>
<td>Paralysis agitans</td>
<td>Discharged</td>
</tr>
<tr>
<td>4</td>
<td>78</td>
<td>Arteriosclerosis</td>
<td>Ambulant</td>
</tr>
</tbody>
</table>
HANDICRAFT WORK (FEMALES.)

1. Solomon's knots in rug wool (succeeded, but did not enjoy this.)
2. Flat-woven rug, with short lengths of wool.
3. Interlocked rug with tapestry pattern. Did not do this well, but enjoyed it.
4. Woven slippers in wool. (Fine finger movements have improved.)
5. Weaving scarves on large table loom with pedals. Follows intricate designs, works hard and does them extremely neatly and evenly.
6. Embroidery for doing in the garden in the summer. (This patient had been a dress-maker but had to give up 15 years ago because of the tremors.)

1. Solomon's knots. Could not learn the knot, so changed in the middle to
2. Buttonhole knotting. Not pleased with the result.
3. Knitting. Done as squares at first, then a scarf
4. Knitted socks on 4 needles, even turning the heel.

1. Flat woven rug. Finger movements too clumsy to use a shuttle.
2. Tufted rug, finger-knotted. Cuts up the wool herself.
3. Knitting for a change.
4. Basketry. Works well at times.
   (This patient was discharged home and attends as an out-patient.)

1. Knitting. Difficult to get started, but improved markedly. Now on to bedsocks.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Condition</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>69</td>
<td>Rheumatoid arthritis</td>
<td>Almost bedfast.</td>
</tr>
<tr>
<td>6.</td>
<td>71</td>
<td>Rheumatoid arthritis</td>
<td>Bedfast.</td>
</tr>
<tr>
<td>7.</td>
<td>64</td>
<td>Rheumatoid arthritis</td>
<td>Bedfast.</td>
</tr>
<tr>
<td>8.</td>
<td>85</td>
<td>Amputation left leg</td>
<td>Ambulant.</td>
</tr>
<tr>
<td>9.</td>
<td>78</td>
<td>Arteriosclerosis</td>
<td>Discharged.</td>
</tr>
<tr>
<td>10.</td>
<td>71</td>
<td>Old rheumatic fever</td>
<td>Bedfast.</td>
</tr>
<tr>
<td>11.</td>
<td>79</td>
<td>Chronic bronchitis</td>
<td>Discharged.</td>
</tr>
</tbody>
</table>
1. Knitting on thick pins with thick cotton.
2. Knitting with thinner pins and thread.
   Stopped - due to change of therapist.

1. Knitted squares on specially short pins.
2. Baby's vests.
   Little improvement as she refuses to try anything else.

1. Raffia slippers. Did well, but had to have raffia rationed as tended to overdo it.
2. Raffia tea-cosy (Dryad).

1. Crotchet. Eyesight too poor for this really, but she likes to try.
2. Woolly balls, as a change. Can manage these.

2. Knitted squares.
3. Flat-woven rug.

1. Knitted scarf - in rib, badly done.
2. Scarf, in plain, on light coloured pins. Better.
3. Jumper, out of proportion.

1. Raffia mats.
2. Woolly balls.
<table>
<thead>
<tr>
<th>No.</th>
<th>Age</th>
<th>Diagnosis</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>80</td>
<td>Prolapsed rectum</td>
<td>Died</td>
</tr>
<tr>
<td>13</td>
<td>56</td>
<td>Hemiplegia (right)</td>
<td>Discharged</td>
</tr>
<tr>
<td>14</td>
<td>75</td>
<td>Recovered hemiplegia</td>
<td>Died</td>
</tr>
<tr>
<td>15</td>
<td>78</td>
<td>Prolapsed uterus arteriosclerosis</td>
<td>Bedfast</td>
</tr>
<tr>
<td>16</td>
<td>68</td>
<td>Paralysis agitans, osteoarthritis of knee</td>
<td>Discharged</td>
</tr>
<tr>
<td>17</td>
<td>80</td>
<td>Arteriosclerosis</td>
<td>Ambulant</td>
</tr>
<tr>
<td>18</td>
<td>24</td>
<td>Arteriosclerosis</td>
<td>Bedfast</td>
</tr>
<tr>
<td>19</td>
<td>54</td>
<td>Rheumatoid arthritis</td>
<td>Bedfast</td>
</tr>
</tbody>
</table>
1. Asked to try a woven rug, but refused to do it when the frame was set up.

2. Crotchetted scarves. All quite well done except the last, which was badly done.

1. Scarf on roller loom, adapted for one handed person
2. Rug, (flat-woven) on upright loom in the O.T. department.

(This patient continued as an out-patient.)

1. Raffia mats. Right hand weak so has learnt to do her work left-handed. Movements improved, but general condition deteriorated and occupational therapy was discontinued.

1. Raffia mats. Does these so quickly that we suspected the nursing staff of helping her.

Occupational therapy stopped when condition deteriorated.

1. Knitted on her own quite well.

1. Sewing on her own (for the ward).
2. Felt toys, beautifully done.
3. Odd jobs of finishing off, etc., for the department.

(This patient was inclined to help others with their work and so was best kept occupied.)

1. Raffia mats.
2. Crotchetting.

1. Knits squares, under extreme protest. A very unco-operative patient in every way, whose general condition was deteriorating.
<table>
<thead>
<tr>
<th>No.</th>
<th>Age</th>
<th>Diagnosis</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>78</td>
<td>Hypertension</td>
<td>Discharged</td>
</tr>
<tr>
<td>21</td>
<td>80</td>
<td>Conjunctivitis</td>
<td>Discharged</td>
</tr>
<tr>
<td>22</td>
<td>84</td>
<td>Varicose ulcer of leg.</td>
<td>Ambulant</td>
</tr>
<tr>
<td>23</td>
<td>63</td>
<td>Subarachnoid haem. with knee contractures.</td>
<td>Discharged</td>
</tr>
<tr>
<td>24</td>
<td>66</td>
<td>Old cerebral thrombosis.</td>
<td>Discharged</td>
</tr>
<tr>
<td>25</td>
<td>80</td>
<td>Coronary thrombosis</td>
<td>Discharged</td>
</tr>
<tr>
<td>26</td>
<td>56</td>
<td>Rheumatoid arthritis</td>
<td>Ambulant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Varicose ulcer of leg.</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>93</td>
<td>Arteriosclerosis</td>
<td>Died</td>
</tr>
<tr>
<td>28</td>
<td>80</td>
<td>Osteoarthritis of both hips.</td>
<td>Bedfast</td>
</tr>
<tr>
<td>29</td>
<td>59</td>
<td>Hemiplegia</td>
<td>Discharged</td>
</tr>
<tr>
<td>30</td>
<td>69</td>
<td>Diabetes mellitus</td>
<td>Discharged</td>
</tr>
<tr>
<td>31</td>
<td>70</td>
<td>Arteriosclerosis</td>
<td>Discharged</td>
</tr>
</tbody>
</table>
1. Knitted on her own. Was re-admitted for general care and attention, and the standard of her knitting was found to have deteriorated at home, but it improved again during her second period in hospital, under the guidance of the therapist.

1. Knitted bedsocks.

1. Raffia slippers.
2. Knitting - squares and bedsocks.
3. Embroidery.
4. Crayon drawing, mostly of birds.

1. Embroiders on her own.

1. Knitted scarves.

1. Knits squares. Kept doing other people's so had to be given something.

1. Knitting.
2. Basketry.

1. Took materials but never produced any finished article.

1. Crochets on her own, very slowly.

1. Crocheted with special large hook.

1. Knitting.

1. Crocheted with an extra long hook.
<table>
<thead>
<tr>
<th>No.</th>
<th>Age</th>
<th>Condition</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>32.</td>
<td>75</td>
<td>Old hemiplegia (right side)</td>
<td>Bedfast</td>
</tr>
<tr>
<td>33.</td>
<td>44</td>
<td>Disseminated sclerosis</td>
<td>Died</td>
</tr>
<tr>
<td>34.</td>
<td>46</td>
<td>Rheumatoid arthritis</td>
<td>Died</td>
</tr>
<tr>
<td>35.</td>
<td>68</td>
<td>Osteoarthritis of spine and shoulders</td>
<td>Bedfast</td>
</tr>
<tr>
<td>36.</td>
<td>80</td>
<td>Hypertensive cardiac failure</td>
<td>Died</td>
</tr>
<tr>
<td>37.</td>
<td>96</td>
<td>Old age</td>
<td>Ambulant</td>
</tr>
<tr>
<td>38.</td>
<td>74</td>
<td>Angina of effort</td>
<td>Discharged</td>
</tr>
<tr>
<td>39.</td>
<td>55</td>
<td>Still's disease</td>
<td>Bedfast</td>
</tr>
</tbody>
</table>
Females, cont. (5)

1. Woolly ball.
2. Wove on one-handed loom.
3. Tried a flat-woven rug, but did not like, and returned to woolly balls.

1. Woolly ball, with help.

1. Knitted for herself before admission.
2. Weaving to improve shoulder movements. Some improvement was noticeable.

1. Knitted string slippers.
   (This patient does a lot of work on her own.)

1. Knitted bedsocks.

1. Knitted squares, badly at first but improved
2. Bedsocks, had the heel turned for her. These were at her own request, as a present for her son.
4. More bedsocks - did these very nicely.
5. Basketry. Loves this, does it quickly and extremely neatly, and has got herself commissioned to supply a boarding-house with waste-paper-baskets.

1. Knits squares and scarves.
2. Crotchets squares together.

1. Knits her own way, which she worked out for herself with two pieces of wood in the days before there was any occupational therapy. Her movements are grossly restricted now (see photographs.)
<table>
<thead>
<tr>
<th>No.</th>
<th>Age</th>
<th>Condition</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>40.</td>
<td>60</td>
<td>&quot;Nerves&quot; following bombing in London</td>
<td>Ambulant</td>
</tr>
<tr>
<td>41.</td>
<td>76</td>
<td>Old hemiplegia (right side)</td>
<td>Bedfast</td>
</tr>
<tr>
<td>42.</td>
<td>78</td>
<td>Ovarian cyst</td>
<td>Bedfast</td>
</tr>
<tr>
<td>43.</td>
<td>77</td>
<td>Fractured wrist, and carcinoma rectum</td>
<td>Died</td>
</tr>
<tr>
<td>44.</td>
<td>82</td>
<td>Varicose excema</td>
<td>Ambulant</td>
</tr>
<tr>
<td>45.</td>
<td>69</td>
<td>Rheumatoid arthritis and amputation leg</td>
<td>Bedfast</td>
</tr>
<tr>
<td>46.</td>
<td>80</td>
<td>Cardiac asthma</td>
<td>Bedfast</td>
</tr>
<tr>
<td>47.</td>
<td>79</td>
<td>Diabetic, with amputation of one leg</td>
<td>Ambulant</td>
</tr>
<tr>
<td>48.</td>
<td>59</td>
<td>Postural spinal</td>
<td>Ambulant</td>
</tr>
<tr>
<td>49.</td>
<td>78</td>
<td>Hypertension</td>
<td>Ambulant</td>
</tr>
<tr>
<td>50.</td>
<td>69</td>
<td>Hemiplegia (left)</td>
<td>Ambulant</td>
</tr>
<tr>
<td>51.</td>
<td>37</td>
<td>Hemiplegia (left)</td>
<td>Ambulant</td>
</tr>
<tr>
<td>52.</td>
<td>83</td>
<td>Old femoral thrombosis</td>
<td>Died</td>
</tr>
<tr>
<td>53.</td>
<td>62</td>
<td>Mild cerebral thrombosis and hypertension</td>
<td>Discharged</td>
</tr>
</tbody>
</table>
Females, cont. (€)

1. Darns for the hospital.
2. Knits squares.
3. Rug-wool canvas embroidery.
   Wants to try basketry next.
   For this patient this desire to go down to the O.T. department was the stimulus which persuaded her to start going out on her own.

1. FAILURE. Refuses to try anything.

1. Knits bedsocks and bedjackets.

1. Woolly ball.

1. Knits in a muddle but knows it is not right, and thoroughly enjoys it. Is improving slowly.

1. Weaving on the special belt loom. (See photograph.)

1. Woolly balls.

1. Woolly balls. Loves these.

1. Embroidery, does it beautifully.

1. Knitted.

2. Soumac rugs.
   (Her eyesight is very poor, unimproved by glasses.)

1. Flat-woven rug. Very unco-operative.

1. Weaves on upright loom in department.


1. Knitted bedsocks.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Diagnoses</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>54</td>
<td>73</td>
<td>Recurring ca. of breast. Ambulant.</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>88</td>
<td>Rheumatoid arthritis. Ambulant.</td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>68</td>
<td>Rheumatoid arthritis. Ambulant.</td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>82</td>
<td>Congestive cardiac failure (hypertension)</td>
<td>Ambulant.</td>
</tr>
<tr>
<td>58</td>
<td>77</td>
<td>Rheumatoid arthritis (mild)</td>
<td>Ambulant.</td>
</tr>
<tr>
<td>59</td>
<td>81</td>
<td>Chronic bronchitis</td>
<td>Ambulant.</td>
</tr>
<tr>
<td>60</td>
<td>75</td>
<td>Diabetic and bronchitis</td>
<td>Died.</td>
</tr>
<tr>
<td>61</td>
<td>63</td>
<td>Inoperable ca. rectum. Bedfast.</td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>91</td>
<td>Fractured neck of femur (un-united)</td>
<td>Bedfast.</td>
</tr>
<tr>
<td>63</td>
<td>79</td>
<td>Fractured neck of femur. Discharged.</td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>44</td>
<td>Rheumatoid arthritis. Ambulant.</td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>76</td>
<td>Rheumatoid arthritis. Bedfast.</td>
<td></td>
</tr>
<tr>
<td>66</td>
<td>56</td>
<td>Rheumatoid arthritis. Ambulant.</td>
<td></td>
</tr>
<tr>
<td>67</td>
<td>93</td>
<td>Admitted for a few weeks following a fall. Discharged</td>
<td></td>
</tr>
<tr>
<td>Females, cont.</td>
<td>(7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>----</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Knits her own things mostly.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Weaving. Did it well but loom caught on her knees.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Basketry. Did well.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Knits squares, slowly and crossly and as little as possible. Could improve a lot if she tried.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Crotchets beautifully, very fine work.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Soumac rugs, does well.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crotchets well in the warm weather.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. FAILURE. Prefers to help with the ward washing up, and then is too tired to try!</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Failure, as condition deteriorated soon after she was put down for occupational therapy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Knitted squares and scarves.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Failure. Refuses to start.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Knitting, all sorts.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Basketry.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basketry.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Tried raffia mats but could not hold them.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Flat rugs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flat-woven rugs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Tried loom, too complicated.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Flat rug, couldn't.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very keen, but did not seem able to grasp how to do things.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Age</td>
<td>Diagnosis</td>
<td>Status</td>
</tr>
<tr>
<td>-----</td>
<td>-----</td>
<td>----------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>68.</td>
<td>66</td>
<td>Rheumatoid arthritis</td>
<td>Ambulant.</td>
</tr>
<tr>
<td>69.</td>
<td>76</td>
<td>Rheumatoid arthritis</td>
<td>Ambulant.</td>
</tr>
</tbody>
</table>
| 70. | 73  | Fractured neck of femur.          | Discharged.
| 71. | 76  | Blind.                           | Ambulant.  |
| 72. | 82  | Mild myocardial failure.          | Ambulant.  |
| 73. | 64  | Hypertensive cardiac failure.     | Died.      |
| 74. | 76  | Carcinoma of breast.             | Ambulant.  |
| 75. | 78  | Disseminated sclerosis.           | Ambulant.  |
| 76. | 56  | Paralysis agitans                 | Ambulant.  |
| 77. | 77  | Rheumatoid arthritis             | Ambulant.  |
| 78. | 66  | Varicose ulcers of leg            | Discharged.
| 79. | 76  | Osteomalacia                      | Bedfast.   |
| 80. | 74  | Fractured neck of femur           | Bedfast.   |
| 81. | 66  | Fractured neck of femur           | Bedfast.   |
| 82. | 76  | Old hemiplegia (right)            | Died (coronary thrombosis) |
Nemales, cont.

1. Knits socks nicely. (Recent admission)

1. Knits baby clothes well. (Has a deformed right hand following a factory accident in her youth.)

1. Woolly ball - works on her own at it.

1. Knits tiny squares.

1. Knits a lot for her friends.

2. Basketry.

1. Tatting. (Knew how before admission).

1. Knits socks.

1. Knits on long needles.

2. Basketry.

(It was hoped that this patient would soon be able to attend the department to use the big loom there for her leg movements.)

1. Crotchetts nicely.

1. Knits on her own (recent admission)

1. Knitted on her own.

1. Knits on her own.

1. FAILURE. Refused to try anything. Was unco-operative with other treatments too.

1. Knitted, eventually on her own.

1. Canvas embroidery with one hand.
<table>
<thead>
<tr>
<th>No.</th>
<th>Age</th>
<th>Diagnosis</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>83</td>
<td>74</td>
<td>Rheumatoid arthritis</td>
<td>Bedfast</td>
</tr>
<tr>
<td>84</td>
<td>56</td>
<td>Pemphigus</td>
<td>Discharged</td>
</tr>
<tr>
<td>85</td>
<td>52</td>
<td>Disseminated sclerosis</td>
<td>Discharged</td>
</tr>
<tr>
<td>86</td>
<td>72</td>
<td>Mild cerebral thrombosis</td>
<td>Discharged</td>
</tr>
<tr>
<td>87</td>
<td>80</td>
<td>Fractured wrist</td>
<td>Died</td>
</tr>
<tr>
<td>88</td>
<td>66</td>
<td>Congestive cardiac failure</td>
<td>Discharged</td>
</tr>
<tr>
<td>89</td>
<td>68</td>
<td>Carcinoma of uterus</td>
<td>Died</td>
</tr>
<tr>
<td>90</td>
<td>78</td>
<td>Ateriosclerosis</td>
<td>Died</td>
</tr>
<tr>
<td>91</td>
<td>70</td>
<td>Fits (? hysterical)</td>
<td>Discharged</td>
</tr>
<tr>
<td>92</td>
<td>80</td>
<td>Mild confusional state</td>
<td>Discharged</td>
</tr>
<tr>
<td>93</td>
<td>37</td>
<td>Carcinoma of breast with spinal secondaries</td>
<td>Died</td>
</tr>
<tr>
<td>94</td>
<td>82</td>
<td>Old hemiplegia (left)</td>
<td>Bedfast</td>
</tr>
<tr>
<td>95</td>
<td>60</td>
<td>Mild cardiac failure</td>
<td>Discharged</td>
</tr>
<tr>
<td>96</td>
<td>80</td>
<td>Carcinoma of colon</td>
<td>Bedfast</td>
</tr>
<tr>
<td>97</td>
<td>69</td>
<td>Carcinoma of rectum</td>
<td>Bedfast</td>
</tr>
<tr>
<td>98</td>
<td>46</td>
<td>Cerebral thrombosis</td>
<td>Discharged</td>
</tr>
<tr>
<td>99</td>
<td>69</td>
<td>Fractured neck of femur</td>
<td>Discharged</td>
</tr>
<tr>
<td>100</td>
<td>76</td>
<td>Pernicious anaemia</td>
<td>Discharged</td>
</tr>
</tbody>
</table>
Females, cont. (9)

1. FAILURE. Unco-operative otherwise too.

1. Lampshades.
2. Canvas embroidery.

1. Knitting, all sorts.

1. REFUSED to try.

1. Flat-woven rug.

1. Knitting, on her own.

1. Beautiful crochet.

1. Woolly balls.

1. Knitted and sewed on her own.

1. Knitted squares and scarves.

1. Fine embroidery.
2. Canvas embroidery, up to the day she died.

1. Woolly ball.

1. Knitting for herself, under supervision.

1. Woolly ball.

1. Embroidery.

1. Weaving.

1. Knitting on her own.

1. FAILURE. Refused to start.
<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>65</td>
<td>Paralysis agitans</td>
<td>Ambulant.</td>
</tr>
<tr>
<td>2</td>
<td>60</td>
<td>Carcinoma of spine (Prostate)</td>
<td>Died.</td>
</tr>
<tr>
<td>3</td>
<td>67</td>
<td>Arthritis of wrist, congestive cardiac failure</td>
<td>Discharged.</td>
</tr>
<tr>
<td>4</td>
<td>74</td>
<td>Old hemiplegia (Left)</td>
<td>Discharged.</td>
</tr>
<tr>
<td>5</td>
<td>85</td>
<td>Arteriosclerosis</td>
<td>Ambulant.</td>
</tr>
<tr>
<td>6</td>
<td>90</td>
<td>Tabes dorsalis</td>
<td>Died.</td>
</tr>
<tr>
<td>7</td>
<td>56</td>
<td>Paralysis agitans</td>
<td>Discharged.</td>
</tr>
<tr>
<td>8</td>
<td>66</td>
<td>Chronic bronchitis, hypertension</td>
<td>Ambulant.</td>
</tr>
<tr>
<td>9</td>
<td>81</td>
<td>Chronic bronchitis</td>
<td>Ambulant.</td>
</tr>
<tr>
<td>10</td>
<td>69</td>
<td>Suspected pulmonary tuberculosis</td>
<td>Discharged himself.</td>
</tr>
<tr>
<td>11</td>
<td>43</td>
<td>Biliary cirrhosis</td>
<td>Died.</td>
</tr>
<tr>
<td>12</td>
<td>84</td>
<td>Hypertension</td>
<td>Ambulant.</td>
</tr>
</tbody>
</table>
1. Dog-lead in cord - Solomon's knots - too fine.

2. Flat-woven rug. Static crises interfered and he could not control the frame.

3. Raffia mats on cardboard - made a set of 6.

4. Tapestry with needle. Did very slowly.

Returned to flat-woven rug, and managed better now. Actually worked on his own occasionally. Very keen.

1. Stool-seating.

1. Solomon's knots - dog-lead.

1. Flat-woven rug. Did not keep edges even.

2. Dog-lead, but kept forgetting how to do the knot.

1. REFUSED. Love: a chat, and reads a lot.

1. Tried a flat-woven rug but couldn't understand how.


2. Raffia - mats.

3. Asked to do some unravelling; and seems to enjoy this best of all.

1. Stool-seating in cord.

2. Basketry.

1. Refused.

1. Knitted bedsocks.

2. Worked with the gardener.

1. Tufted rug.

1. Wanted to do a tufted rug, but condition deteriorated.
<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>15.</td>
<td>84</td>
<td>Osteoarthritis of knees and hands.</td>
<td>Ambulant.</td>
</tr>
<tr>
<td>17.</td>
<td>80</td>
<td>Arteriosclerosis.</td>
<td>Died.</td>
</tr>
<tr>
<td>18.</td>
<td>56</td>
<td>Rheumstoid arthritis</td>
<td>Ambulant.</td>
</tr>
<tr>
<td>19.</td>
<td>58</td>
<td>Old hemiplegia (right)</td>
<td>Discharged.</td>
</tr>
<tr>
<td>20.</td>
<td>22</td>
<td>Duodenal ulcer.</td>
<td>Discharged himself.</td>
</tr>
<tr>
<td>21.</td>
<td>68</td>
<td>Old subarachnoid haemorrhage.</td>
<td>Ambulant.</td>
</tr>
</tbody>
</table>
Males, cont. (2)

1. Raffia mats - very slow.
2. Tufted rug - a special frame was made for him.
4. Scarf on roller-loom.
5. Raffia slippers on Dryad card.
6. Basketry. Likes this and does it well. Has learned different weaves.

1. Flat woven rug. Made a mistake and stopped - but this coincided with a change of therapist and he refused to do anything for the new one.

1. Woven mats.
2. Tufted rugs.
3. Pram cover on a special large frame which he designed and made himself.
   All his work is to his own design and he is a careful and extremely good craftsman.

1. Knotted belts. (Sold these)

1. REFUSED. Unco-operative in other ways also.

1. Weaves slippers.
2. Has learned to make them up as well.

1. Stool seating.

1. Embroidered shopping bag on canvas.
2. Stool seating with cord - does this beautifully and makes a lot of money at this.

1. REFUSAL.
<table>
<thead>
<tr>
<th>No.</th>
<th>Age</th>
<th>Diagnosis</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>22.</td>
<td>80</td>
<td>Old cerebral thrombosis</td>
<td>Ambulant</td>
</tr>
<tr>
<td>23.</td>
<td>82</td>
<td>Osteo-arthritis ankle following compound fracture</td>
<td>Ambulant</td>
</tr>
<tr>
<td>24.</td>
<td>48</td>
<td>Right hemiplegia</td>
<td>Discharged himself</td>
</tr>
<tr>
<td>25.</td>
<td>74</td>
<td>Carcinoma of rectum</td>
<td>Bedfast</td>
</tr>
<tr>
<td>26.</td>
<td>48</td>
<td>Congenital cerebral diplegia Old hemiplegia Aortic regurgitation</td>
<td>Ambulant, Died</td>
</tr>
<tr>
<td>27.</td>
<td>76</td>
<td>Arteriosclerotic aortic aneurysm</td>
<td>Ambulant</td>
</tr>
<tr>
<td>28.</td>
<td>65</td>
<td>Hemiplegia (Right)</td>
<td>Discharged</td>
</tr>
<tr>
<td>29.</td>
<td>78</td>
<td>Blind</td>
<td>Discharged</td>
</tr>
<tr>
<td>30.</td>
<td>40</td>
<td>Duodenal ulcer</td>
<td>Discharged</td>
</tr>
<tr>
<td>31.</td>
<td>56</td>
<td>Right hemiplegia</td>
<td>Ambulant</td>
</tr>
<tr>
<td>32.</td>
<td>56</td>
<td>Right hemiplegia</td>
<td>Discharged</td>
</tr>
<tr>
<td>33.</td>
<td>74</td>
<td>Amputation</td>
<td>Ambulant</td>
</tr>
<tr>
<td>34.</td>
<td>52</td>
<td>Right hemiplegia</td>
<td>Discharged</td>
</tr>
</tbody>
</table>
1. Basketry.

1. Cord seating for a stool – eyesight was too poor.
2. Rug-weaving.

1. REFUSED. Discharged himself.

1. Canvas embroidery.

1. Flat-woven rug.

1. REFUSED.

1. REFUSED. Able to get out on his own, so the attempt was not followed up.

1. Dog-lead; Solomon's knots.

1. Started a flat-woven rug; but never finished it.

1. REFUSED. Troublesome and complaining all the time.

1. REFUSED. Aphasic; so no reason given. Co-operative in other ways, but flew into a rage when occupational therapy was suggested.

1. Wanted to do a woven slipper but would not start.

1. REFUSED. Lazy.

1. Weaving on one-handed loom.
2. Flat-woven rug.

(Continued with this at home after discharge.)
<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>64</td>
<td>Carcinoma of lung.</td>
<td>Died</td>
</tr>
<tr>
<td>37</td>
<td>66</td>
<td>Tabes dorsalis.</td>
<td>Discharged</td>
</tr>
<tr>
<td>38</td>
<td>84</td>
<td>Arteriosclerosis.</td>
<td>Died</td>
</tr>
<tr>
<td>39</td>
<td>56</td>
<td>Deep venous thrombosis</td>
<td>Discharged</td>
</tr>
<tr>
<td>Males, cont.</td>
<td>(4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1. REFUSED. Wrote a lot of letters and seemed quite contented so the matter was dropped.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. REFUSED. Unco-operative.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. REFUSED. Very active until he fell and broke a leg. Died soon after.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Basketry.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The table shows the work records of the 139 patients for whom occupational therapy was prescribed between June 1948, and May 1949. There were 100 females and 39 males in this group, and out of these 8 females and 13 males refused to try anything at all (i.e., 15.1% of the total). These are discussed later.

At the end of the year, 15 of the women and 7 of the men had died (15.8% of the total). The nature of diseases treated in a geriatric hospital makes a high percentage of deaths inevitable.

30 women and 14 men were discharged (31.7% of the total). The remaining 73 patients were long-stay and for many this meant that they would be permanent. 26 of these were totally bedfast (18.7% of the total 139 patients), but the remaining 47 were able to sit out of bed for at least part of the day, and a large number of them were up and dressed in the dayroom all day, even if they had deformities which prevented them from walking by themselves. These were installed in wheelchairs when they got up in the mornings, and remained in them all day, thus being reasonably mobile and were therefore classed as "frail ambulant" or "chair-borne" cases.

The happy busy atmosphere in the dayrooms was largely due to the feeling of usefulness engendered by the handicraft work, even in those cases where it was purely recreational, while those for whom it was remedial were delighted to see tangible evidence of their improvement in the finished articles.
There are more women than men in the group, and the men were more reluctant to start anything than the women, but on the whole they were more particular about the standard of their work when they did start. It must be borne in mind that the lack of any department at all during the first three months, when a boxroom for stores was all the accommodation that could be spared to our occupational therapy staff, and the relative inaccessibility of the room with which they were then provided as a temporary measure, meant that the craftwork was done entirely in the wards, which were already overfull of beds. We were therefore unable to offer the men the more "manly" crafts, such as carpentry or weaving on big looms, but plans for the future included a move to accommodation where such things would be possible and we expected then to get more of the male patients started more easily. Once the initial interest is aroused, we found no difficulty.

Age was no criterion of efficiency, and one of the best workers was case no. 37 of the females, aged 96, who was not content merely to produce beautifully woven wastepaper baskets, but got herself commissioned to keep a certain boarding-house supplied with them!

Case no. 57 (female), aged 82, produced excellent work in whatever line she was given, and had retained her youthful skill with a crotchet hook, being still able to produce the finest work.

Of the men, the most outstanding worker was undoubtedly no. 15, aged 84, who got tired of his
small flat-woven and tufted rugs (see photograph), and asked to be allowed to make bigger ones. As these would require a new and specially large frame, he confessed to having been a carpenter by trade and arranged for himself to be assisted over to the O.T. department daily for a week, while he designed and made a frame to suit his own ideas and which was capable of various modifications if the therapist should so desire in the future.

At the end of the year under survey, about a dozen patients in all were attending the department for their treatments. This number was restricted by the size and situation of the room in use as the O.T. department at this time. When a move is made, all the patients who are ambulant or semi-ambulant would be able to attend there if it was desirable that they should, and I was always in favour of this idea as part of our policy of including as much social activity as possible in the daily routine. The occupational therapy and physiotherapy departments provided contact with patients from other wards, and treatment there was therefore popular as a social treat. In addition our limited dayroom space did not permit much active treatment there, and it was our aim to leave it as far as possible as the patients' own sitting-room. The permanent patients in particular appreciated this.

At the end of the year also, the O.T. staff were able to deal with all the therapy prescribed in the hospital, and it was found that it was only recent
admissions who were being taken on. Therefore all our old patients for whom it was suitable were having it, and our staff of one part-time fully trained therapist with a constant supply of students was adequate for the needs of this unit. At this time, however, only 100 of our 250 beds were in rapid turnover, the other 150 being occupied by patients who had been a year or more in the hospital, although by no means all of these were bedfast. In the future, although more patients will undoubtedly be admitted, their stay is likely to be shorter, and so the department will treat more patients for a shorter time each, and the present staff should still be adequate.

2 This speed-up in the turnover of geriatric beds as a result of modern methods of treatment is shown very clearly by the fact that on the 100 beds in rapid turnover we had been able to admit 200 patients during the three months of February, March and April 1949; 60 of these directly from wards in the Radcliffe Infirmary; for the second half of that period the admission rate was an average of 15 per week, while our discharge over the same six weeks was 13 per week. The waiting list at this time was negligible, whereas we did have a list of some 20 patients who would have been fit for life within the shelter of a hostel for the aged, had there been vacancies, although they were too frail to be discharged to look after themselves.

30 of the patients treated by occupational therapy (21.6%) were under the age of 60 years. These
were 18 women and 12 men, suffering from the following conditions:

- Cerebral thrombosis - 8 (4 female and 4 male)
- Rheumatoid arthritis - 7 (6 " 1 ")
- Paralysis agitans - 5 (3 " 2 ")
- Disseminated sclerosis - 2 (both female.)
- Congenital spastics - 2 (both male.)
- Deformity of spine - 1 (female.)
- Pemphigus - 1 ("")
- Carcinoma with secondaries - 1 ("")
- Biliary cirrhosis - 1 (male.)
- Duodenal ulcer - 1 ("")
- Deep venous thrombosis - 1 ("")

These patients - apart from 3 refusals, all male - were all very keen to try and were usually spurred on by immediate improvement in their physical or mental condition. It was felt that occupational therapy was particularly useful in this group.

At the end of the year, as a result of the introduction of an occupational therapy department, coupled with other methods of modern geriatric treatment, 87 patients were still bedfast out of our total of 250 beds, i.e., 34.8%. This is a reduction of 17.1% on our initial figure of 51.9% in June 1948. Of the 250 patients in May 1949, 105 had been receiving occupational therapy for some time, and 10 more (not included in this survey) had been written up for it within the last 2 weeks of the period, i.e. 46% of our total inmates were suitable cases for this.
Refusals.

13 men and 8 women refused to try any work. The majority of these were difficult patients in any case and were not really expected to co-operate. 3 were under the age of 60, all were males, and 2 were right hemiplegics with speech centre involvement. One of these two discharged himself while under treatment.

5 patients in the group of 139 were aged 85 or over, and only one of these refused to try anything, although two more were unable to do even the simplest craft. The other two, both women, were excellent workers.

No case was recorded as a refusal until repeated attempts had been made to arouse their interest, or two overcome their reluctance to start, otherwise our number of refusals might have been much greater. In some cases who eventually worked well and enjoyed it thoroughly, several sessions with the therapist were sometimes necessary at first.

As mentioned in section I, our percentage of refusals is considered by therapists to be low for this type of patient.

Rheumatoid arthritis.

There were 21 cases treated by occupational therapy (2 male and 19 female). In some of these, procaine lactic acid injections had been started, but only for their knees or ankles, and only during the second six months of the period concerned.
CASE NO. 39 (female) - Hands and elbows are almost completely fixed in the position shown above. Below - how she holds her work.
The occupational therapist was requested to concentrate on the upper limbs, especially finger movements, and no local treatment other than occupational therapy was given in any of these cases. In many, marked improvement was obvious over a period of some weeks, particularly in feeding and doing hair.

Trevor Howell insists upon the unsuitability of knitting as a craft for rheumatoid arthritis cases. While agreeing most heartily with him on this point - no case improved on knitting, and some had been knitting for years and been getting steadily more deformed the while - we did make use of it as a stepping-stone in certain cases who had done nothing, as proof that their crippled hands could indeed do something. When supplied with suitable wool and needles of a length appropriate to their deformed fingers, they all knitted well.

Case no. 39, female, was allowed to continue to knit, as in her case the disease seemed to have ceased to progress and she was so limited in her movements that her own particular style of knitting, which she had devised for herself, was one of her few great pleasures.

Of the rest, those who are shown to be knitting at the end of the trial period were scheduled for a change of craft work in the near future.

I must mention here the narrow belt loom which was made for us at Dorset House, especially for our rheumatoid cases. We could have used several more of the same design. (See section V.)
CASE NO. 13 (female) - Hemiplegia

ABOVE. - Beating down thread with paralysed hand.

LEFT. - Spring sling device to support paralysed arm, and to maintain position of patient at work.
Hemiplegia.

25 cases of hemiplegia (10 male and 15 female) were treated. The recent ones were treated by M.W. Warren's methods from admission; the others were old neglected cases who presented a slightly different problem.

Again we asked the occupational therapist to concentrate minimally mainly on the upper limbs while the physiotherapy staff looked after leg movements and walking. Some, of course, did get arm exercises as well, and in two of the female cases, nos. 13 and 51, physiotherapy had had little or no effect on the muscle spasm which gave permanent clenching of the fingers of the paralysed side. Both these patients started to attend the occupational therapy department to work at wug-weaving on an upright loom where they were made to beat down the threads by using their clenched hand as beater (see photo) and in both cases after attending three times a week for about three weeks, the spasm was so less marked that each patient could open and close her hand voluntarily.

In all other cases, except 5 (4 male and 1 female) who refused to try, finger movements improved slowly, but more rapidly in the more recently admitted cases than in the long-standing ones.

Paralysis agitans.

There were six cases of this type in our group, 2 male and 4 female. It was found that occupational therapy helped co-ordination, especially in the famil-
Case no. 1 (female) - ABOVE: To show dorsal subluxation of the proximal interphalangeal joint.

Below: Splint devised by Dr. J.L. Insley to control the deformity.
ial type, and that all these cases enjoyed it immensely. There was no refusal in this small group, though case no. 14 (male) was only working because he liked our first therapist, and was inconsolable when she left.

Special reference must be made in detail to 28 cases in this group, as they show most markedly the benefits of this type of therapy in chronic nervous diseases.

No. 1 (female) had been a dressmaker by trade, and had been forced to give up working some 15 years previously. Her high dosage of hyoscine had made reading well-nigh impossible for her, and she had never liked knitting which was all she thought she might be able to do. In addition, she had marked dorsal subluxation of the proximal interphalangeal joints of her forefinger and middle finger of her left hand, which had rendered it useless for lifting or gripping unless controlled by her other hand or by some other person.

This presented a grave obstacle to craft work, until October 1948, when my husband, Dr. J.L. Insley, while acting as my locum for three weeks, devised a splint to control the deformity, and with the grip restored to her left hand, this patient was able to make beautiful woven scarves on a table loom in the dayroom. The immense satisfaction she obtained from this was matched by her pride and care in her work.

N.B. - This splint was used to control this deformity when it was met with in other diseases, e.g.
CASE NO. 1. (male) - Paralysis agitans.

Below - fingers in maximum extension.
hemiplegia, rheumatoid arthritis.

Case no. 3 (female) was admitted on several occasions, usually for social reasons. She was put on Diparcol therapy on one of the more recent of these, and received intensive every time she was with us, and from the first time I saw her she showed a slow but marked improvement until on the occasion of her last stay in hospital during the year concerned she had hardly any tremor at all, and informed me that she had been able to try and play the piano at home for the first time in 12 years. As the improvement in finger movements started before her diparcol was commenced, we were convinced that at least some of the credit for the piano-playing must go to her occupational therapy.

Cardiacs.

These were given a wide choice of craftwork, and the only supervision insisted upon was of the hours spent upon it, in order to minimise the danger of fatigue. It was found to be a great help in getting patients to resign themselves to restricted activity in or out of bed, as some were used to a busy life and were unable to enjoy complete idleness. A case in point was no. 25, (female), suffering from a coronary thrombosis, who cheered up considerably when allowed to knit, and who had been most unhappy on admission.

Fractures of the neck of femur.

The orthopaedic treatment of these cases was in
the hands of the appropriate department of the Radcliffe Infirmary, Oxford, and it was our function merely to give them house room and physiotherapy as requested. Their policy at that time was not one of early ambulation without operation as is now being practiced extensively elsewhere, and so we availed ourselves of occupational therapy on a recreational basis to help them while away the tedious weeks in plaster. Again a free choice was allowed.

New-growths.

The majority of newgrowths which came under our care were inoperable, and many were too ill for craft-work of any kind. Occupational therapy was made available to all who wished it. However, and those who were able for it were enthusiastic about it. I cannot speak too highly of the tactful understanding that the Dorset House students - some of them very near the start of their training - gave to these cases, especially to the younger ones among them.
SECTION III - "THE LAURELS" GROUP.

The patients in the group discussed in this section are fit old people, residents in the one large hostel provided up to now for the area by the Oxford City authorities. The number of its inmates varied, usually in the region of 100, and any who turned ill were transferred to Cowley Road Hospital for treatment, usually with a fit patient transferred in exchange. Therefore all the patients in this group, except one who died in the hostel of a coronary thrombosis, were present throughout the year under survey, or were put on occupational therapy after admission as long-stay inmates.

Occupational therapy was not prescribed for the members of this group, but merely suggested by the nursing staff. Fewer hours were devoted to this institution by the therapist, but there were always two students in the department in her absence.

I have tabulated the work done in this group in a similar way to the previous group.

<p>| 1. Knitted squares. |
| 2. Knit garments. |
| 3. Crochet garments. |
| 4. Learning to knit by devil's eyeglass in very poor vision, progressing but the time is very hard work. |
| 5. Crochet mats. |
| 6. Crochet edging. |</p>
<table>
<thead>
<tr>
<th>CASE NUMBER</th>
<th>AGE</th>
<th>HANDICRAFT WORK.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(Females.)</td>
</tr>
<tr>
<td>1.</td>
<td>62</td>
<td>1. Knits well.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Crotchet mats.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(This patient is discharged from a mental hospital.)</td>
</tr>
<tr>
<td>2.</td>
<td>59</td>
<td>1. Knits, not well, and does not improve as she should. Will do nothing else.</td>
</tr>
<tr>
<td>3.</td>
<td>74</td>
<td>1. Knitted multitudes of squares.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Progressed to scarves.</td>
</tr>
<tr>
<td>4.</td>
<td>75</td>
<td>1. Knits very well.</td>
</tr>
<tr>
<td>5.</td>
<td>71</td>
<td>1. Knits plain, not well.</td>
</tr>
<tr>
<td>6.</td>
<td>92</td>
<td>1. Knitted a lot of squares, not at all well, she does not improve and is stone deaf.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Has progressed to scarves.</td>
</tr>
<tr>
<td>7.</td>
<td>58</td>
<td>1. Knitting. Making slow progress, but is over-ruled by her mother, who tells her that she can't do it. Rather slow mentally.</td>
</tr>
<tr>
<td>8.</td>
<td>70</td>
<td>1. Knits baby clothes in stocking stitch.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(She does a lot of work for the home.)</td>
</tr>
<tr>
<td>10.</td>
<td>70</td>
<td>1. Knitted squares.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Knits cardigans.</td>
</tr>
<tr>
<td>11.</td>
<td>72</td>
<td>1. Woolly balls.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Learning to knit by feel (eyesight is very poor indeed), progressing but she finds it very hard work.</td>
</tr>
<tr>
<td>12.</td>
<td>60</td>
<td>1. Knits scarves</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Crotchetts scarves.</td>
</tr>
</tbody>
</table>
Females, cont.

13. 7
1. Crotchets for herself, very finely.

14. 40
1. Did woven slippers very well, then
suddenly did them very badly and was
very sullen when this was pointed out.
2. Knitting quite well.
3. Tapestry canvas embroidery. Very excited
over this and the flowers were too
much for her.

(This patient is an epileptic.)

15. 72
Does all crafts beautifully.

16. 74
1. Knits very slowly indeed.

17. 70
1. Knits very fast indeed.

18. 77
1. Crotchets fine mats.

19. 82
1. Collected patterns from magazines for the
others to do, as she felt her hands were
too frail to work.
2. Was persuaded to do a few crotcheted
mats, fine work and well done.

(This patient was exceptionally well
educated and intelligent.)

20. 71
1. Knits socks, but can never be persuaded
to make the feet big enough.

21. 70
1. Knits frantically "to take her mind off
her troubles", and gets furious if any
other craft is suggested. Knits the legs
only of socks.

22. 60
1. Knitted squares.
2. Bedsocks.
3. Ordinary socks, very neatly done.
23. 81 1. Felt ponies. These were beautifully done at first and better than was expected of this patient. Some weeks later she suddenly produced a very badly made one, and it was discovered that another patient (who had been transferred to another home) had actually been making them for her. She continued to make them herself, and her efforts showed a gradual but steady improvement.


25. 60 Does all crafts well and loves them all.

26. 65 1. Knits fast and often if allowed to use her own rather peculiar stitch and her own choice of extremely lurid colours, but has now been persuaded to do a plain piece.

27. 79 1. Raffia mats.

28. 65 1. Knits socks.

29. ? 1. Knits well but slowly.

(This patient works hard for the home.)

30. 60 1. Knits. Has completed a jersey for herself in an all-in-one pattern she says she learnt at school.

31. 72 1. Knits socks.

32. 80 1. Knits bedsocks. (Very deaf, - lipreads.)

33. 65 1. Knits beautifully.

2. Soft toys as a change.

(She is an epileptic.)
Females, cont.

34. 79 1. Knitting bedsocks, but made them far too small and would not be told.

2. Started following her own patterns and did these well.

(Died suddenly, from a coronary thrombosis)

35. 58 1. Knitted bedsocks if the heels were turned for her.

2. Scarves.

(Works very hard for the home.)

36. 70 1. Knitted squares well.

2. Socks if the heel is turned for her.

3. Scarves, knitted incredibly badly but she likes them and buys every one she makes!

37. 75 1. Knitted with supervision, but forgets how to do it as soon as she stops. Got very upset and unco-operative, and so her occupational therapy was discontinued for the present.

38. 76 1. Crochet. Was delighted at first and started to do a straight strip for her dressing-table top, but unfortunately her silk ran out before she finished it, and she has refused to do anything else. It has not been possible to match her thread.
Males.

1. 79 1. Knotting dogleads and belts very nicely.

2. 78 1. Small tufted rugs, but seems to be tiring of these.

3. 87 1. Weaves simple scarves.
2. Basketry, tried it but simply could not get the hang of it.
3. Rugs. Did not like these so well as his scarves so returned to his scarves.

4. 65 1. Cane-seating. Learned easily and did it well. Takes \underline{XXX}\underline{XXX} orders.
2. Hooked rugs. Learned to do these while waiting for cane and orders. Sells these too.

(He is paralyzed in both legs and gets around on crutches.)

5. 52 1. Basketry. Seemed interested, but was never free to come and learn how.
Examination of this table shows at first two striking features:

(1) The preponderance of females to males (38:5)

(2) The absence of progression.

The first of these we attribute largely to the lack of a department to which the patients could go to work at more "manly" crafts, coupled with the natural greater reluctance on the part of the males referred to in the previous section. But another factor that we felt was important in this was the lack of proper prescribing of occupational therapy by the medical staff, as the nurses were readyer to suggest craft for the women than for the men.

The second feature is explained principally by the fact that occupational therapy was recreational in all these cases, and so progression and improvement were not encouraged by the therapists as intensively as in the remedial cases at Cowley Road Hospital, but partly also once again by the lack of interest on the part of the medical staff, who gave the occupational therapy department no guidance as to what was expected of them and their patients.

Broadly speaking, it was found here that the good workers were good at all crafts suggested to them and enjoyed doing craft-work, while the rest (the majority) could only manage very simple crafts, and these were usually indifferently or even badly done, although repetition of the work brought some slight improvement in most cases. The standard of work was
much lower than in Cowley Road Hospital, possibly
because many patients were working largely on their
own, without much supervision of actual working by
the therapists.

It must be noted also that many of the more
active patients were employed on domestic work in the
home, which activity was quite outside the jurisdiction
of the occupational therapy department.

It would probably be a better thing for the
general physical and mental well-being of these old
people if the medical staff were to prescribe the
total amount of activity allowable to each individual,
and if each were then allowed to choose whether he or
she would spend his or her allowance all on domestic
work, or all on craftwork, or if they would prefer
to do some of each. The available help to the domestic
staff would not be decreased by such a plan, as many
of these old people are glad to continue to shoulder
responsibility for some household chores, and such
responsibility helps greatly in their mental adaption
to the more restricted life of an institution after
having looked after their own homes for so long.

This policy is one adopted by institutions in
other countries, notably by the New York City Home
for Dependents, which is referred to in a later section.

Otherwise, it was found, as here, that keen workers
tend to overdo things, while lazy or lethargic ones
who ought to be stimulated to do more, for their own
good, are allowed to slip by more or less unnoticed.
If the subject of graded activity was to be studied more carefully by the medical personnel attendant on the various homes and hostels for the aged, it is very probable that a great deal of physical and mental deterioration could be postponed or prevented, a gain alike to the overcrowded hospital accommodation that is all that is available to sick or bedridden old folk at present, and to the happiness of the old people themselves.

Certain authorities have already recognised the value of this, and in particular the British Red Cross, which has already established, with great success, handicraft classes in many areas, and plans to have every Red Cross division throughout the country carry out such a program. One drawback to this admirable scheme is that in most cases the craft workers available to the Red Cross are not trained in the remedial application of handicrafts as occupational therapists are, and therefore have not the knowledge or experience to prevent or improve deformities, e.g. in old rheumatic arthritis.

A better step is that visualised by certain Public Health Authorities, who contemplate a home occupational therapy service for the convenience of general practitioners and the follow-up departments of hospitals. Such a service would reach those too infirm to attend handicraft classes and too independent to have sought admission to a home or hostel, though presumably such a service would be available to small institutions who desired it.
That such a scheme would be welcomed by patients is obvious from the numbers of inquiries that both we in Cowley Road Hospital and the staff of Dorset House School received from patients and general practitioners in the Oxford area as to the possibility of something on the lines of the occupational therapy work to be had in their own homes, and the difference between our occupational therapy and the handicraft service provided by the Red Cross was apparently keenly appreciated.

A certain amount of education of general practitioners in the scope of occupational therapy will unfortunately be necessary in some cases - unless it is intelligently and accurately prescribed, as in the case of physiotherapy now, it can be a vastly expensive undertaking, producing results insufficient to justify its cost.

This can be seen to a lesser extent in hospitals where the medical staff do not treat the occupational therapists to the co-operation that the physiotherapy departments now take for granted in this country, and it is interesting to note in this connection that in America the position is reversed, and it is even not unusual for the occupational therapy department to take precedence over and to control the physiotherapy one.

A more rational approach seems to be the one we adopted at Cowley Road Hospital, i.e. to regard occupational therapy and physiotherapy as sister
subjects, complementary to each other, and each equally necessary to the proper functioning of a physical medicine department.

It was decided to try occupational therapy on selected patients from among our restless confusional states. About 70% of the total of these were considered suitable and the results in this group are discussed briefly below.

These patients were all treated by a trained therapist who had some previous experience of mental patients. Their quiet patience was responsible for the low percentage of refusals in this group. Each served individually with them every day for a longer or shorter time. Sometimes several crafts were tried before a favourite was hit upon; in other cases, the first choice was best and progress was made only within the realm of this craft. At the end of the trial period of four months, this group was working so well that a final year student was able to take it over from the fully trained therapist, and she continued to deal with it satisfactorily.

The group totaled 49, there being 16 males and 33 females. All were long-staying cases, as recently admitted semi-confusional state was included. None of these patients received any change in their routines coincident with the stage of their confusional therapy, and it was therefore of interest that no significant change in the condition of these patients at this time was detected, and at their occupational therapy.
Between January and April 1949, it was decided to try occupational therapy on selected patients from among our senile confusional states. About 70% of the total of these were considered suitable and the results are discussed briefly below.

These patients were all treated by a trained therapist who had some previous experience of mental patients. Her quiet patience was responsible for the low percentage of refusals in this group, and she worked individually with them every day for a longer or shorter time. Sometimes several crafts were tried before a favourite was hit upon; in other cases, the first choice was best and progress was made only within the realms of this craft. At the end of the trial period of four months, this group was working so well that a final year student was able to take it over from the fully trained therapist, and she continued to deal with it satisfactorily.

The group totalled 42, there being 22 males and 20 females. All were long-standing cases—no recently admitted senile confusional state was included. None of these patients received any change in their routine coincident with the start of their occupational therapy, and it can therefore be stated quite dogmatically that any improvement in the condition of these patients at this time was directly due to their occupational therapy.
SHOPPING BAG. - Specimen of the unsupervised work of one of the male senile confusional states.
The males.

Of the 22 males, 1 was certified, 1 discharged himself, and 3 died during the four months period.

Only 3 patients refused to try anything at all; one of these said he felt too weak, and subsequently died of a coronary thrombosis, the second was the man who discharged himself, and the third was a long-standing hemiplegic whose speech centre had been permanently affected, and who could not give us any reason for his refusal on that account.

Of the remainder, 2 were started but were later taken off occupational therapy as their failure to comprehend even the simplest tasks was causing them marked distress.

The other 17 all showed a slow improvement in skill and mental capacity. Some were able to be put on quite complicated crafts, such as hooked rugs and basketry, while the rest all showed some degree of progression, e.g. from winding wool skeins to making woolly balls. The ward staff found the patients were quieter and easier to manage than before, and one was able to be transferred from the observation ward to a convalescent ward where there was only a minimum of supervision, while another patient improved so much that he was handed over to the general therapist. It was also found that less sedation was required than formerly in some of these patients.

Here are four case records which have been selected as typical of the patients in this group;
CASE 1.

24.11.48. Sandpapering. Very willing to undertake work, shown how on bag-handles, and asked for more to do later.

25.11.48. Work continued with good result.

29.11.48. Polishing bag handles.

30.11.48. Working well. Asked for more tomorrow.

1.12.48. Working on stool frame now. Keeping work to continue p.m.


8.12.48. Working well polishing the stools.

11.12.48. Very keen, polishes the stools well, and more conversational.

13.12.48. Stool seating. Has begun seating a stool with seagrass, and has a good idea of what he is doing.

15.12.48. Works hard at his stool.

20.12.48. Has learned seating and carries on on his own now.

22.12.48. Weaving sitting belt. Has begun to learn to weave and seems to like it. Not yet able to do it on his own.

30.12.48. Has not been feeling very well, and has not got on very well.

5.1.49. Is beginning to understand how it is done and has tried some on his own.

12.1.49. Continuing well with his weaving.

19.1.49. Tufted rug. He has practised the stitch a lot, and has now begun a rug. He
IV, 4.

has grasped how it is done and he is very keen about his work.

26. 1.49. Is very industrious, and obviously enjoys doing it, especially when the nurses admire it.

3. 2. 49. Continues to do his rug well.

9. 2.49. Works hard.

16. 2.49. Has not been very well and very little work has been done, but he was very apologetic about this.

23. 2.49. Is not working quite so well since he has been transferred from the other ward (now in the convalescent ward).

10. 3. 49. Seems to have settled down now and is doing his rug very well again.

16. 3.49. Continuing well.

23. 3.49. Has nearly finished his rug and is very proud of it, working hard at it all day.

30. 3.49. Continuing well.

27. 4. 49. He finished his first rug by himself and has now started on a second which is a slightly more difficult pattern. He is doing this rug well, and fully understands how the pattern is done.

(This is the patient whose mental condition was sufficiently improved to allow of his transfer from the mental observation ward. The chief feature had been outbursts of uncontrollable rage with violent hysteria, but these grew steadily less frequent.)
CASE 2.

29.11.48. Winding wool. Very co-operative, started winding skein of coarse wool, and continued with finer material, independently. Seemed to tire easily, and required to be encouraged to have rest spells.

30.11.48. Tapestry weaving. Learned to do this after one brief demonstration. Seemed pleased with his success. Wove on alternate thread without any mistake, and used fully extended finger movements in pressing down the weft.

2.12.48. Wove on his own all the wool left for him. Seemed really pleased with progress. Further wool left for p.m. Had also finished winding which had been left in his locker.

4.12.48. Complained of pain. Attempted work, but very little done and he was very sorry for himself.

8.12.48. Worked quite well, and spoke about farming (his job). He puffs and blows a lot while working.

11.12.48. Looks forward to his weaving, but is still puffing and blowing.

20.11.48. Does his weaving on his own now.

22.12.48. Was rather cross today, and would only do about half a dozen rows.

30.12.48. Would not do any weaving today. Was quite chatty, but refuses to work.
5. 1.49. Still refuses to do anything.

26. 1.49. After being told off by the doctor, he has now begun to do his weaving, which he does well and he does understand what he is doing, but there many moans, groans and signs of protest.

3. 2.49. Does his weaving quite well but rather grudgingly.

9. 2.49. Only works when I (the occupational therapist) am there, and is always bad-tempered about it.

16. 2.49. He now seems to be taking more pride in his weaving, and does it very well.

23. 2.49. Has been in a very good humour for the last few days, and is now doing his weaving (mats now) when alone.

10. 3.49. Basketry. He has finished two mats and has started to make a waste-paper basket, but he is doing this very ungraciously.

16. 3.49. Settling down to his basketry, but only does a small amount each day.

22. 3.49. He is now enjoying his basketry, and is usually much more amiable, though sometimes when the cane sticks he gets a burst of temper and handles the cane very roughly.

30. 3.49. Does it slowly and seems to have poor eyesight.

27. 4.49. Better tempered, works slowly, but now perseveres even when eyes are bad.
CASE 3.

24.11.48. Winding wool. Managed this satisfactorily. Was quite agreeable to start, and spoke about his previous occupation - net-making (and poaching in the Thames). Too confused to do this work on his own, but handled it quite confidently.

25.11.48. Continued winding independently.

29.11.48. Continued to wind - string now.

30.11.48. Works steadily to his self-appointed quota.

4.12.48. Continuing as above.

8.12.48. Lazy, will work when watched.

20.12.48. Used the wool cutter for the first time, and did it quite well.

22.12.48. Was quite pleased to do some more cutting.

30.12.48. Likes to do this, but never remembers how from the last time.

5.1.49. Continues cutting.

12.1.49. Enjoyed his daily winding and cutting, but could not manage anything more difficult yet.

19.1.49. Feeling very sorry for himself, and only did a little.

26.1.49. Enjoying his work again.

16.2.49. Now he refuses to start at first, saying that his eyesight is very poor, but once he has explained this, he proceeds to work away quite happily.

23.2.49. Has been winding quite well.

10.3.49. Works very willingly now.

16.3.49. Continuing nicely.
23. 3.49. Sometimes he says he will not do anything but if work is put into his hands he will do it, and often accompanies it with a song.

30. 3.49. Always very cheery now, and loves to make jokes, especially puns. He is quite ready to do his work, and even tries to undo the knots and tangles himself.

27. 4.49. He now understands what he is doing and is much more independent. The work is now being left with him.

N.B. He should be able to go on to something more complicated very soon.

CASE 4.

16.2.49. Sandpapering. Was quite agreeable to do something, but complained of his eyesight and worked very slowly.

23.2.49. Does not do much - seems to be rather lazy.

10.3.49. Does a little every day. If not watched sandpapers the same part all the time.

16.3.49. He is now polishing the stool, but not very well and he gets most of the polish on his fingers.

23.3.49. Does only a small amount every day, and often begins by using his hands in a polishing movement, not realising that he has no cloth or sandpaper.

30.3.49. Quite ready to work a few minutes daily.

27.4.49. In time he should be able for something more difficult.
The females.

Of the 20 females, there were 4 deaths and 1 patient who required certification during the trial period.

There were 4 refusals - one cheery old lady of 91 who prefers to chat, two who at first refused even to speak to the therapist, but who have since become quite friendly and may start yet, and one whose mental deterioration was so marked that she was completely unresponsive to the spoken word, and if given anything at all to hold, promptly tried to eat it. One other patient started occupational therapy, but subsequently refused - probably because she was lazy.

Of the remainder, all showed progression, and all showed improvement in their mental condition as was the case with the men, except for the one case who became violent and had to be certified.

Two cases improved sufficiently to be transferred to general occupational therapy, and one of these was so markedly better that by the end of the trial period arrangements were under consideration concerning her discharge home in the near future.

The following four case records are typical of the kind of response found in these cases.

CASE 1.

3.2.49. Wool ball. First tried with some knitting which she did hopelessly, so started on a woolly ball which she began to do after some persuasion.
9.2.49. Only works while I (the therapist) am there.

16.2.49. Is quite ready to do her ball if I am there.

23.2.49. Seems more sensible now that she is sitting out in a chair, and begins without protest.

10.3.49. She is quite pleased to do her ball now and remarked that it was very simple work.

16.3.49. Does not get on very quickly as she only works when I am with her.

23.3.49. Has done a small amount of her ball, and conversation has been quite rational.

30.3.49. Has only done a little.

27.4.49. Basketry. She is now being taught basketry and is taking a great interest in it. She does not yet fully understand how it is done and so has to be helped a good deal, but she seems to derive great satisfaction from the small amount that she does do.

CASE 2.

9.2.49. Wool ball. Talked nonsense, but did some of the ball.

23.2.49. Was persuaded to sit up, and this has made a great deal of difference to her work, which she now does very neatly.

10.3.49. Always makes excuses, such as: 'she must get the tea ready as she is expect-
IV, 11.

...ing visitors.' But she usually sits up after a while and does some of her ball
16.3.49. Seemed rather confused. Took her ball and started, then put it in the bed and sat on it, insisting that she had lost something in the bed but that it was not her ball that was lost.
23.3.49. Does her ball very neatly after some persuasion to start.
30.3.49. She now does not require so much persuasion to start.
27.4.49. She is still confused, but does her work after a minute or two of persuasion, and she does it very neatly. In time she should be able to do something more difficult.

CASE 3.
29.11.48. Winding wool. Very willing and co-operative, worked well and continued on her own.
30.11.48. No work possible owing to nursing attention.
2.12.48. Slow to start but kept up once she saw how to do it. Dreamy.
10.12.48. Less confused, wound some wool very slowly, quite conversational.
15.12.48. Wound wool slowly, needed a lot of reminding to do this.
22.12.48. Confused, but does her winding well.
12.1.49. Has been winding very well.

19.1.49. Knitting. She is now sitting up in a chair which has made a great difference to her, and she was willing to try some knitting.

26.1.49. Getting on quite well.

3.2.49. Knits very regularly, and the other day she unpicked it and cast it on afresh because she said she considered it was too large for men's cuffs! (It started out as a square.)

9.2.49. She has now decided to make her knitting into a scarf.

16.2.49. Looking much better sitting up in her chair busy knitting.

23.2.49. Has finished her knitting, and has made it a scarf for a little boy, but is going to unpick a bit as it is not well enough done.

10.3.49. Has finished the scarf and is now making bedsocks, which she is doing better, with no mistakes or dropped stitches.

16.3.49. Has done quite a lot with only one mistake in it.

23.3.49. Finished off the bedsock and has started the second one herself. Ribbing is done quite well and she is on to the plain.

30.3.49. She is now knitting a scarf for a relative, who has supplied her with the wool and pins. She is doing it very quickly.
27.4.49. Getting on well with her scarf and should soon be able to go on to more complicated knitting or to another craft.

(This is the patient for whose discharge arrangements were being made.)

CASE 4.

4. 1.49. Unpicking. After a lot of unintelligible chatter she began to wind some wool, but she did not know what she was doing and occasionally put the ball of wool into her mouth and bit it.

7. 1.49. Did her unpicking much better today and seemed to realise what she was meant to do.

12.1.49. Doing her unpicking quite well.

19.1.49. Chats away all the time but does not work continuously, every now and again she gives it back or puts it away in her locker or breaks the wool.

26.1.49. When she sees me (the therapist) with my boxes of wool she now asks for something to do.

3.2.49. Did quite a lot today and only put it in her bed once.

9.2.49. Did not realise she was meant to be winding a ball of wool and kept biting it to see what was inside it.

16.2.49. Was in a very good mood and did a lot of unpicking without once putting it
23.2.49. Asked for her unpicking to be brought over to her and did it quite well.

10.3.49. Has not been very well and so has not done anything.

16.3.49. Has not been well.

23.3.49. Has not worked for some time and always seems to be sleeping.

30.3.49. Still no work. When not asleep, she is in a dazed state.

27.4.49. Wool ball. She has improved very much since she has been out of bed, and has been doing her unpicking well. Has now begun to make a woolly ball with great glee and keeps saying to herself, "I understand how to do it." But she definitely has her off days.

I am grateful to Miss E. Perkins for her work with this group and for her careful and detailed case records, some of which I have quoted above. I am indebted to the Governors of Dorset House, who were responsible for supplying me with Miss Perkins' services, which were outwith their contract, but which were invaluable to the development of the department.
SECTION V. - THE OCCUPATIONAL THERAPY

DEPARTMENT.

Reference has been made in Section II to the inaccessibility of the room given over for use as an O.T. department, and the consequent difficulty of in having patients attend there. A move to accommodation next door to the physiotherapy department was scheduled for the near future. (Our policy with regard to O.T., as stressed in Section I, has resulted in the happiest co-operation between the two departments.)

For the year reviewed, however, the O.T. department was used principally for the preparation and storage of articles, with the exception of the erection of two large looms, one a foot-operated one and the other an upright one borrowed from Dorset House School and due to be replaced by a permanent one of the same type.

This upright one is the one referred to in the discussion of hemiplegia, and with it we used a sling device to provide support for the patients' arms. We supported the good limb as well as the paralysed one as to do otherwise was unnecessarily tiring for the patient. § See photographs of case no.13 (female)).

A lot of weaving was done on small hand looms that could be kept on the wards, and reference has been made to our special belt loom. The principle features were its lightness and the ease with which the changeover of threads could be made (see photo), and the closeness of the working part to the patient's
SMALL BELT LOOM - designed especially for advanced rheumatoid arthritis cases.
body. This we found essential for some of the more contracted of the rheumatoid cases, and it was hoped that by its use they might improve enough to be able to use a wider loom.

Weaving was also done on frames, which were light and portable, and mention has already been made of the man who made his own big frame.

We used wool in all its forms a very great deal. Its soft texture was welcome to stiff old hands, and the variety of bright colours available undoubtedly had a psychologically stimulating effect on ward morale. The squares (so often not quite square!) were crotcheted together into patchwork blankets, and work that was too hopeless to fit in was passed on to the senile dementias for unravelling and rewinding when it could be used again.

Baby's clothes had a great appeal to the women, partly because the did not take long to do and looked so dainty when pressed and sewn up. Bedsocks were made in a heel-less pattern which was a straight strip of knitting folded in half and thonged together with a crotched cord. These in contrasting colours were very gay and were easily sold when the question of disposal arose.

Woolly balls, although expensive of wool, were very popular because of the bright colours employed, and were particularly useful for the senile confusional states.

Basketry was popular when it was introduced, and
in spite of having to use the cane dry (as to use it wet was out of the question for bed patients) the majority of patients found it quite manageable and produced work of a satisfactory standard.

Stool seating and cord knotting were the prime favourites with the men, and their appeal was also through the bright colours in which the cord was available, while the sandpapering and polishing of stool frames was easy work for the less skilled. We occasionally used seagrass for the stools, but it was not popular, possibly because of a poor lot of seagrass available to begin with, which broke easily.

Individual patients produced their own favourite crafts e.g. embroidery and tatting, and were content to get their materials from the department. This facility obviously supplied a long-felt want among the women patients, and was not discouraged as long as it was not abused, i.e. it was made clear that the materials were to be used by the patient herself, and not given away unmade up to relatives and friends.

Felt toys were popular especially in the home group. These were suitable for leaving with the patients for them to do on their own, and the stuffing and finishing touches added by the therapists made them most attractive and inexpensive.

On the financial side, we arranged that if the patient wished to keep the finished article or to dispose of it privately, he or she was allowed to have it for the cost price of the materials used.
Otherwise the article went into store to be sold at the Christmas sale of work. We found that the majority of patients were so delighted with their finished work that they were anxious to keep it, and this, along with the slower rates of work (as compared with younger patients) did result in only a small accumulation of surplus articles. At Christmas, 1948, we found there was insufficient to make a sale of work worth while that year, though this of course would not necessarily be so in the future. It was our experience that the patients were quite willing to pay for their materials when they kept the articles, and felt that this arrangement was a fair one all round.

Early in 1949, we held an exhibition of patients' work which aroused great interest among the general public, and incidentally proved of value in obtaining fuller co-operation with the general practitioners who supplied us with cases.

Our staff consisted of one therapist, fully trained but part-time (8 hours weekly in June 1948, to three-quarters time in April 1949). She was assisted by students from Dorset House, who came in relays for two weeks practical work with us. This gave us a never ending stream of fresh enthusiasm, as well as increasing considerably the number of treatment periods available per patient. Our therapist was only qualified on the physical side of occupational therapy, and so when the question of the senile dementias was
raised, Miss Perkins joined us on a temporary basis to start off this side of the work.

It is undoubtedly essential for this type of hospital that someone with training in both branches of occupational therapy is available. Our head therapist was in full agreement with me that the ideal arrangement for such a department would be to have a person holding the double qualification in charge. Assistants or students are essential in order to provide frequent treatment sessions as in some cases daily work is essential to get the maximum result therapeutically. It is also preferable that the person in charge should have had considerable practical experience.

We were of the opinion, shared by certain lay members of the administrative staff, that the cost of running the department was easily justified by our results. It was generally felt that we compared favourably with O.T. departments in acute hospitals, and that the old people were neither extravagant nor wasteful with regard to materials. The expense of equipment was not unduly heavy when compared with physiotherapy or radiography installations, for example, and the beneficial effects on patients of this line of treatment were even greater than we had hoped when the scheme was started.
Of recent years, the volume of literature on senescence and the diseases of old age has grown enormously, both in this country and elsewhere. In much of this work, great stress is laid on the beneficial effects of interesting occupation on the welfare of the aged. Individual references are too numerous to be quoted in detail, but reference should be made here to the work of Charlotte Buurler, the Viennese psychologist, in connection with the quantitative distribution of achievement in comparison with the curve of life. These studies, based on an analysis of the careers of distinguished men, show four main patterns of output-distribution, regardless of ultimate age attained, and two of these four patterns definitely do not follow the biological curve of life, but show performance relatively independent of the physical vitality of the individual.

The adverse influence in some cases of the changes with aging in what Vischer calls "the subjective estimation of time" in the editorial to the Nov.-Dec. issue (1948) of "Geriatrics", the official journal of the American Geriatrics Society, where a condition called a "time neurosis" is referred to as being common among old people. This is defined as a belief in the effects of time, that tends to reduce ambition and expectations, and resulting in curtailment of endeavour, and a weakening of the will to live.
It is in an effort to combat this "time neurosis" that various authorities recommend prescribed occupation for the aged, who frequently are unable to see for themselves that occupation is what they need, or, if they do, are at a loss as to how to find it.

In America, this has been realised for some years and we find in the literature several references to old people's homes which are supplied with an occupational therapy department for this reason. To give a few examples:

1. In "Occupational Therapy and Rehabilitation" for August 1937, Mary E. Merritt reports on the work done in two homes for the aged and infirm. She refers to the large amount of institutional work done by the old people, and also mentions upholstering, mattress repairing, the making of brushes, brooms, and mops. She also comments on the modern trends in block printing and copper work displayed at an exhibition of the handwork of inmates over 70 years of age, and states her belief that occupational therapy as a diversion reaches its ideal with old people.

2. In the same journal, the August 1941 issue, Helen C. Phillips describes the start of occupational therapy in a small home (68 inmates) for aged and chronically ill women which had been opened three years previously. The majority were arthritics or cardiaics, and few were able to walk even a few yards. The average was 65 - 70. She instances one arthritic patient who loved hammering pewter discs into moulds. This exercised her joints and relieved her feelings.
The point is made in this article that interest is more difficult to arouse in older people, but that, once there, the work becomes part of their daily life. Our experience makes us agree with this.

3. In the same journal, for August, 1942, Hazel Fulton Thatcher gives an account of occupational therapy in a home for the aged in Pennsylvania. Special emphasis is laid on the fully equipped workshop where the old men and women can try out their own ideas. Medical supervision is needed to avoid overdoing it, but the finished products are of as high a standard as from younger people.

4. In the same journal again, this time in June 1943, Eleanor P. Kelley discusses the occupational therapy in a home for 168 retired persons started 15 years before. The aim of this home is stated thus: "We try conscientiously to make the final years of our residents happy and interesting", and the author adds "And we feel that occupational therapy contributes heavily to this ideal." From the first, the need for organised mental stimuli to prevent "vegetation" was realised and it was when the attempt to supply it by entertainment alone proved to be insufficient that occupational therapy was introduced. No compulsion was used but by the time of writing 70% were having it in some form or other, and this was the maximum that one therapist could deal with. It was the experience of the medical staff of this home that the preventative effect of the therapy on the amount of hospitalisation was strong, as introspection and
exaggerated aches and pains diminished.

5. The glowing accounts of the working of the occupational therapy department of the New York City Home for Dependents, Welfare Island, New York, as reported in such pamphlets as "Found Horizons for the Aging" by Grace C. Hildenbrand, director of the department, and the "Program of Care of Guests of the Home", by Maxwell Lewis, the Superintendent, paint almost too rosy a picture of the good times awaiting inmates of this home.

In 1944, the Pilot Press, 45 Great Russell St, London, published a volume in their post-war planning series of "Targets for Tomorrow" called "Old age in the new World", by Emily D. Samson. This is an admirable summary of the state of affairs in social welfare for the aged at that time, and of recommendations for future planning in this country, and it is of great interest to watch these recommendations being gradually implemented in various areas, e.g. to compare the proposals of the Birmingham Public Assistance authorities quoted in this volume with the description in "Picture Post" on November 26th, 1949, which gives some idea of the progress made in the five years.

In the same booklet, the section on occupations has this to say on the merits of handicrafts for old people: "Experience has shown that with encouragement handicrafts of various kinds can be a source of great pleasure to old people who are no longer completely active. For many it is the first opportunity to
This fundamental human desire to create is the basis of the offshoot of occupational therapy, used principally for tuberculosis patients, known now as Art Therapy. This owes its initiation to Adrian Hill, who has devised a potent means of combating the mental lethargy and despair to which a tuberculosis patient is so prone, and which has some similarity to the mental lethargy which comes with ill health in old age.

A development of art therapy is the picture library service operated by the British Red Cross, which supplies pictures for hanging in hospital wards, and which changes these at regular intervals as desired providing in some cases a lecturer to explain and encourage art appreciation among the patients.

In his book, "Art versus Illness", Hill describes early experiences with this service in hospital wards of various types, including one for "incurables" which obviously here means aged sick. It was very popular there - he says: "The interest they take is surprising! In view of the drabness of so many of the wards at present devoted to the care of the aged sick, more institutions might well avail themselves of this scheme.

Hill is insistent on the appeal and value of colour in the success of art therapy, and finds support for his ideas from Florence Nightingale, from whose "Notes on Nursing" he quotes; "Little as we know about the way in which we are affected by form,
by colour and light, we do know this, that they have an actual physical effect. Variety of form and brilli-
ancy of colour in the objects presented to patients is an actual means of recovery."

Visitors to Orsett Logge, in Essex, will find that Dr. L.Z. Cosin believes in this, as the policy of interior decoration carried out while he was the medical superintendent there is novel and extremely stimulating. Coloured ceilings for the wards were only one feature unusual in hospital wards, but his high percentage of ambulant patients lends some support to his policy.

I have already emphasized in Section V the impressions we gained of improved morale as a direct result of the introduction of bright coloured craft materials, and a closer study of the question of colour might provide interesting information.

Reference in occupational therapy textbooks to its use in cases of arthritis are found constantly, if on occasion they are a little sketchy, but its part as an essential in the treatment of advanced rheumatoid arthritis has been stressed again and again by a variety of medical writers, and in particular by Trevor Howell. (Ref. B.M.J. Dec. 11th, 1948, "Treatment of advanced rheumatoid arthritis"; Occupational therapy and rehabilitation, Dec. 1948, "Geriatric Rehabilitation"; Rheumatism, July 1949, "Chronic Rheumatic Disease in the elderly"; etc.)

In "Occupational Therapy and Rehabilitation" June 1940, and article by Gladys Pattee on "Home
Occupational Therapy" describes an interesting aspect of follow-up treatment practiced at the Mayo Clinic for arthritis and other cases. This article contains a valuable analysis of housework, grading domestic work according to its constituent movements, and providing a routine guide for afflicted housewives afflicted with arthritis that general practitioners might well utilise if it were brought to their notice.

A similar graded work-sheet was supplied for the use of spastics and patients with nerve injuries who were being treated at home, and in an earlier article in the same journal, in April 1937) the same author, writing again from the Mayo Clinic, refers also to the use of occupational therapy as "restful occupation" which was there considered the first item on a list of therapeutic measures for the treatment of chronic ulcerative colitis.

In 1929, Caroline N. Shaw, writing in "Occupational Therapy and Rehabilitation" from the Robert B. Brigham Hospital, Boston, advocated it in the treatment of arthritics because: (i) Craftwork can be made to produce every known movement of any joint in the body and thus helps to secure normal movement of joints limited by disease. (ii) It can be graded to any desired effect. (iii) It can be controlled.

In the same article, she refers to its use in the treatment of chronic nervous diseases, e.g., multiple sclerosis, in which it can improve co-ordination and help to arrest progress. This was confirmed
by our own experience with the Parkinsonian syndromes.

In "Occupational Therapy and Rehabilitation" in June 1943, Arthur L. Watkins, M.D., writing on "The Co-ordination of Physical Therapy and Occupational Therapy", with especial reference to rehabilitation after war injuries, says in connection with lesions of the C.N.S. that: "Occupational therapy is particularly helpful in obtaining synchronous movements of several joints and in developing skilful function." It is because of this feature that M.W. Warren advocates its inclusion in her routine for the treatment of hemiplegia and the results from this routine must convince all who adopt it of the efficiency of the policy she suggests.
SECTION VII. - SUMMARY.

The use of occupational therapy as the spearhead of an attack on the problem of the chronic and aged sick in the Oxford city area is described and reviewed after a year's trial.

Work with three groups of patients is reported in detail, and the response is analysed. The introductory section explains the conditions to which this experiment was applied, and there is a brief note on the working of the department itself.

Review of the literature has shown many references to the benefits of this form of therapy in all age groups and to its especial value in dealing with the aged.

The results fully justified our experiment. In addition to improvement in individual deformities, the effect on morale throughout the hospital was most marked, and the resulting bright and hopeful atmosphere was commented on by all visitors, both lay and medical. The nursing staff were in full approval, because they found in many instances that "difficult" patients put on occupational therapy became easier to handle; and the patients enjoyed it because the sense of achievement it gave them convinced them that they were no longer useless. This gave an impetus to their active co-operation in treatment from the medical and nursing staffs and the net result was a speedier return to an independent existence, either at home or within the confines of an institution.
It was also found that as a result of some 10 months of modern geriatric methods, the waiting list for chronic sick cases from the city area had no names on it, and that in spite of the fact that of the 250 beds available in the hospital, 150 had occupants who had been in hospital for one year or more. A proportion of these 150 were of course too far deteriorated mentally and physically to be rehabilitated sufficiently to allow of their ultimate discharge, but as they die in the course of months or years these beds will gradually become freed for the treatment of recent admissions who will respond to modern methods, and it is therefore my contention that, so far from requiring to build additional wards to house the chronic sick, as has been suggested, it should even become possible to use some of the present ward accommodation for other purposes.

It therefore seems reasonable to propose that no new building of hospital accommodation for the chronic and aged sick be embarked on until modern geriatric methods of treatment are being practiced widely throughout the country, and that all funds, materials, etc, thus freed should be devoted instead to the provision of more suitable accommodation for those aged and infirm who are not sick, who are increasing numerically, both in the population generally and as a result of geriatric rehabilitation.

The possibility of earning money through their occupational therapy was not missed by the patients, and in both Cowley Road Hospital and "The Laurels"
there were a few who organised it into an industry, buying their raw materials through the department but organising their own sales. The very high standard of their work, the result of continued supervision by the therapists, ensured a constant stream of orders and opened up new horizons for years of useful life ahead.

The fact that it was possible to keep the standard of work so high gives strength to the idea of running small industrial workshops in connection with long-stay hostels for the aged and infirm. In Birmingham, where sheltered jobs in factories are available to many older workers, an experiment is being tried of opening a workshop for the over 65's only, where they may work, at piece-rates, for as much or as little of the day as they feel inclined to. The tempo of the workshop will therefore be geared to the slower working rates of the men, but it is proving an economic proposition and it is an idea that might usefully be extended in other fields of industry.

Those of us who believe that the possibility of continuance in paid work after retirement age is for many an essential to their complete physical and mental well-being are also watching with interest the work being done at Cambridge under Professor Bartlett in research into the nature of skills. This fascinating study has already thrown some light on the forms taken by changes in acquired skill in the later decades of life, and much information of value and interest to employers, works managers, and others
may be expected to be forthcoming.

That America is ahead of us in recognition of the importance of activity of mind and body for the aged is shown by the policies of institutions there. The New York City Home for Dependents, Welfare Island, New York, sets a fine example in the application of the principle that "continuance of activity is one of the best means of preventing, postponing and immobilising senile decay" (Professor F.A.E. Crew, October, 1948). The existence in this institution of the post of Recreation Officer, and the close liaison of this officer with an active occupational therapy department has ensured the widest choice of activity for every inmate, and this has proved invaluable in helping newcomers to adjust themselves to institutional life, and also, indeed, to the biological changes that are old age.

Contrary to what was once believed, it is now obvious that older people can and do live a full and happy life if sheltered from the bustle of our modern world. Provided - and this is a point of vital importance - that they have easy access to their families and friends, and complete freedom of movement within and without the institution, they may even be happier than when actually living with the younger generation.

This suggests the provision of numerous hostels of varying sizes in most of the towns of this country, in order that the old people need not be removed from
the vicinity they know and like, and may remain
geographically accessible to their friends.

Blocks of suitable houses or flats in appropriate areas, with special modifications such as sunk baths, might be an even better system, although with the decrease in the sizes of families the danger of loneliness in old age is greater than ever before, and any scheme should aim at providing as much opportunity as possible for social contacts between the generations.

There is urgent need in this country for the provision of some communities for the aged, run in such a way that all stigmata of Public Assistance and the workhouse are removed, and where individuals are allowed privacy and space for their personal treasures. Institutions should be for both sexes (though the number of women requiring accommodation is greater than in the case of the men), and should be large enough to allow diversity of interests and activities among the inmates.

From an economic point of view, 30 is an admirable number for a small hostel, as this requires only the same staff as is required for less.

Once admitted to a home, the old person needs reassurance that they have indeed found a refuge for their remaining years, and where possible nursing care should be available but not obtrusive. If removal to hospital for treatment becomes necessary, there should be assurance that the place in the home or hostel will be available whenever the person is considered fit to return to it.
It seems at present that only immediate action in some of the directions indicated above can we hope to provide adequate care for the increasing proportion of aged in the community, and with advances in geriatrics and gerontology adding "not years to life, but life to years;" this growing section of the population can not only be prevented from becoming an intolerable burden, but can make its own marked contribution to the social and economic life of the community as a whole.
I must acknowledge with gratitude the interest of Dr. J. H. Spence, Senior Medical Officer to Cowley Road Hospital during the period of the year's trial, and my appreciation of the free hand he gave me in the matter of prescription of occupational therapy there. I am also grateful to Dr. Warin for permission to visit "The Laurels", and to Professor Witts of Oxford and to Professor Crew of Edinburgh for their advice on the choice of this subject for study.

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