

[HPY34(1)] Submitted 17-7-22 Accepted 5-9-22

Article

The development of a creative work rehabilitation organisation

Jonathan Leach

Retired lecturer, formerly Open University, UK

Peter Agulnik

Retired psychiatrist and psychotherapist, Oxford, UK

Neil Armstrong

University of Oxford, UK

Abstract

Work as therapy has a place in mental healthcare, but there is disagreement about how and why it might be helpful, and how best to conceptualise or represent those benefits. Over the last 50 years, occupational and industrial therapy sheltered workshops have been key elements in the provision of work activities in psychiatric settings, and community-based horticultural activities and creative craft work have offered additional approaches. Using archival material, interviews, witness seminars and personal reflections, this article charts the birth and initial growth of Restore, a charity providing creative work-based services in Oxfordshire between 1977 and 1988. Although Restore might be understood as a response to national trends in mental healthcare policy and research, its trajectory reflects local contingencies.

Keywords

Creativity, mental healthcare innovation, Michael Young, occupation, work rehabilitation

Contextualising the birth of Restore

At the time of writing (2022), Restore is a vibrant organisation, employing 40 staff members supported by 150 volunteers, working with around 850 people with mental health problems across 6 sites in Oxfordshire. On its website, Restore describes itself as:

... a mental health charity that supports people to take control of their recovery, develop skills, and lead meaningful lives. We offer recovery groups, training and employment coaching to make this possible ... we are part of a partnership of local mental health organisations with a commitment to helping people to recover, stay well and participate in and contribute to the life of our county. (Restore, 2021)

However, the origins of this organisation can be traced back 1977 with a handful of staff providing work activities in the form of a gardening group and a knitting group, both based at Littlemore Hospital, Oxford. Our material below shows a flexible iterative process, responsive to local needs and opportunities.

From small origins in rehabilitation practice based at Littlemore Hospital, Restore has grown and diversified with funding from both statutory and charitable sources. It is now integrated within a local provider consortium receiving a significant proportion of its funding

through the local Clinical Commissioning Group. The nature and development of Restore reflects changes in the wider social, economic and political climate of the era, strongly influenced, although not determined, by them. Rather than a series of planned developments, its growth can be interpreted as the result of creative responses to the local challenges and opportunities, sometimes the consequence of happenstantial encounters, that presented themselves over time, based on ideas about work and its potential benefits. This seemingly slightly haphazard, locally inflected history suggests that positioning an institution like Restore within the history of psychiatry is far from easy. Furthermore, uncertainty about how best to understand therapeutic work and a recognition that self-representation is part of the work of an institution further complicates the historian's task.

The valuing of work, or work-like activities, for people with mental health problems in the UK is typically linked to the York Retreat which opened in 1796. At The Retreat, work was seen as central to the care of the mentally unwell. It became known for its gentleness, which stood in stark contrast to the seemingly brutal regimes in the 'mad houses' at the time. The founder, Quaker tea merchant William Tuke, suggested: 'The judicious kindness of others appears generally to excite the gratitude and affection of the patient' (quoted in Shorter, 1997: 20). Borthwick et al. (2001) argue that the distinctive features of the Retreat owe more to Quaker thinking about the dignity of the person than to ideas about madness and its treatment: 'The essential elements of this environment were to be comfort, nurture, beauty, purpose and social responsibility. The Retreat had no new medical theories to propound, it was flying no ideological flags' (pp. 428–9). Staff at the Retreat relied on 'common-sense' and 'intuition,' creating what Borthwick and colleagues call 'an extended family' (p. 429). However, according to them, Tuke needed to 'justify, explain and publicise' the approach of The Retreat, and so he borrowed the phrase 'moral treatment' from Pinel as a scientific-sounding term (p. 429). Moral treatment was suggestive of a very different understanding of how work might lead to health, hinting at something requiring expert knowledge. A tension – that extends into the early history of Restore – exists between expert knowledge that might not adequately represent the benefits of work as therapy (but might be required to justify, explain and publicise it), and non-specialist humane instincts that better represent benefits of work as therapy but lack the capacity to authorise it.

Following the passing of the 1845 Lunatic Asylums Act, publicly-funded county asylums were built across England, many of which had extensive grounds and required the provision of catering, laundry, cleaning and other services for their growing populations of staff and patients. These hospitals, by their very scale at least, could not be run on the same

lines as the York Retreat. However, they did have the scope to provide work activities. In 1930 the UK's first occupational therapy training course was run at Dorset House in Bristol. In 1933 occupational therapy was being recommended as an institution-wide approach within mental hospitals (Hall, 2016: 319). However, it was not until the 1960s that occupational therapy (OT) became widely available within NHS mental health facilities (Mackay, Craik, Lim and Richards, 2014).

In the 1950s a number of psychiatric hospitals started to experiment with Industrial Therapy Units (ITUs), one influential instance being the unit set up by Donal Early in Bristol (Early and Magnus, 1968). By 1967, 100 out of 127 British psychiatric hospitals were running an ITU (Long, 2016: 341). Unlike OT, which embraced a range of craft and other creative activities, IT workshops tended to offer repetitive work such as sorting, assembling and packaging items on a contract basis for external commercial enterprises, and they aimed to replicate the sort of working conditions that would be found in mainstream industrial units; these were also sometimes referred to as 'Sheltered Workshops'. Outside the NHS, the 'Disabled Persons Employment Corporation' known as Remploy had been created by the British Government in 1945 to provide sheltered work for adults with a range of physical and mental disabilities (Edwards, 1958). The growth in the number of staff working in these areas was reflected in the creation of the British Institute of Industrial Therapy (BIIT) which registered as a charity in 1982, offering training and accreditation for practitioners. However, the following decades saw a shift away from segregated sheltered workshops in favour of greater integration of disabled people within mainstream employment settings; BIIT closed in 2004 and Remploy was no longer funded to provide sheltered workshops after 2013 (Leach, 2015: 128).

Despite the enthusiasm for Industrial Therapy in the decades after World War II, other more creative models of human occupation were available. In 1955 Botton Village was started in North Yorkshire, the first community for disabled adults provided by the Camphill Villages Trust, and inspired by the teachings of Rudolf Steiner. This community, which later provided the inspiration for Restore's founders, offered a range of activities such as: organic farming, horticulture and craft workshops, including a printing press (Camphill Trust, 2020). OT departments in psychiatric hospitals continued to offer craft and other creative activities to in-patients and out-patients as part of their recovery process (Thompson and Blair, 1998). The voluntary sector also started to play an increasing role in offering mental health services.

During the twentieth century, there was a steady expansion in the inpatient population, reaching a peak in England in 1954 when there were over 150,000 people

residing in mental hospitals. Given these numbers, it is not surprising that most of the provision for work facilities for people with mental health problems took place within hospital premises. This situation did not last, and the 1959 Mental Health Act emphasised the need to provide care outside hospitals and created expectations for local authorities to provide social work support in the community. The in-patient population started to decline at this time, but it was not until the 1980s that the most significant shifts from hospital to care in the community took place (Rogers and Pilgrim, 2001: ch. 9).

Community psychiatric nurses (CPNs) and subsequently community mental health teams (CMHTs) were established in the 1970s (Bartlett and Wright, 1999: ch. 12). Eventually many of the older asylums were closed down, to be replaced by smaller more modern units that co-existed with the community-based teams. The development of supported accommodation, including ‘group homes’, was significant in the move to community care (Hall, 2023). This shift in mental health policy and practice is likely to have facilitated the establishment of greater numbers of work therapy organisations based in the community rather than within hospital grounds (Long, 2016).

There are many ways of understanding the potential benefits of work for people experiencing mental health problems. As Hall (2016: 314) indicates:

... some form of regular and meaningful occupation for patients in English mental hospitals had been seen as central to their management, for at least three reasons: first, as a continuing legacy of the humanitarian ideals of moral treatment; second, since a pattern of regular daily activity was seen as conducive to less disturbed behaviour (not necessarily therapeutic); and, third, as the use of patient work in utility departments kept hospital costs down.

As Long (2016) describes so well, proponents of Industrial Therapy within psychiatric settings saw low-skilled routine work as being particularly suited to patients with long-term mental conditions. By contrast, other approaches emphasised the creation, or use, of different settings that would foster personal development and growth. In recent years these have been referred to as ‘enabling environments’ and ‘psychologically informed environments’ (Haigh et al., 2012), but they have their origins in the earlier ideas developed within social psychiatry and the therapeutic community movements (Manning, 1989). Two types of such potentially therapeutic environments were particularly relevant in the early days of Restore: craft workshops and gardens.

As already mentioned, there was an existing link between occupational therapy and craft work. In addition, ideas of the beneficial nature of hands-on craft work in small-scale settings, often contrasted with the dehumanising impact of factory or office work, were developed by William Morris and associates in Victorian times and are still valued today (Laws, 2011). Similarly, the opportunities that gardening offers for contact with nature and undertaking satisfying physical work, have often been seen as beneficial in restoring mental well-being (Howarth, Brett, Hardman and Maden, 2020; Stuart-Smith, 2020). Two years after Restore was established, the wider benefits of gardening for health were suggested by the creation of another charity that had a national focus.

Thrive began as the Society for Horticultural Therapy and Rural Training in Frome in 1979 ... Initially the organisation concentrated on supporting the people who were setting up and running specific outdoor projects and wanted to use the concept of horticultural therapy. It aimed to be a bridge between the world of horticulture and the world of health. In the mid-1980s the organisation widened its scope by offering services to individual disabled gardeners. (Thrive, 2020)

Neither craft workshops nor gardens are based on well understood mechanisms or pathways of effectiveness. They arise from the Zeitgeist more than emerging evidence. Non-specialist intuitions about beneficial activities, a healing physical environment and humane social and psychological environments guided the history of therapeutic work, from its inception and through the birth and development of Restore.

The founding of Restore

The conditions for the creation of Restore¹ (an acronym for Rehabilitation Services Trust for Oxfordshire Reemployment) had their origins in the changes initiated at Littlemore Hospital by Dr Bertram Mandelbrote, who in 1959 had been appointed Physician Superintendent there. His contribution to innovative developments in hospital and community psychiatry in the late twentieth century in Oxfordshire is extensively covered by an article in this issue by Millard et al. (2023).

The provision of work activities for patients at Littlemore Hospital was established practice for many years before and just following World War II. Many of these activities were on the wards, in the kitchens and laundries, or on the extensive hospital grounds, in order to keep the hospital functioning as a closed institution. A report to the hospital's

management committee, covering the period 1962–64, listed the following ‘work rehabilitation’ activities within the hospital grounds: building work, car wash units, wood-chopping for firewood sales. Further work groups operated outside the hospital: street cleansing, Post Office (GPO) telephone exchange maintenance, GPO pipe-laying, factory assembly work, seasonal contracts for land work with farmers and local authorities (Littlemore Hospital, 1964, unpublished). In an unpublished oral history interview, Mandelbrote (1995) talks enthusiastically about patients working in the community, and of the building of a hospital social club. Goddard (1996), in her book on an oral history project on Littlemore Hospital, has provided illustrations and accounts of patients being used as part of the work force. With growing concern about exploiting unpaid patient labour, and increasing unionisation, opportunities for such work diminished. Alternative forms of useful work emerged, such as the creation of a sheltered workshop, largely concerned with packing sterile supplies for the local general hospitals.

Following Mandelbrote’s arrival at Littlemore in 1959, the post of Work Rehabilitation Officer was created. This was initially filled by Helmut Leopoldt, a senior nurse, thus continuing a role he had fulfilled when working with Mandelbrote at the Horton Road Hospital in Gloucester (see Hall, 2023; Millard et al., 2023). As Leopoldt increasingly turned his attention to developing group homes, this post was filled by Oliver Carton, another nursing officer; links were made with specialist officers at the local employment exchange, and directly with local employers such as at the car factories in Cowley, with subsequent support for patients in their work settings. However, the economic situation in the 1970s made it increasingly difficult to find such opportunities.

As there was a dearth of any dedicated provision for the increasing number of discharged patients in the local community, many of them kept a link with the hospital by returning as day patients, some attending the OT department, and some the sheltered workshop. Occasionally it was possible to obtain contracts from community agencies, such as for sweeping the local roads or maintaining sites for the local Water Board. However, there were concerns, particularly concerning the sheltered workshop, about how well these activities met the needs of patients with a wide range of residual capacities and interests.

In addition, there was a group of patients, the majority of whom had severe and enduring mental health problems, who either required continuing hospitalisation or a return to the hospital from the growing network of group homes or other community settings (see Hall, 2023). This group undertook gardening work within the hospital grounds, supervised by

nursing staff on shift rotas drawn from ward settings. However, meeting the logistics of providing continuing horticultural expertise as well as caring supervision was problematic.

It is against this background context that Restore was founded in 1977. As described elsewhere (Armstrong and Agulnik, 2023), its origins can be found in the happenstantial meeting between the late twentieth-century social entrepreneur Michael Young (later ennobled as Lord Young of Dartington), and psychiatrist Peter Agulnik. In 1976 Agulnik held a post as assistant psychiatrist to Dr Mandelbrote, taking his day-to-day psychiatric responsibility for people with severe and enduring mental health problems in both ward and community settings. Young had a personal interest in finding appropriate support for his oldest son, who had significant mental health problems and required appropriate residential care (Briggs, 2001: 17). Mandelbrote had been approached because of the growing network of group homes and hostels established through the hospital service in conjunction with its League of Friends (Armstrong and Agulnik, 2020). This is discussed in detail by Hall (2023).

After a period of assessment in both hospital and community settings, which proved not well suited to his son's needs, a joint decision was made to explore the possibilities of the village community established by the Camphill Village Trust at Botton Hall in Yorkshire (Camphill Village Trust, 2022). This provided a model of care, in which villagers were tasked with work responsibilities commensurate with their abilities, however limited, which could be harnessed for the benefit of the community as a whole. Some residents developed craft skills in the creation of articles which were of such a quality that they had a commercial value and could be sold in the village shop. Similarly produce from the fields and gardens, when not used to feed the community, was also sold in the shop. While the residential option was, in the event, not pursued, the experience provided by this visit proved inspirational for Young and Agulnik, and it seemed possible that, with suitable restructuring, something analogous might develop from the rehabilitation services already established at Littlemore.

A key element in the discussions which followed the visit was a conceptual shift which emphasised the role of a participant and responsible 'worker' rather than that of a 'patient' or 'client' who required therapeutic help. The categories were not mutually exclusive. Rather, they provided a different frame of reference which involved a shift of emphasis from a medical model of disablement and pathology to one of enablement, the gaining of agency by utilising practical skills, and the conferring of role identity such as is indicated by the description 'nurse' or 'shop assistant' 'plumber', etc. The achievement of such a social role was facilitated by taking a semi-commercial approach. A product was made, a vegetable grown, and sold in the market place. It thus had a 'value'. The idea was

that the maker or grower could see the product's value and thus enhance his or her own sense of value and self-esteem; such an increase in self-esteem is likely to be therapeutic.

In summary, therefore, Botton Village provided the germ of an idea that was elaborated within the context of the structures created initially by Mandelbrote and informed by therapeutic community practice and a supportive regulatory culture by the extant Littlemore Hospital Management Committee. Staff from a number of professional disciplines had formed a Rehabilitation Liaison Group. This provided a management structure within which new ideas could be considered. It thus seemed as if the building blocks to establish a new type of service at Littlemore were already in place.

Michael Young's long-standing link with the Dartington Hall Trust provided the small amount of funding required for a feasibility study to develop a craft- and horticulturally-based venture. This proved sufficiently optimistic to pursue seed-funding from the hospital's own funds and matched charitable sources. It also seemed possible, provided that the right sort of structure was in place, to harness relevant voluntary skills available in the community. Young's expertise in establishing new social enterprises was of huge value. At that time legislation prevented hospital management committees having direct access to charitable funds, and so an independent charitable company limited by guarantee was formed in 1977. The acronym Restore itself was inspirational, in that it linked the concept of Rehabilitation and Recovery with the idea of the Store as a shop, but also the accumulation of a skills base, and the notion of restoration towards health.

Like many other projects starting in that era, this was essentially a professionally-led initiative. There was some measure of consultation with users of the OT department, but at that time there was no active service user movement in Oxford which could have commented on the proposals. This is in contrast to experimental approaches elsewhere at that time, such as the Glasgow Association for Mental Health (GAMH) which arose from a close collaboration between the voluntary sector and current and former mental patients. GAMH enabled service users and survivors to come together in a social space for mutual support and to campaign against injustices in the psychiatric system (Gallagher, 2018).

In the initial stages of Restore, the number of trustees was kept deliberately small until there was a clearer idea about the direction the new company would take. Young and Agulnik were joined by Oliver Carton, the work rehabilitation officer. The post of a part-time Director was advertised and was filled in October 1977 by Paul Fletcher who had recently retired as secretary to the National Film Finance Corporation. He had no background in mental health, but, as an old friend of Michael Young, had an interest in the project, as well as in crafts, and

had the necessary administrative experiences to take it forward. An unused former staff house on the main hospital estate was made available as a base for the new venture.

Restore described its aims as being:

...to further the rehabilitation of the mentally ill in the Oxford area, and to find the right kind of work to make the most of their latent abilities, and in so doing to regain their self-esteem and recover their independence. (Mission statement, n.d., Restore archives)

Early years

On his appointment, Paul Fletcher set about exploring the ways of implementing the recommendations of the feasibility study. This required making relationships with the members of the Liaison group and a range of staff members already involved with existing work groups on different parts of the hospital campus. The hope that the project could be aided by making use of untapped potential in the community was considerably realised when Sarah Platt, a local resident, with a substantial relevant background in craft work joined Fletcher as a volunteer about six months after he started. Recruited by the Voluntary Services Organiser for Oxford City Council, she described how she overcame her initial alarm and anxiety on first encountering the strange new hospital environment. ‘What I found already established was a small group of elderly long stay women knitters who were all “in patients” of the McKnight Unit, and already known as “The McKnitters”, and a Garden Group.’ (Platt, 1983, unpublished). One of the earliest developments within Restore, during 1977, was a continuation of an original ward-based gardening group. Gardening has long been seen as an effective form of therapy for all sorts of health problems, and this group had some promising ingredients, the main one being an infectious enthusiastic and energetic charge nurse.

The group at Littlemore consisted entirely of men. It was based at the bottom of the hospital on what seemed to be a huge amount of land, probably 3 acres or so, which the old charge nurse, Arthur, was very proud of. He was a keen amateur gardener. And the project was basically working with a group of people who were either inpatients or who were coming from various places in the community travelling to Littlemore Hospital to be part of this work activity programme. (Former staff member A, unpublished interview, 2018)

Sarah Platt described how this initiative developed in 1978 with help from the charity Horticultural Therapy, the forerunner of 'Thrive' which found a full time volunteer who assisted Restore in planning and implementing their vegetable- and flower-growing project. This added the necessary technical knowledge to the enthusiasm of the staff who were responsible for the group. Platt's involvement demonstrated at an early stage how volunteer resources in the community could be harnessed to the experience of mental health trained staff in creating and maintaining a viable project. The nature of the work enabled a flexible approach to rehabilitation.

It was trying to help people use their talents and each group offered a very different influence on the way that people worked. [In] the Littlemore group which operated at the back of the hospital on the allotment site ... there was a relatively slow process ... there was lots of interaction, but you could choose to have as much interaction or not with people in the way that you worked within the garden group. You could dig alongside somebody and they'd talk or they wouldn't talk. (Former Community Psychiatric Nurse, unpublished interview, 2018)

The transition to community settings

The feasibility study had indicated that there were some patients returning to the hospital and utilising the woodworking section of the OT department at Littlemore, who seemed to have the basic skills to be able to apply these to make saleable goods. The Cowley Community Centre was approached, which offered the use of a well-equipped woodworking department that was only used for evening classes, and not in the day.

Platt (1983, unpublished) wrote:

In July 1978 we started the group with six men, some Danish DIY books of Paul's and a great many ideas. We started by making garden furniture and various forms of shelving. We had no money to employ anyone to run the group ourselves, but managed to persuade the hospital to lend us one of their Community Service Volunteers, who was then offered a post as an Occupational therapy aide seconded to Restore, so we were able to guarantee the full-time supervision which was essential.

This was the first venture into the community, and further demonstrated that there were untapped resources in the community, if only ways could be found to capture them.

Another skill already demonstrated in the OT department was screen printing. It fitted in well with another core idea: finding craft-based and aesthetically pleasing work, which could be broken into relatively simple component parts, but required expertise to bring them together to build a potentially saleable object. Screen printing was therefore identified as the third activity on which to concentrate.

In 1978 there was high unemployment in the country, and the then Manpower Services Commission had created their Special Temporary Employment Programme known as STEP. Its introduction could not have been more timely, enabling Restore to employ qualified instructors for each of the three groups, as well as an assistant to help to administer the programme. With this input, a screen-printing group was formed, initially using vacant space at the hospital and then moving to a house adjacent to the Warneford Hospital previously used for medical staff. The use of space on hospital property which was no longer necessary for clinical or other purposes was to prove a major factor in enabling Restore to become established.

In conjunction with already existing local endeavours, needlework groups were set up in West and North Oxfordshire. Although relatively short-lasting, this demonstrated the ability of Restore to look beyond the confines of the hospital. At Littlemore Hospital the horticulture group's activities were supplemented by cement casting of garden ornaments and by a new sewing group. A shop was opened near to the hospital's entrance to sell Restore's products. So by the end of its second year in 1979, the organisation was operating in both hospital and community settings and provided full-time places for around 60 patients, with half of them working on the garden project at Littlemore.

Restore's base at Station Lodge, Littlemore, provides an example of the gradual transition of Restore from a hospital- to a community-based project. Its garden was converted into a market garden and its produce was sold to the public from a barrow at the hospital gates. In September 1979 a shop was established where the new woodwork and screen-printed articles were showcased and sold. This new visibility also encouraged a closer working relationship with nurses and other NHS staff. It contributed to the formation of a Rehabilitation Department which provided support, not only to those with severe and enduring illnesses, but also the acute admission units. The former role of work rehabilitation officer was expanded to form an employment team, where specialist nursing staff made links with past and potential employers, to support people on return to work, or find new possibilities for them by working with local employment offices. This team became the main source of referral and ongoing support for the service users at Restore.

The STEP programme meant that those initial ideas, hatched as a sort of pipe dream in a long car journey to Yorkshire and back, were in fact viable. The new service provided a structure and a pathway for staff as well as patients to exercise their skills. STEP was, however, only for short-term funding. By the time it came to an end, after 15 months, Restore was providing sheltered work places for 50–60 patients. Half of them were on the garden projects at Littlemore, the rest divided between screen printing and woodwork.

STEP had proved vital in demonstrating the viability of the project, but sustaining this progress was problematic. Platt (1983, unpublished), reporting her experience at that time, wrote:

Funding since then has been an eleventh hour, hand to mouth affair. It's hard work, dispiriting, and diverts energies away from the projects themselves. Since the end of the STEP scheme the Health Authority has provided about half our essential core funding costs, and they do help us in many other ways such as with premises, heating and lighting and office costs.

Platt noted that at that time, although the projects were able to generate some income from the sale of goods and produce, they could never meet the staff costs, so charitable funding had to be used to bridge the deficit. Although the funding arrangements through the statutory services gradually changed over the years as different structures and systems were introduced, Restore remained considerably dependent on charitable funding for its survival.

Chance operating in a particular context – which in this Special Issue we call ‘happenstance’ – played its part. Like many of the old psychiatric hospitals, Littlemore Hospital was sited at a distance from the city centre and had its own institutional life largely divorced from the rest of the city. The Cowley Road Hospital had relocated its geriatric services to the Churchill Hospital. An old Poor Law workhouse, it was sited in East Oxford, an ethnically and economically diverse inner-city area containing many shops, restaurants and small businesses as well as residential properties. Although the main buildings were demolished, the Health Authority decided to retain the more recently-built Day Hospital and offer it to the new and expanding psychogeriatric service, for which it was ideal as a community base. At the time, that service could not foresee being able to use the whole building, and so in 1980 a joint bid with the Department of the Psychiatry of Old Age was successfully put forward; shortly afterwards, Restore was able to move its shop, woodwork

and printing groups into one wing of the Day Hospital, and also to start a small horticultural project on that site which later became known as Manzil Way.

The original small management committee needed a wider base to reflect the increased community involvement. Michael Young, as was usual for him, remained on the Council of Management only for a short time. In the early years it seemed important to have all the major local charitable organisations concerned with mental health, such as Oxford Mind and the National Schizophrenia Fellowship (later Rethink), represented on the Board to facilitate cooperation, and indeed this remained the case for many years. Later it was to emerge, because of the way funding came via the statutory authorities, that conflicts of interest could arise. Nevertheless, the principle of close cooperation between the relevant agencies was maintained over the years.

Developing the service

Paul Fletcher had died in 1980 and Sarah Platt was appointed as Restore's second Director. Around this time, the project increased the availability of its products as Oxford's 'Blind and Handicapped' Shop started selling them and the Oxford MIND shop displayed a selection of the goods produced. There was a strong emphasis on producing goods of a saleable quality, and this influenced the type of people on the staff. Supervisors were recruited as much for their design and craft skills as for their ability to work sensitively with vulnerable adults.

Staff were ... we were not clinically trained and that surprised me when I turned up. And I thought these people are craft supervisors, they are not psychiatric nurses.... but are doing a job with other people. So this strange dichotomy of what Restore was all about which was quite hard to make head space for ... (Former staff member B, unpublished witness seminar, 2018)

By now, the quality of the goods produced by Restore was becoming known, and further sales outlets were found as Restore cards were sold in some local bookshops. At this stage there was a strong focus on productive work. When Restore was initially established, the convention whereby patients who undertook work at the hospital were paid token sums of around £2 per week as an incentive or reward payment had been extended to Restore. The emphasis on Restore as a work place was clear:

All our referrals are registered as day patients at the hospital... The working hours are from 9 till 4 five days a week with an hour for lunch. The atmosphere is as much as possible that of a realistic workshop with an insistence on regular time-keeping and an ability to produce work of a consistent and saleable quality. We offer no nursing cover on the premises, no therapy other than the work itself and we expect people to get themselves to and from the workshops. (Platt, 1983, unpublished)

However, as Restore became independent and, with changes consequent to the introduction of NHS trusts, these payments ceased.

This was a time of renewed interest among the wider population in arts and crafts (Peach, 2012) and in the benefits of getting ‘back to the land’ in terms of producing or consuming locally grown fruit, flowers and vegetables (Halfacree, 2006). These cultural trends not only meant that there was a market for craft items and horticultural produce, it also imparted a certain social value to working in these areas of occupation.

In 1982, Restore still had offices and a gardening group at Littlemore Hospital. However, all other work groups were now based at the Cowley Road site. In 1983 a new Manpower Service Commission’s (MSC) Community Programme enabled Restore to take on additional staff which enabled the establishment of a garden group at Oxford’s other psychiatric hospital, the Warneford. The MSC programme also provided a staff member to work with the residents of a group home in Littlemore village to form another garden group. Additional land was fenced in at the Cowley Road site for another horticulture project which started growing shrubs and other garden plants for sale directly to the public, and this became known as the ‘Town Gardens’ nursery in 1987.

The Restore shop at Cowley Road was now the main outlet for the sale of all the goods produced by the various work groups.

The external image of Restore in those days was really very positive. The fact that it was producing these extraordinary and extremely well-designed high-quality products from screen printed to wooden, gardening products and plants etc. and felt that this presented a fantastic image to the community. It was a really important way of changing people’s attitudes to what mental health was or wasn’t. The reality when I came to Restore was that it was a very supportive, nurturing sort of place where people were being encouraged to use their skills and develop new skills. (Former staff member C, unpublished interview, 2018)

Those involved in running Restore believed that the quality of the products was important, not just for achieving sales, but also as part of breaking the stigma around mental ill-health, by showing that people with mental health problems were capable of producing creative and attractive items. In addition to shop sales, Restore's hand-printed cards reached a wider market as a major bookshop in the city starting selling them. The Cowley Road site created a retail environment in which members of the public would feel welcome and which did not have the atmosphere of a mental health facility.

What was important about the Town Gardens project was that it was very much like the high-quality printing and woodwork in the shop, it was about very high-quality products. We weren't growing cuttings in yoghurt pots; we bought proper industry standard pots to sell things in. We went to proper commercial horticultural suppliers for all our supplies and equipment. So if you came into Town Gardens the impression was as good as if you went into a Garden Centre. Plants would be in the same sort of containers, they'd be looked after well, and they'd be carefully labelled up ... There was a real sense of doing a good job and it being as good as anything else that was out there. (Former staff member D, unpublished interview, 2018)

The local context of mental health care at that time reflected the UK national policy of moving from hospital to community-based care for patients with long-term needs. As Peter Barham (1992) and others have pointed out, the implementation of this policy was not always well thought out or sufficiently funded. Furthermore, former patients could find themselves in a strange limbo situation where they no longer had the identity of a patient nor were they fully accepted as members of the communities in which they were now living. Being part of an organisation like Restore could be seen as a partial solution to this situation.

In the latter part of the 1980s work started on closing the old Littlemore Asylum while a more modern facility for a smaller number of inpatients was developed nearby. A team of Community Psychiatric Nurses (CPNs), focusing on employment and activity needs, was created by the hospital's senior nursing team. These CPNs were the main source of referral and ongoing key worker support for the service users at Restore.

We worked with some fairly simple rules. One was that life events are a big issue for people, so it's not a good idea to change your job and where you live at the same time.

When people came out of hospital they would be looking for somewhere to live and a new activity – so we encouraged people to start one and then make the other change ... That was influenced by the way therapeutic communities worked, there was a tolerance of the way people behaved, an expectation that you understood their part in the process and worked with them at their rate. For me it was about working alongside people and what they wanted to do in the future and whether this was step along the way, whether that was Restore or one of the other groups. (Former Community Psychiatric Nurse, unpublished interview, 2018)

The above participant had worked on the Phoenix Unit, run as a therapeutic community, and his comment reflects the legacy of that experience. The CPNs' role in supporting referrals enabled the work supervisors to concentrate on providing work skills training and supervision of work tasks, knowing that any mental health issues would be dealt with by the specialist nurses.

In 1985 Sarah Platt moved from Oxfordshire. Rosie Hallam, the deputy head occupational therapist at the Warneford Hospital, was appointed the third director of Restore, combining both personal skills and interests in craft and design with operational experience within the NHS. By now Restore had four work groups (printing, woodwork, horticulture and retail) based in the community, and the vast majority of referrals were people who had been hospital inpatients and who were moving back into the community. This meant that, in its early days, many of the organisation's service users were people diagnosed with severe and enduring mental health problems and as a result might have been expected to require the support of Restore for many years.

There wasn't that much emphasis on throughput ... and [it] seemed that a lot of people there were seriously institutionalised in the first few years I was here. And I couldn't imagine ... them going on to the sunlit uplands and, you know, being a productive member of society but I kind of knew that this was probably the best thing they were going to have ... (Former staff member E, unpublished witness seminar, 2018)

The nature of Restore's funding at this time, largely provided by the local mental healthcare trust, and supplemented by the sales of products, meant that the emphasis was on the provision of places within workgroups rather than tied to specific outcomes, such as supporting service users into open employment.

The continuing need to raise funds led to public events at Manzil Way. Again, by happenstance, at one of these events in the summer of 1988, the Oxford Morris Men were part of the entertainment, and their leader was also secretary of the Elder Stubbs Allotment Association in Cowley. It emerged that there were a number of plots which were not being taken up by local residents, and these were offered to Restore at a peppercorn rent of one rose each year! The entire horticultural project at Littlemore was able to close and horticultural activities transferred to the new site in 1989. This really was opening out to the whole community in a very visible way, and marked the beginning of the end for reliance on the institutional environment of the hospital.

Towards the end of the 1980s, Restore had a well-established range of work groups and was attracting visitors from all around the country and beyond, many of whom were interested in setting up similar projects in their areas. Although there was not much of a focus on helping service users to move on to other activities at that time, there was an appreciation of the difference that such a project could make to people's lives.

... one of the key messages we always worked with [was] ... the idea that people existed beyond their current presenting difficulties and diagnosis. We would look at what people could do rather than what people couldn't do... Right from the start it always seemed to be quite an empowering environment. (Former staff member A, unpublished interview, 2018)

Other writers, e.g. Barham (1992: ch. 2), Long (2013: 746) and Perski, Wilton and Evans (2020), have commented on service users' ambivalent attitudes towards work schemes. Some felt exploited by the very low rates of remuneration offered, while the often repetitive and low-skilled nature of the work in industrial workshops was also a cause of dissatisfaction. On the positive side, it was recognised that such schemes offered social contact, a weekly routine and somewhere to go outside the home. Restore's staff believed that encouraging services users to engage in productive activities alongside other people helped them in their recovery from mental health problems.

... the way to view it is that activity is as good as talking therapy. It is another form of therapy; it is working with your hands and looking into the future when you're planting things or doing something which will be an end product and will be sold. And that works in a different way to talking therapy, but it does work in terms of self-esteem,

worth and confidence. It doesn't work for everybody. I know some people need to talk as well as work. But we can do both, we can talk to someone for 10–15 minutes when they are in crisis, we can't support them for an hour otherwise the group feels let down; because that's the dynamic of the group. They feel supported in the group as well as well as an individual. (Former staff member F, unpublished interview, 2017)

Continuing involvement with the government's 'Community Programme', started in 1983, had allowed Restore to recruit temporary staff from the local unemployed population to support the work of the various group supervisors. However, the organisation was also facing a period of uncertainty while the local health authority commissioned a Mental Health Consultative Document on the funding and provision of local services. Fortunately, it was decided that Restore could stay on the Cowley Road site and would eventually be allowed to take over the other half of the building when services for the elderly relocated. Less fortunately, the Community Programme came to an end in 1988, resulting in a 50 per cent drop in staffing for Restore's activities. These and subsequent changes to funding structures inevitably created challenges, which are beyond the scope of this article.

Discussion

While the birth and maturation of Restore as an innovative mental health service could be attributed to the vision of its founders and the efforts of those in its employ, it is also contingent on favourable social, cultural, economic and political factors being in place. A newly-planted seed needs fertile soil if it is to grow and flourish. The shift to community care for mental health, the rediscovered attraction of small-scale arts and crafts and ideas of getting 'back to the land' all provided the context for Restore to establish itself in the local community.

When Restore started in 1977, most of the support and treatment provided for people in the UK with severe and enduring mental health problems was hospital-based. However, national policy on mental health provision was changing. Enoch Powell's famous 'water tower' speech, made when he was Minister for Health in 1961, marked the government's intention to reduce the number of hospital beds with a corresponding increase in community-based services (Powell, 1961). In practice, the closure of the old 'asylums' only began in earnest in the 1970s, and the process continued over the next two decades (Bartlett and Wright, 1999: ch. 11).

Restore's fairly rapid move from the Littlemore Hospital to community settings can be understood as an instance of a general trend towards 'community care' supported by government policy which was gradually, if unevenly, put into effect across the UK. However, such an account should not understate the role of local actors and local contingencies. The paper by Millard et al. (2023) in this issue describes how alternatives to hospital care are more loosely related to central governmental initiatives than might appear at first glance. In Oxford, Bertram Mandelbrote, created a humane environment within the hospital, and forged links with external organisations. It was this open, entrepreneurial environment that facilitated the creation of Restore. The shift from ward-based treatments to community care might be understood as part of the *Zeitgeist*, a change in the imagination widespread at the time and critical for those working in mental healthcare described above. Similarly, the all-important issue of how patients occupied themselves during the day, and could come to lead meaningful lives, became a central concern, paralleling the resettlement of patients into community settings. The establishment of a community mental health service over this period was a critical precondition, because service users could receive medical treatment while attending activities based in the community. The support provided by the practitioners in these teams enabled work supervisors to offer a non-clinical service to their service users, knowing they could call on their specialist knowledge and skills if needed.

In this sense, Restore reflected, or perhaps was even in the vanguard of, wider changes in society, related to how people with severe mental health problems were viewed in terms of their potential. However, there is a risk here of taking at face value attempts to represent institutions in ways that made them appear timely. Just as Tuke redescribed The Retreat as offering moral treatment when he needed to publicise its work and seek funding, it is right to be cautious about any single characterisation of Restore or to make any definitive or exhaustive claims about its intellectual antecedents. Rather than just being the outcome of planning, or the implementation of ideas or findings from research, Restore's early history is iterative and messy, involving chance events, creativity and flexibility. This untidy history may not help Restore to authorise its work, or attract funding, but, we suggest, it might explain the close fit between local need and Restore.

The history of Restore suggests that people other than qualified mental health professionals, e.g. those employed as woodwork, printing and horticultural instructors/team leaders, could play a role in supporting recovery from mental health problems. This represents a break from previous biomedically dominated practice where work groups were more likely to be supervised by mental health nurses. This way of working also offers a

different paradigm on mental health. Rather than relying solely on psychiatric or psychotherapeutic practices, organisations such as Restore have demonstrated the benefits of social support for positive mental health, and offer the possibility of building a more positive social identity: that of a worker rather than a mental health patient (Leach, 2015: ch. 6).

Jennifer Laws has explored tensions in the mental health system between different conceptions of work. These recurring tensions are: ‘between economically viable employment and specifically “therapeutic” occupations’; ‘between the competing requirements of protectionism and reality’; ‘between works undertaken by the mass public and the golden work of a pre-industrial age’; ‘does the patient get better through doing work or through the rewards of work (whether esteem or financial compensation) ...?’ (Laws, 2011: 78). Restore, certainly during the first decade of its existence, can be seen to have favoured therapeutic work, a fair degree of protectionism, work redolent of a pre-industrial age and work activities that help the person feel better. Although more recently the nature of many mental health work rehabilitation services has moved away from the positions described above, there is ongoing interest in, and recognition of, the mental health benefits of gardening, nature conservation work and more generally the impact of spending time outdoors in contact with nature (Bragg and Atkins, 2016; Jones, 2020).

In a similar way to which certain landscapes are felt to be therapeutic, a well-run craft workshop can also offer what some writers have described as a therapeutic ‘taskscape’. Smith (2019: 7) describes one such taskscape, a woodworking workshop in Edinburgh that ‘transcends material practices of woodwork, extending to the skilful everyday management of positive social dynamics’. This is a very apt description of what Restore was attempting to put into practice: a dynamic interplay of practical work, beneficial social interactions and sensitive supervision.

While continuing to offer social support, horticultural and some craft activities, Restore went on to develop services targeted at supporting clients into voluntary work, further education and mainstream employment, a move partly driven by the requirements of funders to demonstrate employment-oriented outcomes. By contrast, during the historical period under consideration, Restore was in the fortunate position of being able to offer a therapeutic working environment largely free of external bureaucratic demands for ‘hard outcomes’.

Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Note

1. The authors were given access to the uncatalogued archives of the organisation Restore; these included annual reports, other reports, a time-line of significant events, newspaper cuttings, photos and written personal accounts. In addition, individual oral history interviews with past staff members were audio-recorded and two witness seminars involving former staff were held. The resulting recordings were transcribed, and extracts have been used alongside the documentary evidence to build a rich account of the early years in the life of the organisation. A limitation of the paper is that the interviews and witness seminars were restricted to staff members. We did not speak to service users. Two of the authors were also able to draw upon their personal experiences of past involvement with the organisation and thus inform the content of this article. Peter Agulnik was co-founder of Restore and Chair of the Trustees for many years. Jonathan Leach worked at Restore from 1987 to 1997, initially as a Horticultural Supervisor before taking on the role of Training and Development Worker.

References

(a) Unpublished

Oxfordshire History Centre, Cowley, Oxford:

Littlemore Hospital (1964) The Littlemore Group of Hospitals: Tenth Report to the Management Committee 1962–1964.

Planned Environment Therapy archives, Witney:

Mandelbrote B (1995) Oral history interview with Craig Fees, 24 May; recording, Mulberry Bush TC Voices/138.

Restore archives, Oxford:

Platt S (1983) Restore; typewritten document.

Restore (undated) Mission Statement.

For other documents, see Note 1.

(b) Publications

- Armstrong N and Agulnik P (2020) ‘I was at the right place in the right time’: the neglected role of happenstance in the lives of people and institutions. *HAU: Journal of Ethnographic Theory* 10(3): 890–905.
- Armstrong N and Agulnik P (2023) Happenstance and regulatory culture: the evolution of innovative community mental health services in Oxfordshire in the late twentieth century. *History of Psychiatry* 34(1): xx-yy.
- Barham P (1992) *Closing the Asylum: The Mental Patient in Modern Society*. London: Penguin.
- Bartlett P and Wright D (eds) (1999) *Outside the Walls of the Asylum: The History of Care in the Community 1750–2000*. London: Athlone Press.
- Borthwick A, Holman C, Kennard D, McFetridge M, Messruther K and Wilkes J (2001) The relevance of moral treatment to contemporary mental health care. *Journal of Mental Health* 10(4): 427–439.
- Bragg R and Atkins G (2016) A review of nature-based interventions for mental health care. Natural England Commissioned Reports, Number 204; accessed (3 May 2022) at: <http://publications.naturalengland.org.uk/publication/4513819616346112>
- Briggs A (2001) *Michael Young: Social Entrepreneur*. Basingstoke: Palgrave Macmillan.
- Camphill Village Trust (2020) Our history; accessed (2 July 2020) at: <https://www.camphillvillagetrust.org.uk/about-us/our-history/>
- Camphill Village Trust (2022) Botton Village; accessed (5 Apr. 2022) at: <https://www.camphillvillagetrust.org.uk/locations/botton-village/>
- Early DF and Magnus RV (1968) Industrial Therapy Organization (Bristol) 1960–65. *British Journal of Psychiatry* 114: 335–336.
- Edwards J (1958) Remploy: an experiment in sheltered employment for the severely disabled in Great Britain. *International Labour Review* (No. 77): 147.
- Gallagher M (2018) From associations to action: mental health and the patient politics of subsidiarity in Scotland. *Palgrave Communications* 4(1): 1–11.
- Goddard J (1996) *Mixed Feelings: Littlemore Hospital – An Oral History Project*. Oxford: Oxfordshire County Council.
- Haigh R, Harrison T, Johnson R, Paget S and Williams S (2012) Psychologically informed environments and the “Enabling Environments” initiative. *Housing Care and Support*. 15(1): 34–42.

- Halfacree K (2006) From dropping out to leading on? British counter-cultural back-to-the-land in a changing rurality. *Progress in Human Geography* 30(3): 309–336.
- Hall J (2016) From work and occupation to occupational therapy: the policies of professionalisation in English mental hospitals from 1919 to 1959. In: Ernst W (ed.) *Work, Psychiatry and Society, c.1750–2015*. Manchester: Manchester University Press, 314–333.
- Hall J (2023) The development of supported mental health accommodation and community psychiatric nursing in Oxfordshire. *History of Psychiatry* 34(1): cc-dd.
- Howarth M, Brett A, Hardman M and Maden M (2020) What is the evidence for the impact of gardens and gardening on health and well-being: a scoping review and evidence-based logic model to guide healthcare strategy decision making on the use of gardening approaches as a social prescription. *British Medical Journal Open*, 10(7): p.e036923.
- Jones L (2020) *Losing Eden: Why Our Minds Need the Wild*. London: Penguin.
- Laws J (2011) Crackpots and basket-cases: a history of therapeutic work and occupation. *History of the Human Sciences* 24(2): 65–81.
- Leach J (2015) *Improving Mental Health through Social Support: Building Positive and Empowering Relationships*. London: Jessica Kingsley.
- Long V (2013) Rethinking post-war mental health care: industrial therapy and the chronic mental patient in Britain. *Social History of Medicine* 26(4): 738–758.
- Long V (2016) Work is therapy? The function of employment in British psychiatric care after 1959 In: Ernst W (ed.) *Work, Psychiatry and Society, c.1750–2015*. Manchester: Manchester University Press, 351–367.
- Manning N (1989) *The Therapeutic Community Movement: Charisma and Routinization*. London: Routledge.
- McKay E, Craik C, Lim K and Richards G (2014) *Advancing Occupational Therapy in Mental Health Practice*. London: John Wiley & Sons
- Millard D et al. (2023) Innovation in mental health care: Bertram Mandelbrote, the Phoenix Unit and the therapeutic community approach. *History of Psychiatry* 34(1): aa-bb.
- Peach A (2012) Crafting revivals? An investigation into the craft revival of the 1970s: can contemporary comparisons be drawn? In: MacDonald J and Rossi C, Ideas of the handmade: histories and theories of making, 46–56; accessed (5 May 2022) at: http://www.research.ed.ac.uk/portal/files/10770782/final_craftscotland1_1_.pdf

- Perski M, Wilton R and Evans J (2020) An ambivalent atmosphere: employment training programs and mental health recovery. *Health & Place* 62 doi: 10.1016/j.healthplace.2019.102266
- Powell E (1961) Mental Hospitals of the Future', opening address to National Association of Mental Health conference, 9 March 1961. In: NAMH, *Emerging Patterns for the Mental Health Services and the Public*. London: NAMH, 5–10.
- Restore (2021) About Restore; accessed (31 Mar. 2021) at: <https://www.restore.org.uk/about-restore>
- Rogers A and Pilgrim D (2001) *Mental Health Policy in Britain*. Basingstoke: Palgrave Macmillan.
- Shorter E (1997) *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*. New York and Chichester: Wiley.
- Smith T (2019) Therapeutic taskscapes and craft geography: cultivating well-being and atmospheres of recovery in the workshop. *Social & Cultural Geography*; doi: 10.1080/14649365.2018.1562088
- Stuart-Smith S (2020) *The Well-Gardened Mind: The Restorative Power of Nature*. London: Harper Collins.
- Thompson M and Blair S (1998) Creative arts in occupational therapy: ancient history or contemporary practise? *Occupational Therapy International* 5(1): 48–64.
- Thrive (2020) Our history; accessed (7 Oct. 2020) at: <https://www.thrive.org.uk/how-we-help/what-we-do/about-us/our-history>