The Casson Memorial Lecture 1998: Occupation for Health – and Wealth?

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The Casson Memorial Lecture 1998, given on 26 June at the 22nd Annual Conference of the College of Occupational Therapists, held at the University of Ulster.

Introduction

I am greatly honoured to have been invited to deliver the Elizabeth Casson Memorial Lecture this year. When I was a young therapist, the lecture was traditionally presented by someone outside our profession, often eminent supporters from the medical profession or others who had guided our development. When we 'came of age' and the Council of the College of Occupational Therapists decided that the lecture should be presented by an occupational therapist, I thought that this was rather a nice honour to bestow on the doyens of the profession. Today, I feel that I have been elevated somewhat prematurely(!), but I thank Council sincerely for its gesture of faith.

Since adopting an annual theme to underpin its activities, which culminate in the annual conference, Council has shown remarkable foresight in choosing themes, usually 2 years in advance, which have proved to be right for the time. And so its choice of 'Occupation for Health' is timely as our new Government shifts its public health focus from *The Health of the Nation* to *Our Healthier Nation* (Secretary of State for Health 1992, 1998). Tackling poverty and social exclusion are once again being addressed in this country. How apposite this is as we pay tribute today to Dr Elizabeth Casson, a woman of great vision and commitment who founded Dorset House, the first school of occupational therapy in England.

As a young woman, Elizabeth Casson went to work with Octavia Hill in a pioneering housing management experiment in Paddington. Inspired by a deep religious faith, she was greatly influenced by what she observed around her: poverty, misery and ill-health, delinquency and the evils of unemployment and idleness. Motivated then to become a doctor, Elizabeth Casson became the first woman to gain the degree of Doctor of Medicine of the University of Bristol in 1919. When she became a psychiatrist, the state of idleness of the patients in mental hospitals appalled her and so, in 1925, she embarked on a journey to the USA to see and assess for herself the potential of the newly established profession of occupational therapy.

Elizabeth Casson purchased a large house in Bristol where she established a residential clinic and the school of occupational therapy under the leadership of Mary Macdonald. Driven out of Bristol by the War, Dorset House moved to Bromsgrove and then to Oxford. I think she would be proud to know that it is now an integral part of the thriving Oxford Brookes University, and that its staff are contributing in many ways to sharing their philosophy and knowledge with colleagues in other fields of academic endeavour.

Occupation for health – and wealth?

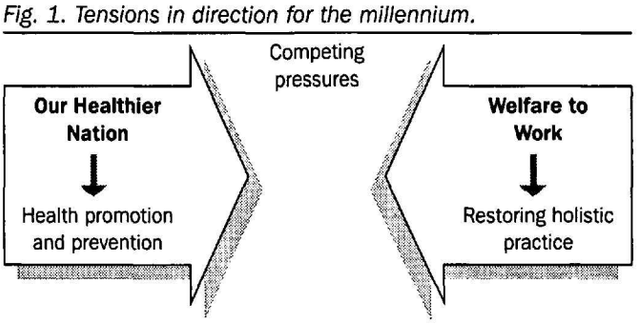
In reading articles written by Elizabeth Casson, I was moved by her descriptions of patients' needs and her conviction that *occupation* was central to health and wellbeing. In choosing a title for this lecture, I wanted to use the College's theme of 'Occupation for Health' but also to capture something of the unique spirit of Elizabeth Casson. An article written in 1953 about the treatment of mentally ill people determined my final choice:

> ... the gap between discharge and full employment is likely to be narrowed if the patient feels that he is as capable of a full and efficient day's work as he was before his illness ... a recovered patient should, if possible, arrive at a fuller personality after his illness than before it (Casson and Foulds, reprinted 1955, p122).

Elizabeth Casson saw return to work, or normal life roles, as the desirable and legitimate outcome of occupational therapy, and indeed that there may be added gains for the individual patient from the therapeutic process.

As well you might expect, my broad intention is to focus this lecture on the emerging policies of our new Government and the opportunities and challenges they might present for the profession. There is a great deal happening at the moment and it is impossible to capture it all. I want therefore to concentrate on the public health agenda set out in *Our Healthier Nation* (Secretary of State for Health 1998) and the *New Deal for Disabled People*, part of the Welfare to Work strategy, as I believe those two strategies reflect our genesis and the values that inspired Elizabeth Casson. They might also characterise the dynamic tensions (Fig. 1) which I believe will preoccupy the profession as we approach the new millennium: whether to reclaim lost practices by restoring return to employment as a fundamental objective of occupational therapy, or to concentrate on new fields of practice in occupational health.

Fig. 1. Tensions in direction for the millennium.



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My choice of 'and Wealth' as a rhetorical question should, I believe, stimulate some fundamental reappraisal of the application and direction of occupational therapy services in the United Kingdom. I make no apology for the immediately crude connection between 'work' (employment) and 'wealth' (income) for we all know that economic hardship is a constant source of limitation for many of our service users. But, for the purposes of this lecture, I want us to have a wider concept of 'wealth' in the human experience – as in 'wealth of opportunity'. As a profession that professes to holism, it seems to me that a great deal of contemporary practice falls short of enabling our clients to resume the life roles that they desire. And I want to propose that the profession can, and should, prove its socioeconomic value towards the wealth, as well as the health, of our nation.

Let me say at this point that, although I will be referring to Government policy, the views expressed will be my own and not necessarily those of the Department of Health.

With that 'health warning', let me progress by going back to our conference opening ceremony and the excellent Keynote Address presented by Dr Ann Wilcock. Ann's lecture on the development of occupational science was inspiring and I would like to record my personal thanks to her for starting our week on such a high note. I will return to the theme of occupational science later, but let me now sketch the scenarios of public health and welfare to work.

Our Healthier Nation

The National Health Service White Paper *The New NHS* (Secretary of State for Health 1997) spells out proposals for a modern and dependable health service, but the Government recognises that we have to do more to stop people falling ill in the first place. That means tackling the root causes of avoidable illnesses, including poverty, low wages, unemployment, poor housing, crime and disorder, which can make people ill in both body and mind. The Government has two key aims, as set out in the Green Paper *Our Healthier Nation* (Secretary of State for Health 1998, p5):

- To improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free from illness
- To improve the health of the worst off in society and to narrow the health gap.

It seeks to achieve these aims through a 'national contract for better health', by taking an integrated, cross-Government view and by working in partnership with individuals and local communities. To help enact the contract, the Government has identified three settings for action (Secretary of State for Health 1998):

- Healthy schools – focusing on children
- Healthy workplaces – focusing on adults
- Healthy neighbourhoods – focusing on older people.

I urge you to read the Green Paper if you have not already done so; clearly, I cannot deal with all its detail today. You will see that it recognises the importance of ensuring that everyone in the NHS accepts responsibility for preventing ill-health and not just those people with 'health' or 'public health' in their job titles. Indeed, the Chief Medical Officer's (1998) consultative report on strengthening the public health function includes occupational therapists as one group of local government professionals who might contribute to joint work between public health and primary care agencies to improve local population health.

Reading the Green Paper, I feel sure that all of you will recognise new opportunities for the application of occupational therapy skills and expertise. Let me postulate with just one example under each setting.

Healthy schools

Felicity McElderry (Chair of the National Association of Paediatric Occupational Therapists) recently discussed with me the profound problems of children with developmental coordination disorder (including dyspraxia) who risk being excluded from schools because of their behavioural problems. I could empathise with her sense of urgency about needing more occupational therapists to give early support to these children and their families to prevent the downward spiral which may result in social exclusion and which will haunt them for the rest of their lives. Of course, most of them will be in mainstream education and not necessarily identified as having health-related needs, so we first have the problem of quantifying the scale of need.

Our traditional thinking would lead us to believe that we just have to keep pushing for more paediatric therapists to prove the role of the profession in treating these children but, if we are to prevent these unidentified youngsters carrying their problems into adult life, the healthy schools initiative might well provide the platform to raise this issue at a much higher level. Alternatively, school exclusion is included in the Social Exclusion Unit's first phase of priorities; that might offer another way into the dialogue.

Healthy workplaces

We might cite the number of occupational therapists and physiotherapists now working in the field of manual handling and lifting training as a good exemplar of our potential to be influential in strategies to promote healthy workplace practices and prevent the distress and cost of avoidable injuries. The numbers may be small but I know that there is a growing band of occupational therapists working within industry, either in a strategic/advisory context or as direct providers of active rehabilitation services. Their concerns may also include supporting the implementation of employment aspects of the Disability Discrimination Act 1995.

The collaborative research partnership developed between the Glasgow Caledonian University and the City of Glasgow Police Force is an excellent example of innovation in this field (Pratt et al 1997). Here is a major employer of people exposed to many health-threatening situations, from physical violence to the extremes of stress and distress, which most of us can only imagine. The introduction of occupational therapy provision by the university staff is being evaluated as the service develops so the organisations learn and adapt together.

With the Confederation of British Industry estimating that 187 million working days are lost each year because of sickness, at a cost of £12 billion to industry each year, I would happily take a platform to debate the merits of occupational therapists (and other rehabilitation professionals) becoming key players in occupational health services. I have no doubt that many of you, including the enthusiasts of occupational science, will think similarly and be eager to join in the healthy workplaces debate. But again, all this is a question of more occupational therapists; after all, the ones we have are already stretched to the limits.

Healthy neighbourhoods

Then we move to healthy neighbourhoods, which the Government recognises will often be a particularly important setting for improving the health of older people. We might reasonably propose that healthy living centres should not only promote general health but might also offer a new focus for community-based rehabilitation which we know so many elderly people (particularly from deprived and minority ethnic communities) have difficulty in accessing. But if we took up the health promotion mantle and positive findings from the

Well Elderly study conducted by Clark and colleagues (1998) at the University of Southern California, we might also see occupational therapists as essential catalysts in developing opportunities for elderly people to engage in a wider range of activities designed to promote a healthier and more meaningful life. As the Government looks for new ways of achieving better health for our population, a golden opportunity exists for the profession to promote the life-enhancing concepts of occupation in its broadest sense.

Pilot Health Action Zones are being established to explore new ways of agencies and communities working together to promote better health and tackle health inequalities.

Given the holistic nature of our philosophy, this is an agenda with which occupational therapists can readily identify. The opportunities are exciting and I can almost hear you thinking 'if only we had more hands on deck'. Before going on to how we might respond, let me now deal with my second major policy initiative.

A New Deal for Disabled People (Welfare to Work)

There are in this country 2.2 million people of working age with a disability or long-term illness and who are living on one or other disability benefit. Over 1 million without jobs want to work. In launching the New Deal at the end of March, Harriet Harman, Secretary of State for Social Security, outlined a package of measures, including:

- £195 million for schemes to enable sick or disabled people to remain in, or return to, employment
- Initial piloting in 12 areas of a new personal adviser service
- Measures to reverse perverse incentives in the benefits system.

Some of these positive changes to the benefits system were announced by the Chancellor in his last budget statement.

Pilot return-to-work schemes

The Department for Education and Employment has already run the first bidding process for innovative projects to test new ways of helping people on disability and long-term sickness benefits to retain or secure paid employment. The first 11 projects, sharing funding of around £5 million, will seek to develop new partnerships between public, private and voluntary sector organisations for new or enhanced integrated services. A second bidding process is now in hand. I hope some of you have been, or are, involved in these developments.

Personal adviser services

The introduction of personal adviser services is being piloted in 12 areas before a decision will be made on possible national extension from Spring 2000. These pilots will cover over a quarter of a million people on incapacity benefits in England, Scotland and Wales. Pilots in the first six areas will be run by the Employment Service from this October. The remaining six will be put out to open tender where the Government anticipates that voluntary bodies active in the field of disability will seek to develop partnerships with other organisations in submitting bids for new services.

The intention is that personal advisers will invite people on sickness and disability benefits to participate in the New Deal, make an employability assessment and agree an action plan to assist their return to, or progression towards, paid employment. For some people, the action plan will be relatively straightforward with intensive job search support. However, others will need employment rehabilitation, prevocational, occupational or skills training with, perhaps, spells in voluntary work or supported employment.

This policy initiative recognises that some sick and disabled people may well require access to NHS rehabilitation services, or assistance from social services professionals. Personal advisers will be expected to identify such needs and include them in the individual's action plan. It is therefore reasonable to assume that, in the first pilot areas, local agencies will need to discuss the support and services they may be able to offer, either to individuals or to groups of clients with similar rehabilitation needs. The pilot schemes will enable the Government to develop its knowledge base on the costs and success of different strategies for helping disabled people in different labour market circumstances and to evaluate the impact of outcomes on the lives of people with different kinds of disabilities before the roll-out of a national programme.

Health – and wealth?

In the context of the values of our profession, we might view the New Deal as representing the ultimate objective of an integrated and comprehensive approach to improving the range of services that enable disabled people to achieve personal and economic autonomy and participate as equal and valued members of society.

On many occasions in the past, I have asked audiences of occupational therapists whether returning people to work is still part of their role and concern. Usually the response has been that the recession has presented disabled people with a double jeopardy and occupational therapy might more realistically focus on helping people to develop alternative life roles. Doubtless that is to some measure fair and reasonable. But I wonder also if the profession has not colluded with the notion that sick and disabled people should automatically lower their expectations when conditions for society in general are tough. You might argue that therapists in specialist services (such as spinal injuries and learning disability) or mental health services, where intervention may be longer term, still see helping people to regain employment as an important part of their role. And you might argue that those working in fast-track general physical medicine are no longer able to treat people for long enough to restore their optimal general functioning, never mind getting back to work. Offering continued outpatient care will be compromised by the relentless demands of simply getting more people through the system.

These realities are now well understood and are reflected in *Better Services for Vulnerable People* (Department of Health 1997). There the emphasis is on improving rehabilitation services for elderly people but there is also concern about services for younger adults. So, for the disadvantaged groups occupational therapists work with, employment must return to our agenda for it not only provides the opportunity of moving from dependency to economic freedom, but also raises the prospect of improving the 'wealth of opportunity' that I referred to earlier.

Partnerships and integration

An important point in both these policy areas, and across the wider reforms which will take place in both health and social services (and other public authorities), is the fact that their success will rely on breaking down the barriers between agencies to ensure that patients and clients receive a more integrated approach to their care. (Roy Taylor, President of the Association of Directors of Social Services, spoke of the new emphasis on partnership this morning.) There will be no 'big bang'. The Government has emphasised that its approach is about evolution, not revolution, hence the commitment to pilot and evaluate different ways of working. That might make it more difficult to see where we are heading or to keep in touch with the nature of change. There are complex details to

be dealt with, such as finding ways of enabling agencies to pool financial resources or moving funds to areas where investment will represent better value. Such detail will be dealt with in legislation or relevant guidance later in the year. For the moment, we should be encouraged that this new environment should allow occupational therapists to get out of some of the narrow boxes they have been confined to in recent times. We are used to working across boundaries to access different support and services for our clients and we are good at it. But the span of possibilities and expectations should increase in the future. *Our Healthier Nation* (with Health Action Zones, Healthy Living Centres and so on) and the New Deal for Disabled People are new opportunities for your innovation and ideas – for taking a proactive approach, and not waiting to see what happens.

More occupational therapists – or more of the perennial juggling act?

So how does the profession respond to these exciting new opportunities? On the one hand, we will be attracted by the force of logic in adopting a stronger orientation towards health promoting and preventive strategies. And on the other, we cannot but embrace the values of the New Deal by reasserting the time-honoured holistic values of the occupational therapy profession and by advocating for the proper restoration of high quality and integrated rehabilitation services which, amongst other things, help the Employment Service to deliver on its aims for sick and disabled people.

At the start I said that these were the only two new strategies that I aimed to address in this paper, but I know you are being asked to take them on board at the same time as many others, including:

- *Better Services for Vulnerable People* (Department of Health 1997)
- The implications of the Green Paper *Excellence for all Children* (Secretary of State for Education and Employment 1997)
- Planning the implications of Primary Care Groups or Trusts and how occupational therapy services will feature in those developments
- The concern of the High Security Psychiatric Services Commissioning Board to improve rehabilitation in forensic services
- Improving health care services for prisoners
- Contributing to the development of the first National Service Frameworks for mental health and coronary heart disease
- Continuing to tackle the unacceptable waiting times for local authority occupational therapy services.

It seems as if there is an agenda for virtually every area of occupational therapy practice and that might seem daunting or even overwhelming. However, from where I stand, there has never been a time during my career when the agenda seemed so right for our profession to make its proper contribution to both the health and the wealth of our society. Many of you will tell me that we just need more occupational therapists and our impact will be limited until we do. We will proceed in our own inimitable way with a time-served juggling act, trying to be all things to all people.

Well, let me say now that I do not believe that numbers of occupational therapists are the only issue. Yes, we need more and that fact has recently been recognised by the Government's increased investment in education and training. I was talking recently to a Swedish professor who expressed his admiration for the occupational therapy profession with its range of skills which cross the health and social care divide; he saw our values and knowledge base as being fundamental to the Swedish Government's efforts to improve rehabilitation services and reduce expenditure on social insurance. But he also expressed his concern that occupational therapists in Sweden were marginalised in their health care system and asked if that was also our experience in the United Kingdom. In the country with the highest rate of occupational therapists per thousand of the population, it seems that they too have their challenges!

If numbers are not the only answer, then answers have to lie in our styles of working; in the ways in which we communicate and share our values, knowledge and skills; in the ways in which we actively market the profession; and in the language we use to impact on our service users, policy makers and society at large. I want to develop some of those ideas in the last part of this lecture and, to do so, I first want to return to occupational science and the power of language.

In her paper on 'Occupational science: a new source of power for participants in occupational therapy', Yerxa (1993, p8) persuasively argued for the potential of occupational science to bring credibility to the discipline within its academic environment:

> Occupational science is an emerging discipline based upon the traditions and values of the occupational therapy profession. It promises to contribute, not only to society as a whole, but to occupational therapy's practice, curriculum and future as an academic discipline. The recipients of occupational therapy will benefit from a practice which deals with the essentials in their lives, making a significant difference by connecting them with their place in the culture.
>
> Academic programmes will thrive since they will make essential contributions to other academic disciplines with their perspective of the human as an occupational being.

I find those aspirations stimulating but we do not have to wait for occupational science to expand our thinking and horizons.

Playing on a bigger stage

Models of human occupation appear to have consumed vast amounts of our mental energy in recent times but, from where I stand, I constantly look for the evidence of these developments improving the quality of occupational therapy practice and the outcomes for service users. I am happy to leave you to reach your own conclusions. However, from my perspective there is some urgency in the profession moving on from its constant preoccupation with its internal state of affairs.

Over my 6 years in the Department of Health, I have witnessed a sea change. There has never been a time when the profile of the therapy professions generally, and occupational therapy specifically, has been so high. The profession is on the crest of an exciting phase of its development but I believe that it will only maximise this opportunity if it takes a bigger view of the world.

Those of us who have just attended the World Federation Congress in Montreal enjoyed many excellent presentations from overseas colleagues, but I think we also returned very proud of the quality of presentations from our own colleagues here in the United Kingdom. Although happy to share our work on the international stage, it seems that back home we keep so much of our goodness within the profession; how modest we are. Some of you sitting there will have had the personal experience of telling me of your achievements only to be met by the question 'Have you published this anywhere?'. And usually you say you are trying to find time to write it up for the Journal. Well fine, the profession needs to share its knowledge and expertise amongst its own ranks; that is essential if we are consistently to improve practice. But if the discipline and the profession are really to progress, we need also to play on a bigger stage and to articulate the value of occupational therapy outwards, to policy makers, service commissioners, service users and society at large.

To quote Yerxa (1993, p8) again:

> Occupational science promises to provide a significant, viable, fresh way of thinking about the occupational human which is greatly needed to improve the life opportunities not only of people with disability but for all people.

Although Yerxa's (1993) statements are about occupational science, I see no reason why the principles cannot hold good for our contemporary practice in the United Kingdom. There might be an immediate response amongst practitioners that this is something for the College, academics and managers: their job to develop the science whilst those at the sharp end will get on with treating patients and tackling waiting lists. Not so. I have been talking about the public health and welfare-to-work agendas and it seems to me they are entirely about improving life opportunities for sick and disabled people. These are strategies for all of us; we need to act on them now.

So how do we move forward from the perennial juggling act? You will not be surprised if I say that there is no easy answer and I certainly don't have it; all I can offer is some personal reflections and ideas. I want to approach them under two broad fronts: the question of sharing our skills, knowledge and philosophy and the way in which we communicate about occupational therapy.

Sharing skills, knowledge and philosophy

Sharing skills

In her Casson Memorial Lecture in 1988, I well recall my predecessor Elizabeth Grove urging us to stop being precious and to share our skills with colleagues. Many of us did so, and then found managers talking about overlap and duplication! We know of our own muddy waters; of territorial confusion with physiotherapists, nurses, community psychiatric nurses and social workers. Despite it being a hot topic for several years, we have never quite taken control of the issues and some of these chestnuts have a distinctly aged and tiresome feel. With a Government intent on breaking down 'Berlin Walls', it would be to our credit to resolve some of them before more emerge.

My starting point is relatively simple; first, that the profession's capacity to extend the scope and influence of its practice is virtually limitless and, second, that demand for the profession will continue to rise. If we are to respond to the opportunities that I described earlier, the profession needs to create a culture where we start from people's needs and what the nation requires of us, not from where or how the profession wishes to prove its value. That will flow from getting it right. Hence my liking for Yerxa's (1993) statement on service recipients benefiting from a practice which 'deals with the essentials in their lives'. There are essentials to which we now give low priority; we cast off the goodness of 'diversional activity' because the coat had become tainted in our search for a more fashionable appearance. Now many have cast off bath aids on the spurious justification that elderly people don't die of being dirty and a strip wash should suffice. (Our voice has been tragically silent on this issue.)

The unavoidable fact is that we cannot do everything of which we are capable, nor do all the tasks which come within the broad remit of our services need the skills of advanced practitioners. If we are truly client centred and concerned to deal with the essentials in people's lives, then occupational therapists need, and can afford, to take a positive and generous attitude towards sharing their skills. There is an abundance of valuable work for us to do; instead of denying people's basic needs, we should be advocating and working with others to create new and imaginative ways of meeting them.

Practitioners should find this a more empowering way of working but they will only do so if they operate in a culture of confidence.

Sharing knowledge

The concept of working in partnership with patients and clients, and their carers, is central to the practice of occupational therapy. Sometimes the profession gets criticism for not getting it quite right, but more often we get credit for being one profession which really understands and engages with our service users. Here I want to propose that many of our services would be enriched if we were to take this a step further.

The disability movement is progressing from the theories of advocacy and self-determination to much more practical ways of enabling people to take control of their own lives. The College has in the past worked with many charities – the Motor Neurone Disease Society and the Stroke Association to name but two – to develop some excellent and informative literature for their members. However, the concept of self-management goes a step further. It seeks to give individuals a great deal more information about their condition, about the pros and cons of different treatment options and about the range of services that may be available to them. Usually the movement trains its own volunteer members to become 'enablers' to their peers and will offer advocacy support when that is necessary.

As a profession signed up to empowerment, I believe that we should build on our good foundations by harnessing the self-management concept with added vigour. Any of us going through the experience of being a service user or a carer ourselves will know how eternally grateful we are that we know and understand the system. We get power from knowing the language; services don't necessarily like us for it but, by Jove, we smile with satisfaction when we win. I say this with added conviction, having taken on the battles for a dementing stepfather and a very poorly mother in recent times. Why should we not wish the same for our service users?

Rightness apart, such approaches make good managerial sense. Professionals spend a great deal of time sign-posting people round the system. Empowering them to do so with more information and confidence has to be in their best interests, whilst having added benefits in terms of service efficiency and effectiveness.

As a second example, let me return to the issue of children with developmental coordination disorder. If we reflect on the experience of children with dyslexia, it took many years for knowledge and expertise in dealing with their needs to disseminate across the education system. We already have great pressure on paediatric occupational therapy services and, with the best will in the world, there is little prospect of this small cadre of specialists addressing this issue with the urgency it deserves, even if they work in a consultancy way, sharing skills, as I know they do. For the moment, I am left wondering if new teachers in training know much, if anything, about this condition and how to recognise children who may have developmental coordination disorder. This seems to be vital step number one.

Then there is the question of intervention strategies. In the absence of sufficient paediatric occupational therapists, could the profession consider alternative strategies to accelerate at least some understanding and skills being made available to the children and their families? Could some paediatric occupational therapists and some of our educators possibly collaborate with a faculty of education to develop training material for wide dissemination to school teachers? Sharing knowledge would be a start, although I have no doubt such a process would engender some lively discussion about how far to share skills. But if our starting point is to imagine more immediate

help being available to children and their families, surely that is a more noble goal for the profession to pursue. I believe they would thank us for it.

Sharing our philosophy

The integration of our courses into universities is a development that we have all welcomed. In a relatively short space of time, the strides that have been made in interdisciplinary learning, collaborative research and the sharing of knowledge have been a credit to our educators. I'm sure our academic programmes are already making a contribution to other academic disciplines as Yerxa (1993) proposed. Although I cannot pretend to have any comprehensive oversight of current activities, I wonder if these new academic partnerships offer us new gateways for addressing urgent and complex service priorities. I have just suggested one to do with knowledge and skills. On the question of philosophy and values, I immediately think of the challenges of developing rehabilitation services within high security psychiatric and prison services, both of growing interest to occupational therapists. At the recent high level seminar we held on forensic services, and which has been reported in the Journal (Mountain 1998), it was widely acknowledged that occupational therapy could only be successful if, first, the cultural environment was supportive and 'enabling' and, second, if a sufficient investment was made in setting up a service capable of making an impact. Appointing the token therapist to swim against the custodial tide is doomed to failure.

In thinking how we might take this agenda forward, I am gripped by the concept of 'occupational deprivation' described by Whiteford (1997) in her study of the occupational opportunities (or the lack of them) in a state prison in New Zealand. This is not about time in prison workshops but about all the other practical and sensory engagements which enable an 'occupational being' to survive and to develop towards a meangingful return to society. I suggest to you that this is not a furrow that we should aim to plough alone, but a complex field where we might make more significant advances by sharing our philosophy and stimulating joint research and academic endeavour with other like-minded disciplines, such as sociology and psychology.

I am aware that some of these views might seem like professional heresy, and that's from someone who has long argued that occupational therapy is not something for packaging and teaching other folk on a wet Thursday afternoon. But I referred earlier to a culture of confidence and that is what I have attempted to convey this afternoon. I sincerely believe that by sharing our philosophy we generate interest in our knowledge, and by sharing our knowledge we generate more understanding of our skills. We have plenty of those and we can afford to give some away. It is after all our ability to synthesise the three which makes us occupational therapists and that is not what I'm proposing to give away.

Moving concepts – changing language

During the recent programme of conferences on local authority occupational therapy services, I referred to other changing concepts which offer the profession the opportunity to articulate its value in a way that is more attuned to contemporary policies. The report of those conferences will be published shortly but let me conclude with just a few pointers.

Promoting independence – or preventing dependence ...

For years, 'promoting independence' has been one of our stock terms for describing the aims of occupational therapy

Sheelagh Richards is thanked for a thought-provoking Casson Memorial Lecture.

but as a general truism that has somehow lost its cachet. We now have good evidence (from the Riverside and Nottingham projects) that occupational therapy also has the potential to reduce dependency – dependency that represents avoidable misery, avoidable stress on carers, avoidable admissions to residential care and reducible demands on home care services. All this represents a sizeable burden of costs. More research is needed but we should have no shame in occupational therapy's potential to represent a sound investment by preventing or reducing dependency.

From mortality to morbidity ...

Similarly, our health services have been preoccupied with mortality; there is deserved kudos in saving lives but that credit belongs to doctors and nurses, not to therapists. Instead, we have the potential to reduce morbidity which, like dependency, incurs avoidable costs and reduces the life opportunities for people with a disability. We should be champions of this cause.

From optimal functioning to lifestyle restriction ...

I see lifestyle restriction has provoked some philosophical debate in this month's Journal (Creek 1998, Lambert 1998) – I hope that is not another theory we are going to torture to death! Wherever that comes to rest, for me the concept that occupational therapy can positively enhance lifestyle is a much richer concept than simply promoting 'optimal functioning', a term more redolent of narrow medical models.

And finally,

Promoting integration – or agents for social inclusion ...

At the recent conference of the Association of Occupational Therapists in Mental Health (Feaver and Fowler Davis 1998), I floated the notion that occupational therapists might move from 'promoters of integration' to 'agents for social inclusion'. Perhaps that one is a little bold, but I would be very pleased if it did provoke some debate in the Journal!

Seizing the agenda

Our Chairman, Kate Minto, opened this conference by expressing her view that the time had never felt so right for occupational therapy. I hope you sense that I agree with her and that, in the course of this presentation, I will have helped you to connect a little better with Government policies and the challenges and opportunities ahead.

Am I optimistic that you will take up the agenda? On the one hand, yes, when I see the wealth of ideas, creativity and innovation in the profession – which is so manifest on occasions such as the annual conference. But on another level I am less certain and question why; perhaps there is some innate mistrust of what comes out of Government? As an example, many managers of mental health services freely confess that they do not have former *Health of the Nation* targets enshrined in their service policies. Yet one of those targets was about improving the quality of life of people with enduring mental ill-health; if that is not our business, then I am not sure what is. Perhaps it is simply back to the question of professional language having an external focus.

So I do have some concerns and I think these revolve around the issues of leadership. The profession needs to have a bigger view of the world; to look at what the nation needs of it. By responding positively and keeping a firm eye on patients' and clients' needs, cost-effectiveness and outcomes, the value of occupational therapy will be appreciated: not because you have set out to promote your role but because you are seen to produce the results.

Council has set six strategic objectives concerning the future of the profession. As it takes them forward, I hope it will stimulate a lively debate and involve you, and other key stakeholders, in reaching a clear consensus on the best ways in which the profession can, and should, contribute to the health and wealth of our society. We are expert jugglers but we have to decide which balls to keep in the air and which we should happily toss to others.

Taken together, the policies I have described this afternoon give you a very clear signal: rehabilitation is back on the agenda. I said earlier that there would be no big bang; this is about evolution, not revolution. So you too have time to experiment and evaluate your contributions to the new agenda: to use pilot Health Action Zones, New Deal initiatives and so on to foster new ideas in collaboration with service users, other disciplines and other agencies. I hope this won't lead to more models ... but to developing our ability to play on the bigger stage, remembering

> Wherever we are, it is but a stage on the way to somewhere else, and whatever we do, however well we do it, it is only a preparation to do something else that shall be different (RL Stevenson).

Thank you again for this privilege.

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