The Casson Memorial Lecture 2005, given on 23 June at the 29th Annual Conference of the College of Occupational Therapists, held at the Devonshire Park Centre, Eastbourne. The conference theme was 'Activity, Participation, Occupation'.

The Casson Memorial Lecture 2005: Challenge – to Confront, Defy, Face up to; a Difficulty that Stimulates Interest or Effort

Gail Mountain

Introduction

Before I start the 2005 Casson Memorial Lecture, I want to thank those that I have worked with in the past and those that I work with now. There are many that I consider should be sharing this lectern with me today. It is their joint wisdom that I hope to convey to you this morning. I also want to acknowledge the knowledge, skill and patience of the many people that I have approached for help and information during the preparation of this lecture.

What excites and interests you at work? Is your work a source of stimulation for you? What makes you take action and gives you satisfaction? Do you have a vision of the way you would like things to be in your professional life and for the people that you work with?

I wonder what our founder, Dr Elizabeth Casson, would say if we could ask her some searching questions about why she chose to strive to introduce occupational therapy education into this country in the early part of the 20th century? I would have loved the opportunity to find out more about what made Dr Casson tick as a professional, as an academic thinker, as a business person which she undoubtedly was and as a woman.

The challenge created by our legacy

The story of Dr Elizabeth Casson is frequently recounted. There are many texts and papers to refer to both in hard copy and on the Internet. Professor Jenny Butler of Oxford Brookes University, and last year's Casson lecturer, documented a tribute to her life in the January 2005 edition of the *British Journal of Occupational Therapy*. Professor Butler's tribute was based upon a service of thanksgiving for the life of Dr Casson during 2004, the 50th anniversary of her death. Professor Ann Wilcock has discussed her life in a number of publications, including the history of the profession, published by the College of Occupational Therapists (Wilcock 2001, 2002). The August 1955 edition of *Occupational Therapy*, the official journal of the Association of Occupational Therapists, was devoted to her life and achievements:

> … as a tribute from the Association to her faith in Occupational Therapy, to her courage and unsparing work in establishing it as a treatment, and to her foresight in setting up a means of professional training (p83).

Dr Casson established the first occupational therapy school in the United Kingdom (UK). The story is repeated annually at this lecture; I have heard it on many occasions. However, how many of us have stopped to think about what it really means? It was not until I started to prepare for this lecture that I began seriously to consider the woman behind the well-told story.

1881-1919

Let us look at the timeline of her life in more detail and compare it with concurrent events in the UK, particularly those involving women. Elizabeth Casson was born in 1881 to an upper middle class family in Wales. Throughout her lifetime remarkable events took place, which would shape the world as we experience it today.

At the beginning of the 20th century, a number of organisations existed for women including the Mother's Union. These organisations concentrated upon fostering domesticity and motherhood. However, societal change was occurring. The 1901 census showed that there were a surprisingly high number of women in work and a falling birth rate.

After a period working as a secretary for her father, in 1909 Elizabeth Casson went to London to train and work as a housing estate manager in Southwark, London, under the leadership of another remarkable woman, Octavia Hill. During this time she would have been highly aware of the suffragette campaign and, in particular, Black Friday in 1910 when the suffragettes clashed with police outside the Houses of Parliament. Women continued to demand a better role in society in other ways: 1911 saw the first woman admitted to the Royal College of Surgeons.

In 1913, Elizabeth Casson commenced medical training at the University of Bristol, qualifying in 1919. The war years marked a time of great suffering but also of emancipation for women. As a consequence of the war, women were called upon to undertake male jobs, such as munitions and office work. They were also recruited to the forces and to work on the land. The vote for some women (those over 30 years and with property) was achieved at the end of the First World War. In 1918, the pioneer Marie Stopes published her book *Sex, Marriage and Love*. In the same year, compulsory education was introduced for all children up to the age of 14 years. During the next year, the first woman MP took her seat in the House of Commons and the Sex Discrimination Removal Act ensured the entry of women into the professions. Women could now become vets, lawyers and civil servants.

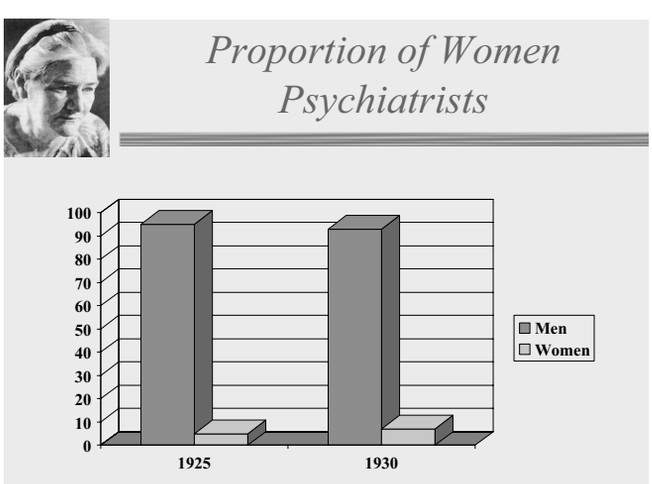
Following the war, there was a desire to return women to the kitchen. However, the experiences that women had gained during this time combined with the devastation to the working male population meant that things were never going to be quite the same again.

The early part of the 20th century also saw the introduction of occupational therapy into the UK. The first British occupational therapy department was introduced in 1919 in Gartnavel Hospital, Scotland, under the influence of a psychiatrist, Dr David Henderson. He brought occupational therapy to the UK following a period of time working with Adolf Meyer in the United States (US). Dr Casson was introduced to occupational therapy through hearing Dr Henderson speak of his work (Wilcock 2002).

1920-1939

We know that the poor social and public health conditions that Elizabeth Casson observed during the time she worked in housing contributed towards her desire to embark upon training as a doctor. Following qualification, Dr Casson decided to specialise in psychiatry. In 1925, the proportion of female psychiatrists of the total number registered with the Royal Medical Psychological Association was 5%. By 1930, this had risen to 7% (see Fig. 1).

Fig. 1. Proportion of women psychiatrists.



Source: Extrapolated from the records of the Royal Medical Psychological Association, 1925 and 1930.

The emancipation of women continued into the early 1920s and then appeared to slow down. In 1920, the University of Oxford opened its doors to women for the first time. In 1921, unemployment benefit was extended to include wives. In 1923, the Matrimonial Clauses Bill was passed so that a woman could make a petition for divorce based upon her husband's adultery. By 1928, all women could vote.

By the close of the 1920s, however, the effect of the impending depression was beginning to take hold. Women were encouraged back into the home as jobs for men became scarcer. The ban on married women working as teachers, in the civil service and for the BBC in 1932 was indicative of the accelerated desire to return women to domesticity.

Dr Casson's career blossomed during the 1920s and 1930s. She obtained her Diploma in Psychological Medicine and, in the mid-1920s, visited an occupational therapy department in New York while on holiday, followed by a visit to the Boston School of Occupational Therapy. I have been left wondering about the vision she would have had at this stage for what she intended to achieve in the future.

Dr Casson was undoubtedly a psychiatrist of exceptional skill. This is evidenced by the fact that she was awarded the Gaskell Gold Medal in 1927 (one of the foremost academic distinctions in clinical psychiatry) for her enlightened approach to psychological medicine. This prize is awarded annually to exceptional junior doctors to this day. She also continued to study and was the first woman to obtain a Doctorate in medicine from the University of Bristol in 1929. Also in that year she established Dorset House in Oxford, a nursing home for the treatment of women with psychotic and neurotic illnesses, where the philosophy of treatment was underpinned by occupation. This was one of the first unlocked facilities for people with mental health problems in the country. This was before the days of psychotropic medication so the levels of disturbance would have been higher than we are used to experiencing today. The open door approach that she introduced might well have caused consternation. It was not until 1930 that people could be admitted voluntarily into mental health facilities as a result of the Mental Treatment Act. Prior to that everyone was compulsorily detained. This would have included people perceived to be social deviants. The implications would have been great in that once admitted, people were rarely released. It was also after the Victorian idealism of the need for space and asylum. Facilities were becoming overcrowded. Dr Casson's approach would have been revolutionary.

Following the setting up of her clinic and nursing home, in 1930 Dr Casson went on to establish the first training school for occupational therapists in the UK within the Bristol clinic, yet another revolutionary idea. It moved to Oxford in later years.

1940-1954

The 1940s were also a time of great change and challenge for society and for Dr Casson. Unfortunately, we do not have time

this morning to visit the events of this decade. The 1950s saw the establishment of the World Federation of Occupational Therapists. This was another development in which Dr Casson had been instrumental. In 1953, her work in establishing and developing occupational therapy was acknowledged through an OBE and in the following year through an honorary appointment with the World Federation of Occupational Therapists. She died in 1954, aged 73 years.

Imagining the challenges and obstacles

Can we even begin to imagine the challenges and obstacles that Dr Casson must have encountered once she had made the decision to embark upon introducing this new profession of occupational therapy? She lived her life during turbulent times. The changing context of women's lives may well have aided Dr Casson in her entrepreneurial work. Nevertheless, it must have been difficult to be a professional woman then, particularly if you were undertaking work that might not receive universal approval.

What arguments did she have to make to convince others of the need for a new profession and to whom did she make such arguments? She was undoubtedly from a privileged background. The £1,000 to establish Dorset House was made available through her family. However, it is difficult to believe that even family backers would have provided substantial sums of money without many hours of discussion and persuasion. How did she attract people to join her in fulfilling the vision? Can you also consider how she might have felt at times when things might not have been going so well, particularly in the light of the fact that, once it was established, she continued to finance the occupational therapy training school herself? We all know that sinking feeling when our plans do not appear to be going as we had anticipated. There must have been some individuals and organisations waiting in the wings for evidence of failure. It must have been difficult for her to keep going at times.

What motivated Dr Casson, who must have already battled to become an extremely successful medical practitioner in what was then almost an exclusively male-dominated world? She experienced great success in her chosen field. This being the case, what made her introduce a new profession with all the challenges that this must have entailed? What fired her up?

Using our legacy in the present and future

Dr Casson was undoubtedly a remarkable woman, so remarkable that her story may appear to lack relevance for the more ordinary of us as we continue with our day-to-day professional and personal lives in the 21st century. However, by considering the woman behind the story, as well as those men and women who followed her in helping to establish occupational therapy in the UK, we can individually draw strength as we grapple with the challenges that we have to face in the present and the future.

I now want to move us on to an individual and professional consideration of how the challenges within the legacy left to us by Dr Casson can be taken forward. In other words, how does the story translate for present-day occupational therapists? To do this, I am going to consider the meaning and experience of challenge from three different perspectives.

First, I want to consider some of the many challenges that those people who use occupational therapy services have to face. I will use some of my recent research to illustrate a few of the situations that ordinary people can encounter and to describe the remarkable strength and resilience that they can draw upon in the most unsatisfactory of circumstances. I will consider the issues for service users first because this must be the bedrock upon which we build our practice.

Second, I want us to consider some of the contemporary challenges for the occupational therapy profession and how they can be taken forward by us in our various work settings as a professional group.

Third, I am going to try to underscore the relevance of the Casson legacy for each and every one of you by getting you to think about the challenges that you face as occupational therapists and as individuals. To get you engaged with this, I will describe some of the personal challenges posed to me at various stages during my professional career, how I dealt with them and how they continue to shape my thoughts and reactions and actions to this day.

I am going to end this lecture by visioning what the occupational therapy profession of the 21st century and beyond might ideally look like, reflecting again upon what Dr Casson's intentions would have been were she here with us today.

The challenges for users of health and social care services

First, then, challenges from the perspectives of the people that we might work with as occupational therapists. Given that the people we work with should always be at the centre of all that we do, it is essential that we try to recognise the challenges that they face from their viewpoint. This is a challenge that is often aspired to but is actually very difficult to achieve. I am going to use examples drawn from current research projects at Sheffield Hallam University.

Challenges for community-living older people

Health promotion and prevention is a relatively new area of work for many of us, stimulated by a raft of current policy initiatives (Department of Health [DH] 2004). As you will all be aware, each time we switch on the television or radio we are confronted with warnings of the adverse consequences of our inactivity and poor diet. However, this relatively recent policy preoccupation is also opening up new avenues for service development.

Together with colleagues in Sheffield and York, I recently completed a one-year feasibility study to look at whether the American study of lifestyle redesign undertaken by Florence Clark and colleagues at the University of Southern California (Clark et al 1997) can be translated into a UK context. The lifestyle redesign concept is grounded in occupational therapy and occupational science. It includes a package of group and individual interventions delivered over several months to community-living older people with the aim of maintaining functioning and quality of life, the changes being led and shaped by the older people themselves. Our programme is called 'Lifestyle Matters' because 'Lifestyle Redesign' did not have resonance with our Yorkshire participants.

The first of the many challenges that we faced as researchers was how to locate community-living older people and recruit them to our study. We wanted to work with those defined in the National Service Framework for Older People as being in transition between wellness and frailty (DH 2001a). We found that this group was easily spoken about but less easily reached. Nevertheless and much to our surprise, with the support of community groups and activists, we managed successfully to recruit two groups of community-living older people, 28 people in all. They all continued to participate in our study over an 8-month period. Taking into account the fact that all our participants were living independently with little contact with services beyond primary care, they each described a number of challenges in their daily lives and how they wished to make changes to bring about improvements to their quality of life.

We found a high level of depression in some older people. This was expected but also distressing to encounter. One person was found to be severely ill with no formal help for this. The participants all described various situations and conditions that compromised their quality of life, the majority of which could be attributed to the combined effects of the life course. They included loneliness as a result of bereavement, loss of confidence, poor mobility and sensory loss as a consequence of the frailty of older age and various physical illnesses. In addition, some participants described pressure from family members, particularly in the form of limiting the occupations in which the person might engage. One of our frailer participants described not being able to accompany her family when they went shopping because they considered her to be too slow. However, they also put pressure upon her not to go out alone, thereby leaving her unable to go out at all.

What has impressed us over the months is the determination of the people that we have been working with to try new and re-engage with neglected occupations, with the desire to engage helping them to garner the strength and necessary determination to overcome barriers. Some people have also made measured moves to disengage with some occupations. We all had to stop and think when an older man who is part of our steering group suggested that one of the things that should be valued in older age is the ability to reflect rather than always being engaged in activity.

With the assistance from the group and from individual sessions with occupational therapy facilitators, they have achieved much; for example, the use of technologies like digital photography and computers, the use of public transport, going swimming, driving and rambling, doing tai chi and cooking, and delivering adult literacy sessions to others. Each person identified his or her personal goals and the occupations that he or she wished to engage with. The lady who was being dissuaded from going out due to pressure from her family decided to go out anyway because accomplishing the occupation was of paramount importance to her. These achievements serve to remind us of the power of occupation for all of us, a theme that I will return to later.

Challenges gaining access to services

Some challenges for the people we work with are concerned with gaining access to the rehabilitation services that they need. Another research project that we are currently engaged in is concerned with the use of technology for active stroke rehabilitation: the SMART Project. Stroke is one of the most common causes of morbidity and mortality in this country. The impact of stroke 6 months after the event can be severe: 49% of people need help with bathing, 31% need help with dressing and 33% need help with feeding (Rudd et al 2001). It is a frequent cause of admission to long-term care. We also know that intensity of rehabilitation has a positive effect upon outcomes, irrespective of whether the treatment modality is motor relearning or Bobath therapy (Forster and Young 2002).

The demand for stroke rehabilitation services combined with poor levels of investment in the past means that despite the requirement to improve access to stroke rehabilitation services (DH 2001a), the extent and quality of service provision remain patchy across the country. The availability of specialist rehabilitation units is increasing. However, the availability of therapy time remains limited in many settings. Hospital care is geared towards early discharge, even though people who have had a stroke often require intensive rehabilitation, particularly in the post-stroke period. Furthermore, last week I heard that even though the number of stroke rehabilitation units is increasing due to policy requirements, the lack of new money into the service system means that this has led to cost shunting from community services and a resulting demise in the availability of community rehabilitation. The use of technology for active stroke rehabilitation could be one answer to this predicament but is still a developing area.

Technologies have been developed in the past. However, mainstreaming has not occurred for a number of reasons, including the lack of an infrastructure to support these developments combined with the fact that engineers and other technologists were producing devices that practitioners, service users and carers did not want to use. As a consequence, a key aspect of our study is to consult with the users of services and their carers about the possibilities and what they think of them. We have now undertaken pilot focus groups with users and carers respectively and are about to conduct a second round of groups when we have a prototype device. Here are two quotes, one from a carer and one from a user

participant of those groups, demonstrating the problems that they were having gaining access to services:

> My wife is 18 months since she came home and I think we've had 3 visits from the physiotherapist – 3 days and that was it.
>
> There are times when you get to the point when you want to see your physio … I think that you ought to be able to ring up and say please can I see you for half an hour … (McNair et al 2004, p5).

Challenges concerned with quality of service provision

Unfortunately, many of the challenges faced by people might extend beyond their personal circumstances to encounters with the very services established to help them. Last year at the College of Occupational Therapists' annual conference in Harrogate, James McKillop, a 64-year-old Scottish man with early onset Alzheimer's disease, movingly described his experiences and the impact for him and his family of living with the effects of the condition but without a diagnosis for an extended period of time. He also went on to describe the difference that taking a positive approach towards the diagnosis had made to his quality of life despite the fact that he was living with the reality of having dementia. As those of you who heard him speak will recall, he described becoming involved in photography, music and writing. The beginning and end verses of one of his songs are given in Fig. 2 (McKillop 2005).

Fig. 2. Diff'rently the same (McKillop 2005).

Diff'rently the Same: James McKillop

Just look through my eyes
And then you'll surely see
The spirit of the person
Still deep down in me
But when I'm looking outwards
I'm still me, despite being so much
Diff'rently the same

Mmm Mmm friends of bygone years
Don't know how to react
Some speak past me in hushed tones
Others have less tact
And fidget in my presence
Yet, some day they might also become
Diff'rently the same

Through his work with the Scottish Dementia Working Group, James McKillop continues to campaign to improve services for people with dementia. I found this story to be uplifting. It also radically challenges longstanding perceptions of people with dementia.

There is little doubt, however, that people with dementia, and in particular those who are old, often suffer a triple jeopardy. Dementia is an illness of older age in the vast majority of cases, leading to stigma and nihilism. The nature of the illness can arouse feelings of helplessness in the person, in his or her family and sometimes in health and social care professionals. The final jeopardy can be the quality of the services provided in response.

When I embarked upon my research career in the late 1980s, I was involved in observing people with severe dementia living on long-stay wards. I found this distressing because being a researcher I was unable to intervene. We observed some quality services but also examples of neglect, petty tyranny and mocking (Bowie and Mountain 1993). Negative behaviours were not limited to nursing staff. On one memorable occasion, a therapist entered a room where people were looking at a working television that was facing the wall. I felt sure that the situation would be remedied but she did not notice that anything was amiss.

Even though the wards we observed have now all closed and the situation has undoubtedly improved, I still feel slightly uneasy. Where have all those staff gone, has staff supervision and training improved, why do negative situations continue to surface? Nevertheless, there has been a recent sea change in attitudes towards people with dementia. There is a growing awareness of the importance of building upon the current skills of the individual rather than concentrating upon lost skills and problem areas. The growing voice of people with dementia, such as Bryden (2005) in her recently published book *Dancing with Dementia,* is helping us as professionals to see new ways forward. There is also a much greater acknowledgement of the importance of staff being properly trained in the care of people with dementia. Improved access to training should mean that what I observed in the late 1980s really does become history. Finally, there is an increasing acknowledgement of the separate needs of user and carer and the importance of responding to both.

Nevertheless, the legacy of stigma and poor provision remains and we must do all that we can to combat it. The quote in Fig. 3, given to me by Claire Craig, is from an older woman with dementia providing her views of residential care. Let us hope that her feisty spirit managed to survive the negative attitudes that can still pervade the care system.

Fig. 3. Perspectives of Beryl, an older woman with dementia (Craig 2003).

Perspectives of Beryl, an older woman with Dementia

They take your handbag off you, then your keys and the next thing they'll want is your liberties. Well I'm holding onto mine I can tell you!

Extract from Craig (2003)

These then are only three examples of the many challenges faced by the users of health and social care, including occupational therapy services. I am sure that you can bring many others to mind.

Challenges for the occupational therapy profession

Now let us move on to consider the occupational therapy profession of 2005. There are many challenges and opportunities. The time has never been better to bring to the fore the abilities of our profession, our skills and what we have to offer. To do this we need to take a leaf out of the book of our founder and to have the courage and determination to do what we believe to be right and in the interest of those using our services, even if at times it means feeling like a lone voice. We also need to take forward our personal learning and the experiences of the users and carers of services into our professional philosophy.

I will describe three main areas where as a profession we need to be more proactive and to lay down the challenge. Even though a proportion of you will be working in different areas, I hope that you will be able to relate to the principles underpinning what I am going to say.

The challenges presented by policy

The first and most important area of challenge is concerned with policy and the external world. Policy and practice are inextricably linked, with policy being extremely influential in determining the path taken by a range of health and social care professions including occupational therapy. The National Service Framework (NSF) for Long-term Conditions (DH 2005) is the latest opportunity for us further to underscore the value of rehabilitation for people with neurological conditions, building upon the understanding that people with long-term conditions are experts in their own condition (DH 2001b).

A number of quality requirements are identified within this latest NSF, including a person-centred service, early diagnosis and treatment and early and specialist rehabilitation. However, as you must have realised given the recent general election, policy makers do not always get it entirely right. In my opinion, this latest NSF is lacking in some respects. How many of you have given thought to the fact that people with dementia have been left out of this initiative, even though dementia is a neurological condition? You will reply that this is because the needs of older people are provided within the National Service Framework for Older People (DH 2001a). However, dementia was not dealt with particularly well in the NSF for Older People and also services have moved on since 2001. Are we always prepared to accept and do rather than to question?

The conclusions that I have drawn are that we have to work with the government agenda in order to maximise the effectiveness of our contributions. Policy knowledge can be empowering in that it can help both practitioners and service managers to anticipate the changes that will occur and to develop proactive rather than reactive strategies. The more senior members of the profession should ensure that they are positioned to influence at national and local levels whenever the opportunity presents itself. We need to develop the skills to examine policy critically rather than merely accepting its consequences.

The challenge of appreciating our core mission

The second set of questions and challenges is concerned with how we perceive ourselves professionally. In recent years, there has been a renaissance in the profession's view of the centrality of occupation and its value in creating meaning for life and maintaining health:

> The human being can attain enhanced health and quality of life by actively doing things that are personally meaningful and purposeful (Nelson 1997, p11).

As Nelson (1997) stated, the fundamental nature of this purpose should be sufficient for occupational therapists confidently to use it as a firm foundation for independent mature practice.

The history of our profession reminds us that we are linked to medicine: the origins of occupational therapy are clearly traced back to the pioneering work of doctors and we have much to acknowledge them for. We also have much to thank social work colleagues for in the development of our role in social care settings. However, we now have to identify ourselves as a mature profession, working in partnership with others rather than for others. In 1989, the Commission into Occupational Therapy led by Sir Louis Blom-Cooper set the scene for a greater shift into community services accompanied by increased numbers of occupational therapy staff. The Commission recommended increasing professional maturity and greater independence from social work and medicine. We have to challenge ourselves to consider honestly whether this recommendation has been taken forward. I think that it would be timely for the profession to revisit the Blom-Cooper (1989) recommendations and to use them as a foundation for discussion of our progress over the last one and a half decades.

In 1998, as a result of studying occupational therapists working in services for older people, I identified the adverse cycle of events shown in Fig. 4 (Mountain 1998). As you can see, my hypothesis is that if we look towards external recognition for our work, we are more likely to become involved in work to bolster our recognition. We should all be able to think of activities that we have undertaken to try to improve our professional credibility rather than being rooted in the needs of the users and carers of services. If our work is not user centred, the outcomes are less likely to be satisfactory for users and for ourselves. This leads to a further downward spiral in confidence and motivation. Instead, we should work to the cycle shown in Fig. 5.

One of the main factors underpinning professional confidence is clarity of role. This is necessary for sound

Fig. 4. A negative cycle…

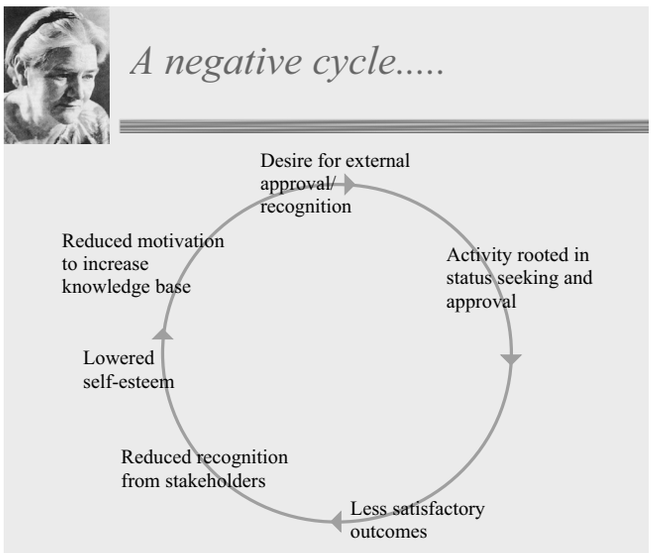


Fig. 5. Ensuring that the mission remains central.

judgement and the delivery of appropriate clinical activity. Also, with clarity of role comes the confidence to be able to work in partnership with other professional groups rather than being dictated to by them. These requirements demand that all occupational therapists constantly extend and refine their skill base as well as being policy aware. We need to be able to draw upon a specific body of professionally based expertise as well as being equipped to undertake roles of a more generic nature. This will lead to more positive outcomes and improved personal and professional belief (Mountain 1998).

Since I developed this hypothesis, the introduction of the Health Professions Council has fostered the requirement for evidence of our continuing professional development and the need for the profession to encourage appropriate opportunities in response. I hope that the positive cycle is now more prevalent, but we need continually to check whether this is actually the case.

The challenge of going global

Finally, the challenges presented by globalisation. A colleague of mine was the coeditor of a book published earlier this year called *Occupational Therapy without Borders* (Kronenberg et al 2005), based on the work of a number of occupational therapists worldwide. The book describes the many different occupational therapy developments that have occurred globally and the different cultural approaches that are taken towards occupational therapy. It also describes the understanding of alternative cultures that is required to deliver meaningful occupational therapy in different countries. The publication of this book is an achievement that I know Dr Casson would have supported wholeheartedly. After all, she was instrumental in the creation of the World Federation of Occupational Therapists in 1952.

The new generation of occupational therapists are embracing the opportunities that increased globalisation is presenting through practice placements abroad (Westcott and Whitcombe 2003). These developments are to be applauded. However, those of us for whom these opportunities were not available can also benefit from globalisation. We must all make more of the existence of our own unique networks and really use them to the benefit of practice, education and research. There are few professions that can boast the existence of a worldwide organisation and two European ones and yet I feel that we have not fully exploited their potential.

In the case of the European Network of Occupational Therapy in Higher Education (ENOTHE), the extension of activity into research has only recently been allowed due to European Union restrictions. As a consequence, I have only relatively recently become actively involved in ENOTHE through the creation of a network of excellence to consider how research into lifestyle redesign for older people, introduced by American colleagues and taken forward in Sheffield as described previously, can be extended across Europe. I cannot deny that the effort of undertaking this and other European Union projects that I am involved in is considerable; for example, that of trying to coordinate concurrent activities across Europe. However, the gains are significant. One of our first tasks is to compare the different service delivery contexts for older people in Portugal, Norway, the Netherlands, Belgium, the UK and Georgia. This is proving to be fascinating. I am also making new friends and colleagues.

Contemporary challenges for individual occupational therapists

Let us now consider the personal challenges for us as individual occupational therapists. Over the past few months since being asked to deliver this lecture, I have

spent a good deal of time reflecting upon my career as an occupational therapist and as a researcher. I have pondered upon the many challenges that I have had to face over the years. Some of the situations and issues that I am going to describe today may have resonance for you; some may not. However, I challenge you all to take time to consider what they might be for yourself.

The challenge of appreciating the experiences of users of mental health services

As I have already described, Dr Casson worked in an innovative way with people with mental health problems. And as also illustrated, it can be difficult for us always to see things from the perspectives of those using our services. As a young occupational therapist, I was fascinated by psychiatry and mental health and chose to spend the first 10 years of my professional life working with children and adults with mental health problems.

Services for people with mental health problems have changed significantly over the last three decades. The 1980s saw the closure programme of the Victorian asylums accelerate, with a move to create smaller community units (Knapp et al 1990). The attitudes towards people with mental health problems have now changed largely for the better and there has been a clear shift away from a custodial service provision to services that espouse to maintain the user and his or her carer at the heart of provision. However, contemporary change cannot make up for past injustice. The users of mental health services have been particularly vociferous over the last few years in their condemnation of a service system that left many disempowered (Beresford 2003).

A memorable event in my career was hearing Dr Viv Lindow, psychologist and survivor of the mental health system, speak passionately in 1996 about the experiences that she and others had endured (Godfrey and Mountain 1996). Even though I had over 10 years of working in mental health services, I do not think that I had really grasped the reality of what it might be like to be on the receiving end of the system until that point. Unlike what I had seen earlier on the wards for dementia, her presentation had deep personal significance for me. This was for two reasons: I had worked predominantly as a mental health practitioner and I was also her contemporary. In different circumstances, it could have been me.

Dr Lindow's presentation disturbed and unsettled me. It gave me much food for thought. What impact had I had upon service users in the past, to what extent had I accepted things as they were without putting myself in the shoes of the users of services, how could I improve things for the better? Here are some quotes from people who had experienced psychiatric services, expressed during the conference 'Thriving, not surviving: users' needs in mental health' (Godfrey and Mountain 1996):

> Professionals are often interested only in users' experiences of their illness and not in the total person or the skills they have to offer.

> Some workers do not want to hear about the experiences of people who have had mental health problems and who are now well because this is too challenging.

> There is so much to do in the user movement. Working with psychiatrists is important and some people wish to do that.

What was heartening was that despite the adverse experiences recounted by some people at the event, and the power that it was perceived that professionals have, the predominant attitude was one of wanting to change things for the better. By hearing the experiences of users, I hope that I have learnt to be more sensitive and more aware of the ability of individuals to manage their own condition. I also have greater understanding of the value of partnering with users rather than maintaining the established professional/patient power relationship.

The question for us all as occupational therapists is as follows: how can we keep the service user at the heart of all that we do when we are managing difficult problems daily and it appears at times as if local politics and predominant methods of service delivery are negating our efforts? This is a tangible, ongoing challenge.

The challenge of developing new areas of expertise

Another major challenge that I have faced during my professional career was concerned with entering a completely new domain of work. I embarked upon a research career in 1987. Those of you who know me well will know that (in common with many women of my age) the underpinning reasons were practical rather than that of following a desired career path. I found the transition extremely challenging. It challenged my intellect and my view of myself as a person and it also challenged me financially for a while.

On the intellectual level, after being required to read little if anything during my day-to-day work as a practitioner and manager (this was before the days of evidence-based practice), I was suddenly required to locate and read academic papers that I could not readily comprehend. My new working base was a university, a very different environment to that of my previous work setting. Also, because I was a diplomate from the Derby School of Occupational Therapy prior to its incorporation into mainsteam higher education, I had not experienced university life before.

I was challenged financially because as a diplomate rather than a graduate I was not viewed by the university as being appropriately qualified to command anything above the most lowly research assistant salary. These were the days before the now accepted role of occupational therapy researcher and I was given the role of very junior social scientist.

Taking the long-term view, it was extremely fortunate for me that by the time my downgraded salary had been confirmed I had already become totally fascinated by the project in which I was participating. The project was the one that I have already referred to, concerned with the relationship between ward environment and the behaviour

of the severely demented older people who lived on those wards (Bowie et al 1992). Once my fear had abated, I began to realise that, armed with my clinical background and experience, I had much to offer the project. The technical side of the research was learnt as we went along. This experience really fired me up and captured my imagination. I also realised that there are several ways in which service improvements can be made and that reflection might be more valuable at times than continuing to perform work tasks in the manner that I had sometimes undertaken them previously.

The challenge of working with other disciplines

Research in the UK and in Europe is now moving towards programmes of work rather than individual projects undertaken by single disciplines. As a consequence, I now find myself working with professions that I never imagined that I would have to encounter, let alone undertake project work with. As well as working with social scientists and psychologists, I now work with robotics and structural engineers, informatics experts, designers and industry. For the SMART Project, which is looking at technology for stroke rehabilitation, I am leading a consortium that includes a range of very different and disparate professional groups. This presents many challenges in terms of developing mutual understanding and a common vision of what we are all working towards. We all continue to work hard at this. It is not easy because each individual is continually challenged on a personal as well as a professional basis. However, the gains when we are successful are significant and I have learnt so much. This is what I have to remind myself of when I find myself becoming impatient and tired.

The challenge of increased working with a range of professional groups extends to us all. The writing was on the wall in the NHS Plan (DH 2000), which prioritised the creation of a range of services that cut across acute, primary and secondary care services. In 2001, I challenged the occupational therapy profession to ensure that as a professional group we were communicating together, setting aside the longstanding cultural divide between health and social care that in my view can blight our united strengths (Mountain 2001), building upon the new opportunities presented in the NHS Plan of 2000. Since then, and as predicted, integration and boundary blurring have advanced at a pace, throwing out expected as well as some unexpected challenges.

Using our legacy to vision occupational therapy in the 21st century

I have described the nature and experience of challenge from the perspectives of the users of occupational therapy services, the profession of occupational therapy and myself as an occupational therapist. I now want to complete this lecture by reflecting upon the occupational therapy profession for the 21st century, drawing upon a final experience from the past. All of us, whether young or older, will be able to recall seminal events or insights, which have stayed with us and have shaped our thinking and actions from that point onwards.

Dr Gail Mountain reflects on the occupational therapy profession for the 21st century in her stimulating Casson Memorial Lecture.

A few years ago, while working at the College of Occupational Therapists, I was privileged to be able to participate in a focus group with Professor Ann Wilcock. This was one of a series of groups undertaken across the country as part of the preparation for her now published work on the history of occupational therapy. A description of the participants of these groups and what was discussed is documented in Volume 2 of *Occupation for Health* (Wilcock 2002). The group that I participated in involved several retired occupational therapists, some of whom were well known for their ground-breaking work (Wilcock 2002).

What I heard was accounts of the early days of occupational therapy and occupational therapy education from a group of extraordinary, feisty older people. What they had achieved was astonishing. As an occupational therapist with a background in mental health, I was particularly struck by accounts of the experiences of being the sole occupational therapist within a large asylum and of working in partnership with the medical superintendent (who often also worked in isolation) to bring about change. They were a sparkling group, a shining example of energy and vision. They gave me a reborn sense of vocation that afternoon in a way that I like to think that Dr Casson would if we could speak with her today.

If Dr Casson were here today, would the UK occupational therapy profession have fulfilled her dream? Would we be able to look her straight in the eye and feel confident that we had done our best? Would she be pleased by the manner in which the profession has grown and developed? As Douglas (2004) stated:

> I wonder if she [Dr Casson] ever thought that there would be more than 24,000 occupational therapists working in the United Kingdom by June 2004? I don't think for a moment that she did, but obviously she recognised the benefits of engaging people in occupation … (p239).

We need to use the visionary notion upon which occupational therapy was founded to develop our vision for the future. This is perhaps the most important principle both for individual occupational therapists and for the profession as a whole. We were reminded of this by one of the leaders of occupational therapy in the US:

> Occupational therapy has a great deal to learn from its history. The profession was founded on the visionary idea that human beings need, and are nurtured by, their activity as by food and drink, and that every human being possesses potential that can be achieved through engagement in occupation (Yerxa 1992, p82).

In a few decades' time (depending upon your age now), if you are asked to recall what the main challenges are that you have faced during your career as an occupational therapist, what do you imagine that you will say? Will you be able to answer without hesitation? Will you be able to describe your achievements clearly? Will you be confident that you have made a difference?

Enduring messages for the present and future

Proactive responsiveness to change will secure the future of occupational therapy and ensure that our services remain both needed and appropriate. The greater numbers of older people in our society and the increasing incidence of chronic disease mean that the involvement of occupational therapy will continue to be sought. Demand for services is certain to shift from those promulgated by an illness model to one with health promotion and prevention at its core. Reinvestment in occupation as the main theoretical and practical construct underpinning practice alongside new opportunities presented by policy initiatives, technological advances and inclusive design is creating the optimal climate for the profession to demonstrate its true worth. We need to embrace the new opportunities offered by technology and by different ways of working. We must build upon our capacity to form partnerships with those who use our services.

As occupational therapists, we are required to do our best despite the obstacles that may be presented by attitudes, culture and longstanding practice. I am proud of the achievements of my profession, the challenges that we have overcome over the years and the standing that we can command in a range of varied forums and groups.

Some of what you have heard today is about my own journey as an occupational therapist and the wisdom that I have acquired or been handed along the way. You will all have your own stories and acquired wisdom. Use them well as the founder would have wished.

- Activity, participation, occupation and activation: our challenge now and in the future.

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- SMART Project: http://hsc.shu.ac.uk/smart
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