The Casson Memorial Lecture 2000, given on 21 July at the 24th Annual Conference of the College of Occupational Therapists, held at the University of Keele.

The Casson Memorial Lecture 2000: Reflect on the Past to Shape the Future

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Introduction

We are entering a new millennium and it is a great honour to be invited to give the Casson Memorial Lecture at such a time in our history. At the beginning of this new millennium, maybe we should be asking ourselves again the question that Mary Reilly asked in 1962: 'Is occupational therapy a sufficiently vital and unique service for medicine to support and society to reward?' (p1). Certainly, health economists and managers of services are asking this in some quarters. Over nearly 100 years we can see vast changes as our profession has developed but, as I reflect on those years, I have a feeling that there is something nearly circular in all this progression! I will explain this more when I move into the first part of my talk.

Let me introduce the theme and the content of this lecture first. There are two main sections which will demonstrate my choice of title: 'Reflect on the Past to Shape the Future'.

- First, as we move forward, we should also look back: reflect on what has been good and has guided our development both as individual occupational therapists and as a profession, a group of people, it is hoped, working together with common professional goals. As we do this, it will give us positive indicators for our future individual and group professional development. I am sure that some of my reflections will be similar to yours and I trust that my hopes for our future development will match your hopes and aspirations.
- Secondly, the users of our service are central to our work as occupational therapists. Our intervention should include time for the user to reflect on his or her past roles, occupations and quality of life before, and since, his or her problems occurred, so that together we can work alongside the user to plan and shape as positive a future as possible for that individual. The second part of the lecture will show how we can apply the important reflections from the first section to our service delivery, with older people being an example of this.

These are the two main sections of this lecture. And the word that is central to these two sections and to the thrust of my lecture is 'occupation'. So let us move on to the first section.

Reflecting on the past

As I was thinking about this, it was interesting to read Yerxa's recent article entitled 'Confessions of an occupational therapist who became a detective' (Yerxa 2000). She talked about 'sleuthing for evidence to support occupational therapy' (p197) – I liked that. I hope that it is something that we are all doing all the time in our professional lives. We have historical evidence, we have images of clients/patients, we have colleagues whose practice and theory development we have admired, discussed and challenged, and we have the evidence of research.

Let me bring together some of the evidence that I have thought about as I have reflected on the last 100 years.

Historical evidence

As I returned to the United Kingdom from the South of Ireland about 15 years ago, I became very interested in the beginnings of discussions that British occupational therapists were having about models and approaches specific to occupational therapy. However, I became more interested in the discussions on the philosophy of occupational therapy, which I felt should guide any occupational therapy models and approaches that we developed. The more I read, the more certain I became about the circular route that I mentioned earlier.

Meyer

Meyer, an American psychiatrist, while discussing the importance of 'occupation' in 1922, said:

> A pleasure in achievement, a real pleasure in the use and activity of one's hands and muscles and a happy appreciation of time began to be used as incentives in the management of our patients … The main advance of the new scheme was the blending of work and pleasure (Meyer 1922, 1977, p640).

Meyer (1922, 1977) also talked about the necessity for 'balance of activity' and of the newer concept of 'mental problems as problems of living', not merely as diseases (quite a move from the medical model!) He said:

> Our role consists in giving opportunities rather than prescriptions. There must be opportunities to work, opportunities to do and to plan and create … It takes above all, resourcefulness and ability to respect at the same time the native capacities and interests of the patient (Meyer 1922, 1977, p641).

So here we have Meyer saying, 80 years ago, what we are so clearly trying to state within the philosophy underpinning occupational therapy today, hence the 'circle':

- Making meaningful activity (occupation) central to our intervention
- Enabling a balance of activities: personal and domestic activities of daily living, work/play and leisure activities
- Providing opportunities for our clients to problem solve and plan, with our help if necessary, so that they can take ownership of decisions.

This all indicates a client-centred/user-centred approach.

About the time that Meyer was inspiring occupational therapists in the USA, Dr Elizabeth Casson was graduating as a doctor in the UK. She went to work in the area of psychiatry and was appalled at the idleness of and the lack of meaningful tasks for patients in mental hospitals. She travelled to the USA to see the potential of occupational therapy. Dr Casson returned to establish a residential clinic in Bristol and the first British School of Occupational Therapy was formed. Like Meyer, she certainly appeared to be convinced that meaningful use of the day was central to the physical, social, emotional and spiritual healing of her patients (Richards 1998).

Reilly

This theory and thinking of Meyer (1922, 1977) underpinned the work of the first occupational therapists in the USA. However, as the profession developed, both in the USA and here, a more reductionist flavour appeared within the profession and this still persists in some areas. As well as by the work of Meyer, I have also been greatly influenced by the work of Reilly and Yerxa, who both encouraged occupational therapists to move away from a reductionist approach. In the 1960s, Mary Reilly developed the theory of occupational behaviour. Underpinning this theory was her belief:

> … that man has a vital need for occupation and that his central nervous system demands the rich and varied stimuli that solving problems provides him and that this ought to be the basic need that occupational therapy ought to be serving (Reilly 1962, p5).

Over the past years we have heard the following statement from Reilly (1962, p2) repeated:

> Man, through the use of his hands as they are energised by mind and will, can influence the state of his own health.

Unpacking this, we see that:

- The client should be involved in the decision making within his or her life and within occupational therapy
- Meaningful activity must be part of this process
- This involvement will increase intrinsic motivation
- The client has the potential to be motivated to improve his or her quality of life
- The client is able to adapt and has the coping strategies to do so. Humans have a need to master their environment, to alter and improve it.

Again, this is all central to the philosophy underpinning occupational therapy (Mayers 1990).

'Motivation', as well as 'meaningful occupation', are the words that come instantly to my mind as I read the work of Reilly. Clients know what they want to be doing, they know where their own special, individual goals lie, and they know what is meaningful for them – we *do not* know until we ask and discuss. How many times have you, have I, made judgements or decisions without asking the client at the beginning of the intervention?

Yerxa

Reilly's (1962) theory began to move many occupational therapists away from the more reductionist, medical model form of practice, both in the USA and more recently in the UK. I do not think that I have ever worked according to the 'medical' model. This may be because I spent much of my younger life in hospital and was aware, whilst in my teens, of the frustrations of being a 'patient' with an active brain, able to problem solve and sort out my own problems, but still being told 'This is what you *ought* to be doing' – guaranteed to make an individual *not* want to be doing! Yerxa's (1983) comparison of traditional values supporting the practice of occupational therapy with those of medicine should be regular compulsory reading for anyone working in a district general hospital!

Yerxa was inspired by Reilly (Yerxa 2000) and I, in turn, have been inspired by Yerxa (as many occupational therapists who were educated at York will confirm!) We should believe that:

> Occupational therapists have the optimistic faith in the potential of every individual to grow, change and move towards purposefulness (Yerxa 1979, p27).

Do we believe this? As a profession? As individuals?

Yerxa et al (1989), Yerxa (1993, 2000) and Wilcock (1998a) have encouraged occupational therapists to consider the whole concept of 'occupational science'. Those two words appear to cause some occupational therapists to freeze, in the same way that 'models and approaches' did a few years ago! I was over at the University of Southern California about 11 years ago when the PhD programme in occupational science was being developed. I must admit that I was very unclear then what it was about. I am now much clearer; to me, the easiest way of explaining it is to say that it is the study of *why and how* humans do what they do or 'the study of humans as occupational beings' (Yerxa et al 1989, Yerxa 1993, p5).

By studying occupation which is 'central to human experience' (Wilcock 1998a, p25), 'the fabric of everyday lives' (Cynkin and Robinson 1990, cited in Wilcock 1998a, p26) and integral to human behaviour, we will help to strengthen our profession's knowledge and theory base, which will in turn enhance our practice of occupational therapy. We need to try to unravel the complexity involved in factors like, for example, why some people with what we consider huge disabilities find meaning to life whereas others do not, and how best we educate society about the individual needs of people who are disabled by environmental and societal barriers. We need to analyse the 'illness experience' (Kleinman 1988), clients' stories, in more depth and discover the importance and meaning of occupation to them.

Evidence from colleagues and users

I have seen Yerxa's (1979) 'optimistic faith' in a number of my colleagues over the years. One example is Helen, a tutor at the college where I was educated as an occupational therapist. She clearly had this optimistic faith in me, who had many problems as a student. I have certainly moved towards purposefulness! Thank you, Helen.

Another example is a colleague and friend who had a major chronic disability herself. She was practising before Yerxa appeared on the scene, but she certainly put this optimistic faith into practice as she set about starting the occupational therapy service in the Republic of Ireland. Ann sat down with her clients, who became her friends, and problem-solved with them; regardless of how severe the dysfunction was, she majored on the abilities of these people and motivated them (often by her own enthusiasm).

This is the drive that I have subconsciously looked out for in all my colleagues and clients and I have seen it in many of them. This is the exciting aspect of occupational therapy: it is about living, doing, being (as Wilcock [1998b] stated); it is about the nitty-gritty activities of living; it is about *helping people to do what they want to do,* whether it be getting in and out of the bath, doing the ironing, going hill walking, having a holiday abroad, following a professional career or sitting quietly reading a book.

We can also apply Yerxa's (1979) quote on 'optimistic faith' to the students with whom we work, if we are in education or undertake fieldwork supervision. It is exciting to see the enthusiasm of students as they begin to put the occupational therapy picture together and move towards that goal of being an occupational therapist with, it is to be hoped, a clearer view than some of us appeared to have when we entered the profession. It is only in recent years that I have clearly begun to hear occupational therapists say: 'Yes, I *can* explain what I do and show that it is different to other health care professionals' and 'Yes, I am proud of the name '*occupation*al therapist'.

Evidence from research

The Canadian occupational therapists have really put client-centred practice on the map (Canadian Association of Occupational Therapists [CAOT] 1983, 1986) and their Canadian Occupational Performance Measure was being developed as I was developing a client-centred approach for use in community occupational therapy. The Mayers' Lifestyle Questionnaire is the tool of this approach. Meyer, Reilly and Yerxa certainly inspired me as I developed a client-centred approach. I now have a 'client-centred approach cum quality of life' label hanging round my neck because my research for the past 12 years has centred round these areas (Mayers 1993, 1998). More and more, I see the whole concept of a positive quality of life being complemented by 'all purposeful human activity' which Wilcock named as 'occupation' (Wilcock 1998a, p3).

I am an active researcher and all my research has been centred on developing the theory base of our profession and showing how we can improve the motivation and quality of life of service users by targeting their individual priority needs. As both the Mayers' Lifestyle Questionnaires (1) and (2) were being developed, users were consulted. My own experience has shown that users wish to be used in research projects if the study is going to aid intervention with other users. I interviewed people with enduring mental health problems about their quality of life, in order to make sure that the wording of the Mayers' Lifestyle Questionnaire (2) would reflect the quality of life issues that are important to this client group. They all said that they felt valued because their opinion had been asked (Mayers 2000).

I have been a practitioner, an educator and a researcher, but within all these roles I am still an occupational therapist – and proud to be. However, I think that the research aspect has had the most influence on my own professional development. In order to do research, one has to read, one has to evaluate the research process of self and others critically, and one must disseminate the results of the study – preferably in published material. We have an obligation and an ethical responsibility to do this for the sake of our profession's development and for the service users. We want them to be given the most effective intervention. Any researcher has to be a 'detective', back to Yerxa's (2000) 'sleuthing' again, and I find that exciting to do. Evidence-based practice has been a buzz phrase for a while now and long may that continue. However, in order to have the evidence, we need to write up what we do so that others can reflect on their own practice in the light of our evidence.

Moving forward

A paradigm

And so we need to move forward … I have reflected briefly on the past and now we need to move on to see how these reflections can shape our future. As I said earlier, I have seen a keen interest in the development of occupational therapy specific models and approaches since returning to the UK. Much has been written on these subjects. The reflections that I have made do move me forward as I think about the development of our profession. The major gap I see is that of a clear paradigm for the profession of occupational therapy. We have a reasonably clear philosophy of occupational therapy and we now have models, theories and approaches, some generic that all health professionals can use and some occupational therapy specific, but what we do not have is a paradigm. Much has been written on the meaning of a paradigm; for example, we have discussion and definitions in Kuhn (1974), Creek (1990), Hagedorn (1992) and Kielhofner (1992).

From my own research on the subject, may I suggest that a paradigm:

- Reflects the philosophy of our profession
- States our common purpose as a profession
- Helps to guide and make sense of our professional action
- Enables us to understand what underpins our practice and why we do what we do
- Should unify the profession and define the nature and purpose of occupational therapy.

If we believe that this is so, then may I suggest that we need a British occupational therapy paradigm that has 'Occupation – all meaningful human activity' central to it. In practical terms, this suggests that we need to reword our definition of occupational therapy so that it reflects more clearly our fundamental principles and philosophy.

Here is a definition for us now as we enter a new millennium, worded with help from the students and staff at the College of Ripon and York St John:

> Occupational therapy is the process of enabling individuals to participate in a self-determined balance of (meaningful) occupations – work/productivity, play/leisure, rest, and personal and domestic self-care – in order to maximise their abilities and enhance quality of life.

- 'Meaningful' is in brackets because I was looking for a definition that was appropriate and understandable to our profession, other health professionals and the lay person. Occupational therapists know what is meant by 'occupation' but others probably need the 'meaningful' there too.
- The balance must be self-determined because we all balance our time in different ways. Linda Finlay and I used to joke about whether writing books or doing a PhD should be viewed as work and/or leisure. Linda viewed both as included within work and leisure whereas I considered both most definitely work activities!
- 'Maximise' is very individual too. For some clients, 'maximise' will be minimal because their problems will be so profound. However, we will still go for it alongside the client to maximise the abilities that he or she does have.

A shared vision

Then we insert our shared vision into the paradigm. If it is a shared vision, it should be common to *whatever area of occupational therapy we work within.* When I was observing the practice of occupational therapists a few years ago, as part of my PhD research, I decided that there were three different 'breeds' of occupational therapist: those who work in social services, those who work in physical rehabilitation within the National Health Service and those who work in mental health (community or hospital based). It was sometimes hard to believe that all had done very similar educational programmes, wherever that educational programme had occurred! Rigney's (2000) article on 'Physical or mental health: should we divide?' reinforces this thinking.

The College of Occupational Therapists' position statement on clinical governance states that it is necessary for us 'to [have] an organised, integrated approach, thus safeguarding the quality of service provision to individual clients' (1999, p261). The words 'integrated approach' need underlining in our professional thinking.

Let us look at what should be included within this shared vision, which is central within the paradigm and determines our definition of occupational therapy:

– Our respect for the individual
– Our valuing of, and belief in, the importance of occupation.

Respect for the individual

Our respect for the individual includes his or her:

- *Uniqueness:* Why are people still referred to as strokes, amputees, schizophrenics, rather than people with … ? Also, why do we label people with a diagnosis when it is the abilities and problem areas of their lives with which we are involved?
- *Abilities, rather than dysfunction:* If we look at a person's intervention priorities, key occupations and roles, we then look at how best the client can do these activities, thus emphasising the abilities. At the same time, the client will be motivated to problem solve, with our help, the areas of dysfunction.
- *Priority of needs – choice of occupational performance tasks:* These must be identified by the client right at the beginning of the intervention. Isn't it nice to have a lie-in on a Saturday morning or lie in the sun by the swimming pool when we are on holiday? Yes, but these are chosen occupations at a set point in time. We are in control of when we get up and where we go on holiday. If we have no impairment, we are free to participate or not participate in all life's experiences and activities (World Health Organisation 1997). However, if we are sick and need to stay in bed, we do not want to be there because we have no choice.
- *Coping strategies:* Carers, belief and value system, intrinsic and extrinsic motivation – who or what are your coping strategies when the going gets rough? Your partner, your pride, children, a friend, smoking, eating, faith in God, prayer, squash, walking, music, screaming? These coping strategies, some more positive than others, must never be overlooked when we plan intervention alongside our client. They are so important and are often the driving force initiating the motivation that a client has to succeed and thereby alter his or her personal situation.
- *Potential for the client to be motivated* and enabled to alter his or her personal situation, environment and quality of life.

The importance of occupation

Our valuing of, and belief in, the importance of occupation, which:

- Is a basic human need (Polatajko 1994)
- Is an essential component of life: gives meaning to life and therefore improves an individual's quality of life
- Enables a healthy lifestyle
- Has physical, social, psychological, emotional and spiritual dimensions.

We implement this process by one of 'mutual cooperation' (Yerxa 1983, p152) with the users of the service. The occupational therapist works alongside the client and thereby helps the client to help himself or herself. The client is an active participant within the partnership.

Shaping the future

So where have we got to now? I have reflected on the work of Meyer, Reilly and Yerxa and on my own research in

initiating discussion on an occupational therapy paradigm that states clearly that 'all meaningful human activity' or 'occupation' is central to it. This must make our intervention client centred and determine how we work with the users of our service. Any model or approach that we use should sit comfortably within the paradigm, which is underpinned by the philosophy of occupational therapy.

Looking at our intervention

So with these thoughts in our mind to underpin our practice as occupational therapists, I will move on to the second section of my lecture and start thinking about the application of all this theory to our intervention. If we are going to work within this paradigm, then those of us who are practitioners have got to stand back from our practice and evaluate whether our respect for the individual and our belief in the purpose and function of occupation are central to it. We need to step back and look at our intervention, what we are doing and why we are doing it. As Dickinson (2000, p247) stated: 'Quality is now a statutory responsibility within the health service.' This includes evaluation, audit and research.

Those of us who are in education need to take a fresh look at our education programmes and see if the central focus just described is there. Those of us who are researchers need to be including more on the value of occupation. With occupation central to our definition and our paradigm, it is essential that we develop the research aspect of this, which brings us back to occupational science again. OccupationUK came into being this year: a web site, at present being developed by Matthew Molineux, a colleague of mine at the College of Ripon and York St John.

Let me repeat what I said in the introduction: our intervention should include time for the user to reflect on his or her past roles, occupations and quality of life before, and since, his or her problems occurred … so that together we can work alongside the user to plan and shape as positive a future as possible for that individual.

There are so many questions that we need to ask ourselves if we believe in client-centred practice with occupation central to it. Let me give you some examples of this from my own research. This demonstrates clearly that getting in and out of the bath is a key priority area for many of our clients with problems caused by physical disability (Mayers 1998). So why is bathing bottom of the priority list in social services if we say that we use a client-centred approach?

People do not like having to sit in a chair because their mobility is not good and watch the dust accumulate (Mayers 1993). They still do want people who are happy to clean the house, not a generic health care assistant; maybe the new name of 'personal assistant' will help this.

My research has also shown clearly that the reason that a doctor refers a client is not the priority area for most clients; it may be *one* of his or her priority areas (Mayers 1998). In addition, people with mental health problems *do* want to be employed in meaningful occupation that enables them to be financially independent (Mayers 2000).

I would like to suggest that a more client-centred approach, that is, asking our clients what their priorities are at the beginning of intervention, will reduce the revolving door syndrome. I have no research to prove it as yet, but my hypothesis is that if all occupational performance areas of a person's life are taken into account when intervention begins – work/productivity, play/leisure, rest, and personal and domestic self-care activities of daily living – then the person will not be referred again so quickly.

Work with older people

We are entering a new millennium with an ageing population. At present, there is just over 1 person in 6 aged 65 years and over. By the year 2031, it is predicted that there will be nearly 1 person in 4 aged 65 years and over (Central Statistical Office 2000; Government Actuary's Department, personal communication). I would therefore like to apply the paradigm that I have suggested in the first section to our work with older people. I will do this with reference to relevant governmental pronouncements, work and leisure occupations, our role within primary care and residential and nursing home accommodation for older people.

Governmental pronouncements

The government is striving to ensure that the health of the population improves (Secretary of State for Health 1998). This will increase the length of people's lives and the number of years people spend free from illness. However, our predicted ageing population is not only due to improving the health of our nation. The post-war baby boom of 1920 is reflected in this picture because the people born then are now in the 75 years and over grouping. This percentage of older people, aged 75 years and over, is going to increase considerably in the next 25-30 years. I am very aware of this because I am one of them – part of the post-2nd World War baby boom!

How are we preparing for this demographic picture as occupational therapists? I hope that we are taking this very important trend into account as we look ahead. Can we still afford to have occupational therapists working in acute orthopaedic services, when all there appears to be time for is a quick dressing and cooking assessment in the unit's possibly unreal-to-the-client kitchen? I know that this is due to the fast throughput of patients; I am certainly not criticising occupational therapists working in this area, but maybe we should be looking again at what we are doing and how and why. Is there a better way?

May I suggest that we should be concentrating our services on people with long-term problems, with a service that is streamlined to follow these clients from hospital into the community? This must include the older members of the population, individuals who often have problems due to multiple pathology. The occupations that are so much a part of daily living …

- Feeling pleasure in that daily living
- Feeling able to succeed, being well motivated
- Able to have close relationships within and without the family
- Having accomplished tasks

… are all very necessary aspects of a good quality of life. As I said earlier, this is what occupational therapy is all about: we are here to enhance quality of life.

As the government is serious about a healthier nation, we need to have a much clearer policy regarding our service and its future than we appear to have at present. A news release from the Audit Commission (2000) referring to its publication *The Way to Go Home* stated much that we need to be considering as key players in health services for older users. It called for major changes to be made by NHS and social services departments and proposed a framework for strategic joint working. Occupational therapists need to have a united front.

Let us look at how we can do this in relation to some of the statements quoted from the Audit Commission (2000) news release:

'Many older persons said they had not been asked what therapy they needed and were not involved in their own rehabilitation programme' (p1): This first statement clearly can be met by occupational therapists putting into practice what I have stated about respect for the individual and the value and purpose of occupation. We should be identifying the priority needs of the client and this can only be done by asking him or her about them. Assessments like the Canadian Occupational Performance Measure, the Occupational Case Analysis Interview and Rating Scale and the Mayers' Lifestyle Questionnaire enable this to occur.

'More effective rehabilitation services help reduce waiting lists and winter pressure' (p1): The Mayers' Lifestyle Questionnaire (1) is now being used by social services to reorganise waiting lists. This questionnaire is sent to the client as soon as the referral has been received and the client completes it, identifying his or her needs, prioritising these and indicating the occupations that he or she wishes to be doing. The client returns the form to social services, who then decide where this client should be on the waiting list.

'Stroke is the leading cause of major disability in the UK but only half of acute hospitals have a dedicated stroke unit … Over a third of stroke patients were not even told what a stroke was whilst in hospital; and the majority of stroke patients never received ongoing therapy at home on discharge' (p1): A number of studies carried out emphasise this last sentence (Labi et al 1980, Niemi et al 1988, Morgan and Jongbloed 1990, Angeleri et al 1993). The studies showed clearly that although the individuals within them had been independent in relation to personal and domestic activities of daily living on discharge from hospital, the majority displayed clear signs of social dysfunction several months after discharge. This resulted in deterioration of the leisure-time activities that they had enjoyed pre-stroke; or, it may be asked, did the deterioration of leisure-time activities lead to social dysfunction? As Radomski (1995, p488) stated: 'Recovery after stroke is typically measured by the extent to which the patient is able to walk and perform self-care activities.' Our definition and paradigm of occupational therapy indicate clearly that there is more to life than this. I do sincerely hope that if the number of stroke units is increased, *all* areas of each client's occupational performance will be assessed; that his or her past roles and meaningful occupations will be considered and used to help to shape the future of the users of the service.

These studies with people who have had a stroke indicate clearly the need for a seamless service – one where the users of our service are supported by occupational therapists, or whoever is required, from hospital into the community. Much has been indicated about the value to individuals of improving partnerships in order to continue the support of clients once they have left hospital (Department of Health 1998, 1999, 2000). However, there is still an emphasis on personal and domestic activities of daily living to the detriment of leisure, work and social occupations. This is limiting our skills and our service.

Work and leisure occupations

There are very many fit older people. The majority want to stay in their own homes and maintain their interests as they become older. The over-75-year-olds that we have at present, and the majority are women, were not within a generation of women that worked in paid employment. Their work was looking after the family and the home. These are the folk that cannot bear to watch the dust accumulate. They want to clean the house properly because that is what they did and this was a meaningful occupation for them. If they cannot do it properly themselves, they want someone who can.

As the family grew up and left home, their interests often revolved round the grandchildren. However, we are now living in a culture where young people leave home and leave the area where their parents live. As a parent is widowed, loneliness sets in and this is a common factor in older people unless they have leisure pursuits outside the home. Just under 1 in 3 households comprised one person living alone in 1998/99; this suggests that a huge percentage of older folk are on their own (Central Statistical Office 2000).

All occupational therapists should read Margaret Forster's books *Hidden Lives* (1995) and *Precious Lives* (1999). These are her biographies about her parents' lives. Pages 293-296 in *Hidden Lives* are a wonderful demonstration of how important it is to respect the past interests and meaningful occupations of older persons. We must use these past interests and activities to give older people the motivation to cope with the future. It would be good to see occupational therapists being invited to speak at pre-retirement classes, using our definition as a starting point in such a class.

Chapter 13 in *Social Trends 30* (Central Statistical Office 2000) states the leisure activities that are popular with older people:

Home-based: Television is the most common activity – approximately 38 hours a week – but is this by choice or through a lack of alternatives? Reading, visiting friends and relatives are also popular. The proportion of home-based computers has almost doubled between 1988 and 1998/99, from 18% to 34% (Central Statistical Office 2000). The majority of those moving into the 65 and over age-group in the next 10 years will be computer literate and probably own their own computer.

Activities outside the home: Walking and playing bowls are the most popular physical activities. The most common leisure activity away from home continues to be visiting a pub. Older people are more likely to attend a classical music concert than those aged 35 and under (Central Statistical Office 2000). Many town centres have drop-in centres for older people to get together for coffee, tea, discussion and company. Do be on the watch that as your town becomes pedestrianised these folk are still able to access such centres.

Spiritual beliefs: In 1998, over 1 in 5 people (all ages) agreed with the statement: 'I know God really exists and I have no doubts about it.' Over 8 million people regularly attend religious services in the UK (Central Statistical Office 2000). This is 13% of the population (all ages). How many of us as occupational therapists have been invited to assess the accessibility of a church, mosque or other building where people go to worship God? The Department of Health (2000) document, *A Health Service of all the Talents: Developing the NHS Workforce,* emphasises 'flexible working' and 'streamlined workforce planning … which stems from the needs of patients not professionals' (p5).

I hope that I am not stretching a point too much when I say that 'flexible working' speaks to me of a service, such as our profession, working flexible hours. If we have a client who wishes to go to a church, synagogue or mosque regularly, then we should be there with him or her on the Friday evening, Saturday or Sunday, whichever day is most appropriate, to check that the building is accessible and our client can have his or her spiritual needs met. Such places also enable key social contacts for older people.

Within primary care

A survey carried out by the Social Services Inspectorate (1994) showed that 71% of all local authority occupational therapy referrals were for people aged 60 years and over and 40% of these were aged 75 years and over. We can assume that these percentages will increase as the population ages.

The General Household Survey of 1996/97 (Central Statistical Office 2000) stated that more than 25% of men and 40% of women aged 75 years and over had problems performing their usual activities.

Since April 1990, general practitioners (GPs) have had to offer an annual home visit and functional assessment to all their patients aged 75 years and over (Brown et al 1992). Many of these assessments are carried out by practice nurses rather than the GP. In a study done by Nocon (1993), it was seen that more referrals were made to the community occupational therapy service than to any other service following these assessments: 5% of all people assessed.

Occupational therapists are working increasingly in primary care. May I suggest that we clearly have a role in undertaking these functional assessments, particularly as occupational therapists say that to be able to do what we want to do leads to a healthier lifestyle and a positive quality of life. The Mayers' Lifestyle Questionnaire (1) (Mayers 1998) is being used by occupational therapists working in this area to assess the functional needs and priority needs of clients aged 75 years and over. This questionnaire does not just include personal and domestic activities of daily living; it also includes work/productivity and play/leisure. If these areas are checked each year, problems and priorities can be investigated before referral situations occur.

Residential and nursing home accommodation for older people

Ageing International (1996) advised that all those who had an interest in older people should put maximum effort into addressing the quality of life that accompanied the increase in life expectancy. At present, about 6% of people over the age of 65 years are living in residential or nursing home accommodation. This is likely to rise with the projected figures seen earlier regarding the demographic trend, even though there is an emphasis on keeping older people in their own homes if this is their choice.

I have spent much time in and out of residential and nursing homes over the past few years as the friend and carer of a lady who took up residence in both. I must admit that with some homes I visited there was the feeling of what Whiteford (2000) defined as 'occupational deprivation'. Her definition was 'A state of preclusion from engagement in occupations of necessity and/or meaning due to factors that stand outside the immediate control of the individual' (p201). The experiences that Whiteford described of prisoners that she interviewed surely match those of residents in residential and nursing home accommodation, such as 'gross disturbances in orientation: … unable to "locate" themselves in time' (p203). This was due to a lack of occupations to provide structure and variation to the pattern of the day. Sleep was reported as a predominant response to the prisoners' occupationally deprived state and we have all seen that this is a very regular pattern of behaviour by older people in residential accommodation. Of course, this may also be due to the medication used.

I therefore wish that every person entering such accommodation could meet with an occupational therapist during the first few days. There should be discussion about the roles, interests, abilities and problem areas that each person has. Many will come with a care package but this may have been decided upon without discussion with an occupational therapist.

Green and Cooper (2000, p17) stated: 'Occupational therapists … would wish to promote the preventative role of meaningful occupation in maintaining nursing home residents' health and enhancing their quality of life.' This meaningful occupation is going to vary with each person entering the accommodation but many will have interest needs that can be met: discussion groups (maybe one on the soaps!), e-mailing and surfing the net (will be very important when my generation arrives), relaxation sessions, Open University degrees, horticulture (indoor or outdoor), outings, concerts, cooking and keeping own space clean. I really enjoyed the quotes in Green and Cooper's article (2000, pp20-21): 'By the time the residents had fed the squirrels, groomed the dog and tidied away the library books, it was usually time for them to lay the tables for lunch … A home owner encouraged residents who were interested to help to

decorate.' Even if residents are not physically able to take part, they can use their knowledge and skills to advise.

The occupational therapist would also be concerned with other priorities that a resident may have. I remember an argument that I had about the need for a raised toilet seat for my friend who wished to stay as independent as possible concerning her self-care. 'Oh that is not necessary here, we help all the residents to the toilet.' I won that discussion.

Conclusion

The title of this lecture was 'Reflect on the Past to Shape the Future'. Knowing what I wanted to include, but having difficulty in coming up with a snappy title, two of my second-year students suggested that I think of wording around a 'rear-view mirror'; that is, we look back in order to direct our movement forward. I could not incorporate this into the title, but it certainly demonstrates a good way to move forward.

I have endeavoured to do this by reflecting on the profession's history and on evidence from individuals and colleagues, and also from my own research. This has aided my thoughts on wording a clearer definition of occupational therapy and starting debate and discussion on an occupational therapy paradigm. I then used the definition and thoughts on the paradigm to remind us that as we enter a new millennium, we must include time for the clients/users of our service to reflect on their past – roles, occupations and quality of life. This is in order to enable the user and the occupational therapist to work together in mutual cooperation to plan the user's intervention. I used examples from our intervention with older people to illustrate this.

Let us enter this new millennium ready to respect the past and to embrace positively the future of our profession, occupational therapy.

Acknowledgements

Many thanks go to Deon Falcon for her guidance with the PowerPoint presentation and also to Carol Walker and Deborah Williams for their very helpful feedback. Thanks also go to the year 1 and year 2 students at the College of Ripon and York St John for their encouragement and humour as I decided on the content and title.

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