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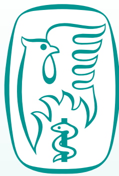
# The Elizabeth Casson Memorial Lecture 2013: Transformational leadership in occupational therapy — delivering change through conversations

*Elaine P Hunter*



**Key words:**
Leadership, engaging, transformational.

The Elizabeth Casson Memorial Lecture 2013, given on 19 July at the 37th Annual Conference and Exhibition of the College of Occupational Therapists, held at the Scottish Exhibition and Conference Centre, Glasgow, Scotland.

## Introduction

It is a privilege and honour to be standing here as this year's invited speaker to give the prestigious Elizabeth Casson Memorial Lecture. I am even more delighted to be presenting the lecture in Scotland — my 'home turf'. Indeed, Scotland has a strong occupational therapy history (Paterson 2010). Looking back, we can see that some of our work started right here, in Glasgow: the first British occupational therapy department was introduced in 1919 at Gartnavel Royal Hospital (Paterson 1998, p312) and, in 1932, a group of 15 women met in Glasgow to form the Scottish Association of Occupational Therapists, the first such professional body to be established in the United Kingdom (UK) and the third in the world (Paterson 2012). Those earlier pioneering occupational therapists understood the benefits of working together; eventually, in 1974, when the Scottish Association amalgamated with the Association of Occupational Therapists (founded for England, Wales and Northern Ireland in 1936), we became what we are today: the British Association of Occupational Therapists (Paterson 2007).

With the leadership and vision of those earlier pioneers in mind I have chosen a topic as relevant now as it was then, and one that I hope will inspire and inform us today and beyond. My lecture will focus on leadership, and the need for more occupational therapy leaders as we move forward into the coming health and social care modernisation agenda. We need occupational therapists with vision, who are innovative and able to collaborate with policy makers, members of the community and leaders in other professions. Occupational therapy leaders such as these will enable us to create and implement solutions for the many challenges facing services at present and in the future.

My aims in this lecture are twofold: I want to reach out to those of you who are already leaders for our profession, encouraging you to think about your own leadership journey and make connections between your stories and what I have to say; at the same time, I want to inspire our next generation of leaders to step up and become transformational leaders. I will present my leadership journey to you as a narrative about engaging transformational leadership.

Writing this lecture has deepened and challenged my thinking about leadership and my role as a leader; in fact, I never saw myself as a leader — for me, becoming a leader arose out of 'doing my job' to the best of my ability. However, writing my ideas down has offered me the opportunity to

**Correspondence to:** Elaine P Hunter, National Allied Health Professions Consultant, Alzheimer Scotland, 22 Drumsheugh Gardens, Edinburgh EH3 7RN.
Email: ehunter@alzscot.org

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*Elaine Hunter, National Allied Health Professions Consultant for Alzheimer Scotland, in an inspiring Elizabeth Casson Memorial Lecture, calls for occupational therapists to become transformational leaders as the profession moves forward.*

reflect on my role and practice, as I re-read the literature and synthesised some of the current thinking on leadership so that I could share it with you today.

My lecture will focus and build on these three key messages:

1. We can all be leaders.
2. By engaging others in our work, we can accomplish amazing changes.
3. We should share what we do and in so doing, as leaders and as a profession, become more visible.

While I am speaking, I invite you to think and reflect on what three key messages you might take away from this year's lecture. I will come back to this at the end of my address.

## What has shaped my leadership?

> *... one of the most powerful motives we have is curiosity.*
> Elizabeth Casson (quoted in Butler 2004, p286)

To set the scene for my narrative, let me tell you about myself. As my story unfolds, you will see that my leadership journey is a story of an ordinary occupational therapist who has had extraordinary opportunities, allowing me to make a difference to how occupational therapy can be in the future — but at no point did I achieve this on my own:

> You cannot have leadership without at least three ingredients, a leader, a follower or co-leader and a shared endeavour. Take any one of these things away and leadership evaporates (Hawkins and Smith 2006, p45).

My roles in life are many, the most significant being those of friend, mother, wife, sister, aunty and daughter. I was the child who was quietly curious, stubbornly independent, always asking for explanations and with a need to understand. I moved from my home in Edinburgh and started my occupational therapy career at St John's College, York (now York St John University), at the age of 17. My placements were wide ranging, varying in location from Durham to London, and my diploma course grounded me in the detail of knowing every single bone, muscle and nerve in the hand, and other aspects of anatomy. We were well informed about psychology and taken on a journey of group and personal awareness. The course content and methods of teaching have changed significantly since the 1980s; however, I left with a deep understanding of our profession's continuing fundamental belief that, like a phoenix, we can adapt and change how and where we practice, but the 'why' remains the same: the significance of engagement in meaningful and satisfying occupation and its importance to our health and wellbeing (Wilcock 2001).

On graduating, I returned to Edinburgh to start work in mental health, at a time when treatment options were advancing and community care was beginning to become a reality. I started my work at the Royal Edinburgh Hospital, which was at the forefront of occupational therapy practice; engaging occupational therapy students was integral to our day-to-day work. Even at this early stage in my career, I understood how important it was for people to be engaged with local communities, and the benefits that ensue.

My leadership journey has been influenced by many great inspirational occupational therapy leaders. However, in looking back to enable me to move forwards, my first role model had to be the distinguished and highly respected occupational therapist, and pioneer in the field of mental health, Hester Monteath. She had wide international recognition, being a key figure in the World Federation of Occupational Therapists (WFOT), established in 1950 and on whose Council she served from 1973–88, chairing the organising committee for the first WFOT Congress, held in Edinburgh in 1977. You always knew that Hester's first concern was the rehabilitation and welfare of her patients and, no matter what changes Hester brought into the workplace, we all knew we were in 'safe hands'.

An influence on my practice has been the importance of supervision to my professional and personal development. I have always valued supervision and this led me to explore the 'why' of supervision for my BSc honours in Health Studies dissertation (Hunter 1991) and then to implement an evidence-based supervision package in practice (Hunter and Blair 1999). A further driver for my practice was the implementation of evidence-based practice in the workplace to strengthen and enhance services for patients. I wanted to understand how to achieve that so, in order to answer my own question, studied for an MSc and made this the topic of my research (Hunter 2007).

My leadership roles have since taken me far beyond my initial interests in the field of mental health. I have been a National Health Service (NHS) Trust professional advisor for occupational therapists in a range of hospital and community-based services. This role was the real beginning of my leadership journey, where my greatest lessons were from the mistakes I made in leadership and then, importantly, tried not to repeat. More recently, I took what felt like my biggest professional leap of leadership: I moved out of the NHS and into the policy arena and took up the post of Allied Health Professions Advisor to the Scottish Government, working

on programmes in both mental health and dementia. In a single weekend I moved from being an expert to a novice and, do you know, it was scary — but I loved it. I was given the opportunity to bring a strong practice voice to the delivery and direction of national policy.

In 4 years in this position (from 2008–12), I worked with civil servants, contributed to ministerial questions and parliamentary debates, and to a mental health allied health professional ministerial policy document (Scottish Government 2010). The policy document that I co-authored is changing the way occupational therapists work, and the way they are perceived, in Scotland today. With a group of allied health professionals, mainly occupational therapists, we have produced (and are currently still implementing) a policy document to redesign allied health professions' services in mental health. The outcomes of this work far outweigh anything I could have ever imagined, with amazing projects being developed and delivered on a regular basis (Ferguson et al 2011, Curnow 2012, Hutcheson 2013) making an enormous difference to how the profession is contributing to the modernisation of mental health services in Scotland (Scottish Government 2012b).

I did not set out to be a leader, but when offered the chance to lead I grasped it with both hands. Today, I want to try and make leadership accessible to everyone here, through sharing my journey.

### Go back to go forward

> *And if we are to go forward, if we are to make this a better world in which to live, we've got to go back. We've got to rediscover these precious values that we've left behind.*
> Martin Luther King, Jr (Washington 2003)

When thinking about leadership, let us go back to where we started, to a history of having exceptional occupational therapists who have contributed significantly to the development and the recognition of the profession.

Dr Elizabeth Casson, after whom these lectures are named, is one of the most significant of the early leaders in occupational therapy. She has been described variously as dynamic (Ellis 1987), determined, proactive and academic (Drummond 2010) and as a pioneer of diversity (Taylor 2007). One thing is clear: she dared to think beyond the habits and traditions of her time (Mountain 2005), convincing others of the merits of the, then new, profession of occupational therapy (Groom 2005). I wonder what Dr Casson would say now about the profession to which she made such a contribution, if we told her that, as a profession, we have grown from the original 15 therapists in Scotland to a UK profession with 33,837 registered occupational therapists (Health and Care Professions Council register on 1 June 2013). No doubt she would be overjoyed, but what advice would she offer us if she heard also that 'much of what we offer remains hidden' (Middleton 2007) and we lack 'political and public profile' (*OTnews* 2012, p14).

I was presenting at a Scottish Government event yesterday, celebrating 1 year since the publication of the Allied Health Professions National Delivery Plan (Scottish Government 2012a); a minister drew attention to the view that Allied Health Professions (AHPs) do not have a sufficiently high profile, and that for occupational therapy this was in part due to a lack of understanding about what, exactly, occupational therapists do. Would it not be fabulous if occupational therapy were to change this widespread perception, to become more visible and so maximise the profession's contribution to better quality care and improved outcomes for our patients? I will share with you some ways that I believe we could to do this, through cultivating the habits of transformational leadership.

## Decide what type of leader you want to be

What has become more noticeable to me recently, whilst in a policy role, is the importance of leadership. Leadership makes all the difference when it comes to targets being met, staff being supported or evidence being implemented. However, as a leader, I know that in order to be a credible leader, and to enable others to be leaders, it is also necessary to understand what the evidence is saying.

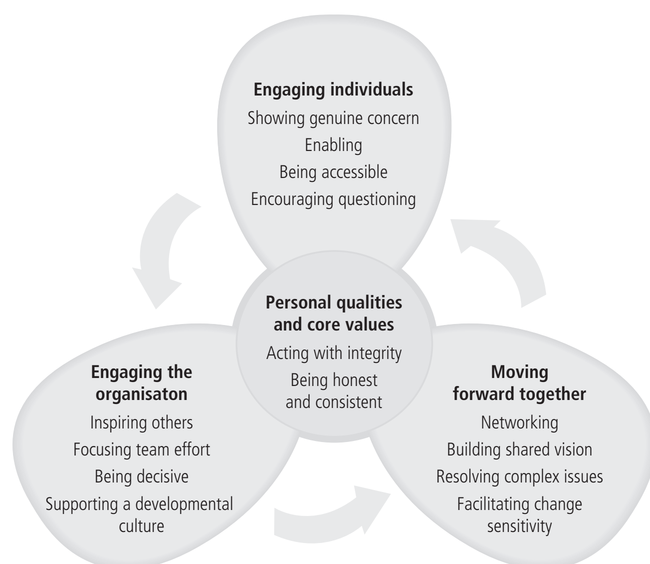
On reviewing the literature, there are many definitions and models of leadership (Stewart 2007, Wylie 2009); the concept is multifaceted and complex, and earlier work on leadership focused on transactional/managerial leadership. Within the literature there was a development in thinking and of debates on the relative merits of transactional and managerial leadership versus transformational leadership (Alimo-Metcalfe et al 2007).

The concept of transformational leadership was initially introduced by Burns (2010, original edition 1978) and later expanded by Bass (1985), who developed the idea of a continuum between transactional/management leadership and transformational leadership. Management takes place through transactions, and is about coping with complexity; without good management, organisations become chaotic in a way that threatens their existence. Leadership comes through transformation, and is about proactively enabling change through people (Scottish Government 2009, p5). It is clear, therefore, that management and leadership differ, but are complementary (Alimo-Metcalfe et al 2007, College of Occupational Therapists [COT] 2013).

Recent publications, mainly from The King's Fund, call for a 'new approach to leadership' that is shared within and across organisations, and has a focus on teams rather than just individuals, and on followership as well as leadership (The King's Fund 2011). Evidence and opinion is now emerging that a transformational engaging style of leadership is an effective strategy to adapt to in a rapidly changing environment (Firestone 2010):

- It can motivate staff to optimal performance (Stewart 2007), contributing to organisational effectiveness in health care in particular (Millward and Bryan 2005).
- It is also viewed as a credible model in recent papers on professionalism (Scottish Government 2012c).

*Fig. 1. Engaging transformational leadership through 14 dimensions in 4 clusters.**




*Alimo-Metcalfe and Alban-Metcalfe (2008, Figure 1), used by permission.

- The more engaged staff members are, the better the outcomes for patients and the organisation (West and Dawson 2012).
- Interpersonal and engagement skills are undisputed as crucial for NHS improvement (Hardacre et al 2011).
- It can support team innovation in mental health (West et al 2012).

Transformational leadership behaviours have been studied in the six largest AHPs in Scotland, of which occupational therapy was one (Wylie and Gallagher 2009). Their research demonstrated that self-reported transformational leadership behaviours in AHPs were significantly influenced by whether a person was of a more senior grade and had prior leadership training. They suggested two interesting ideas, one being that by the very nature of how we, as occupational therapists, work with clients we exhibit consistently higher transformational scores than some of the other AHPs; they noted that 'the elements within transformational leadership behaviours therefore must be identified and made clear to junior staff or even students at an early stage in their career' (Wylie and Gallagher 2009, p72).

Seeking clarity for the behaviours of a transformational leader brought me to the evidence-based model, by Alimo-Metcalfe and Alban-Metcalfe (2008), on engaging transformational leadership (see Fig. 1).

The model is characterised by a strong sense of inclusiveness, where leadership is 'distributed' throughout all levels of an organisation, the leader at all times being guided by ethical principles and working with others towards achieving a shared vision, enabling them to display leadership, with an emphasis on team working, collaboration and connectedness — the model is about encouraging questioning and challenging of the status quo (Alimo-Metcalfe et al 2007, Alimo-Metcalfe and Alban-Metcalfe 2008).

These are not bad qualities for our current or aspiring leaders to use as a benchmark, and also provide an opportunity for reflection, whether you are a manager, a leader — or both. The model also gives us all permission to be leaders, irrespective of titles or level in an organisation. Let me share with you some of my habits and routines of leading change through developing a vision that incorporates a policy context, includes patient narratives, maximises the evidence base and uses data to 'tell an interesting story'.

## Have a vision

*The very essence of leadership is [that] you have to have vision. You can't blow an uncertain trumpet.*
Theodore M Hesburgh (attributed)

To engage people in your work you need a vision: an image of the future.

If you have no vision, you will have no followers who wish to share it. As a useful reference to describe what I mean, I refer to the work by Covey, who suggested one should 'begin with the end in mind' (Covey 2004, p97): that is, start a project with a desired direction and destination, and then continue by 'flexing your proactive muscles' in order to make things happen.

Your vision has to reflect practice but be translated from the policy context, and from your local context: it needs to include patient narratives, maximise the evidence base, incorporate data to tell an interesting story and be achievable and measurable. When developing the vision, gaining consensus is a challenge; having 'ownership' of the vision is essential, and enacting the vision requires a consistent effort from all involved, ranging from your interactions with clients to strategic planners (Corcoran 2005). However, always remember that the motive for promoting our vision, and our work, 'cannot be anchored in professional self-interest or corporate history … ultimately it is dependent upon us being proud of what we do, and wanting to share it with others' (Findlay 1998, p143).

## Understand your policy context

*There is nothing permanent except change.*
Heraclitus (in Diogenes Laërtius 1925)

When researching for this lecture, one thing was clear: we continue to work in services where change is constant. Current political and health policy contexts may differ between the four countries that make up the UK (England, Scotland, Wales and Northern Ireland) but the messages are the same: we are working with people with increasingly complex conditions and with an ageing population. We need to make the strategic shift to deliver healthcare within the communities in a mixed model of integrated services (Naylor et al 2013). We will need to consider how we use technology to deliver services. In addition to these dynamics, this all has to be delivered in a context of providing services within

considerable financial constraints, and at a time of high-profile reports that highlight severe systems failings as a consequence of disengagement from managerial and leadership responsibilities (Care Quality Commission 2011, Department of Health 2013).

However, innovation can thrive in this climate of change — that's the honest truth! There can be new and expanding roles for us in this ever-changing world if we embrace the changes. We need to think *like our earlier pioneers* and seize the opportunities that co-production, asset-based communities and integration can offer us. In our vision, we need to *translate the policy context* and articulate how occupational therapy can contribute to the wider policy agenda, having understood the drivers and the language of policy, government and our own regional and local context. Gough, when writing about 'What is policy' offers us some practical tips on how to do this through building what she calls our 'policy capability' and 'policy intelligence' (Gough 2009, p27).

### Patient narratives and stories

*Storytelling is the most powerful way to put ideas into the world today.*
Robert McAfee Brown (attributed)

It has been my experience that our service users' stories can be as powerful as hard data when articulating a vision and enabling change. In recent reports, engaging and empowering patients to be fully involved in their care, and share in decision-making, and having patient-centred leadership has become increasingly important (The Kings Fund 2012, 2013). As a profession, we need to have the capacity to engage with our clients and reach into their stories (Smith 2006), finding effective ways to integrate their personal narrative into a strategic vision.

We are a person-centred, relationship-based profession; this is our strength. So, let us build on this by sharing our service users' stories to give a voice to our work with clients. I have done this recently through working with colleagues and filming four stories. The DVD was incorporated as appendices to our policy document (Scottish Government 2010) and also posted on YouTube. The stories focused on real life, and real people, and proved to be a powerful way to highlight the realities of people's lives and the positive impact occupational therapy interventionism can have.

### Maximising the evidence base

*If we are well informed, it is much easier to speak (and be heard).*
(Williams and Bannigan 2008)

As transformational leaders we need to use the available evidence to make a difference: we need to integrate it into our vision and support its implementation in practice. To do this, we need to have gathered evidence to support our profession's role, using profession-specific research to articulate the value of occupational therapy and to link this evidence to government and local strategies. Maximising the evidence base will require new ways of working and will, potentially, require us to stop doing some things and start doing others.

My more recent roles have been to integrate our evidence into both policy and everyday practice. I understand I am asking occupational therapists to foster new ways of working and that this change to practice can be challenging. However, with the right support it can be done. I look to the research (NHS Centre for Reviews and Dissemination 1999, Wimpenny et al 2010) and published practice evaluations (Bannigan and Birleson 2007) to offer a range of strategies to implement the evidence base, and have had the privilege to support a number of new evidence-based approaches being developed in Scotland, and more recently the work to embed the Tailored Activity Programme into occupational therapy practice (Gitlin et al 2009).

### Data development — 'an interesting story'

*We know it is good for us and our clients so we just need to do it.*
(Unsworth 2011, p209)

What became apparent to me when I went into national leadership roles was that both our patient stories and evidence base are critical. However, of equal importance in a vision is the ability to articulate the efficiency, productivity and cost benefit of occupational therapy.

I sought to understand how data is collected, analysed and used (whether to support the delivery of a national target or inform a service change), in the process discovering that by this means data can become interesting, and indeed can tell us a story about our practice and role. I also made myself aware of the economic evaluations and cost benefit factsheets we already have in occupational therapy (COT 2011a, Gitlin et al 2010) and worked hard to integrate this into policy, practice and my everyday work.

I support and work with colleagues to develop and collect data, embedding profession-specific outcome measures into routine occupational therapy practice. I am aware that only when we do this will we be able to meaningfully communicate patient progress and demonstrate service impact and efficiency (Duncan and Murray 2012).

## Build a community of influence

*Never doubt that a small group of thoughtful, committed citizens can change the world; indeed it is the only thing that ever has.*
Margaret Mead (attributed)

In any role undertaken in my career, I know that I am more effective, and the work is more sustainable, when I work collaboratively with a team of people towards building networks, relationships and a community of influence. To do this takes time, and you have to be prepared to be a 'leader among leaders' (Marshall 2011, p101). In this community of influence it is not about more meetings; it is about sharing and shaping the vision so that we can ensure its delivery.

My recent work on developing a community of influence has been with a group of AHP mental health leads, where we have used strength-based approaches that are encouraging and affirming (West et al 2012), and where we have shared practice and celebrated success.

To enact the vision, we have used appreciative inquiry. This is an approach that has worked for us as a group over the past 4 years, which we were first introduced to on a leadership development programme. Appreciative inquiry focuses on what works, looking at the root cause of success (Whitney et al 2010). So, instead of asking what went wrong, you ask questions that focus on what has gone well, guiding a group to seek what might be, rather than what is not (Marquardt 2005).

Central to the process is the art and practice of asking powerful positive questions: those questions that begin with Who, What or How (Vogt et al 2003), described by Whitney et al as 'treasure troves of best practice, success stories and creativity' (Whiteney et al 2010, p28). This is a method that we have used successfully at a national conference of over 250 people (Smyth 2010), in the role of an AHP mental health lead (Mickel 2012) and also in workshops, inviting participants to have a conversation about:

- What would it mean to people who use our service if occupational therapists worked from a recognition of the importance of work in promoting recovery, health and wellbeing?
- What would it mean to people who use our service if there was a set of national outcome measures that all occupational therapists used in everyday practice?

By using positive, powerful questions such as these we have learnt that by changing the question we are having new conversations with a range of stakeholders, contributing to positive changes in practice.

Once you have your vision, you then have to decide whom you want to influence, who is your audience, and to whom you need to speak. To do this, my colleagues and I designed a visual map of influence that asked:

- Where are the important connections for implementation?
- Where do you have influence?
- Where do you need more influence?
- Where is your circle of influence?
- Where is your circle of concern?

Maps of influence are important visual models of the key people and relationships that can support your work and vision implementation. Then, to enact this map of influence, you need to go out of your way to build working relationships in order to make yourself more visible and share your vision.

## Sharing the vision

Once developed with our community of influence, we can share our vision in a number of ways that might include:

- Purposively preparing a 'story moment': a 30-second version of your vision, so that 'when someone asks you what you do, you have already chosen the story and set each word as a jewel in a setting to share your clear and compelling message' (Marshall 2011, p121).
- Developing driver diagrams, where you provide a visual diagram that includes the aim you are trying to achieve, with primary and secondary drivers that will deliver your aim, and including measures to indicate that you are achieving your aim.
- Preparing policy documents, which could include a comprehensive review of current literature whilst challenging therapists to use evidence-based models in practice (Scottish Government 2011).
- Giving the Elizabeth Casson Memorial Lecture!

These are some of the traditional ways to share your vision, but we also need to develop new ways of getting the message out to a wider public — about why services need to change and the contribution that occupational therapy can make. One way to do that is through social media, and by being a digital leader.

Twitter, for instance, is a social network that enables users to write and read online posts that are limited to 140 characters. It is a free service, and has over 500 million registered users, who generate over 340 million tweets and 1.6 billion search queries per day (British Columbia Patient Safety and Quality Control 2013). In short, Twitter can help you to amplify your vision by reaching your target audience more easily and quickly than by only using traditional communications methods. Along with many others, I have been using social media in my work in the form of Twitter and blogs and have become aware of the opportunities that social media presents. As an illustration, we created Project Gandhi (2012), an online project about informing the wider community of the value of AHPs in Scotland. It was established in March 2012 with a group of four of us, all in strategic leadership roles, and ran for 12 weeks; the name was chosen for the project's resonance with the words attributed to Mahatma Gandhi, that we should 'be the change we want to see in the world' (Holdsworth et al 2013). We evaluated the project, concluding that the use of social media can positively promote greater awareness of our role and impact, forging new relationships, connecting with individuals and organisations globally, in a manner not routinely experienced.

Twitter has been a valuable resource for me to become aware of new resources, share practice ideas for improvement or find out about a newly published research article; it is also a great way to find and connect with colleagues around the world with whom you share a common interest, and is acknowledged as a valuable tool for leaders that flattens hierarchies and increases transparency. I have found that you can have direct access to a range of key people, including service users, carers, NHS chief executives and ministers.

As a real-world practice example, and in preparation for today, on 28 May 2013 I became the guest host on OTalk for an online chat with the topic of 'a place to talk leadership'. I contributed a blog (Hunter 2013) that went out the week before the session and where I asked three questions:

- What does 'good leadership in occupational therapy' look like?
- How do we build leadership (confidence), capacity and capability in occupational therapy?
- What can social media offer leaders in occupational therapy?

From 8-9pm on the day we had a great response to the online chat (OTalk 2013). Here is an overview of what took place and some considerations that arose:

- There were excellent contributions from a range of disciplines.
- The e-conversation was fast-paced and of a relatively short duration.
- The chat challenged my thinking about what I was going to present to you today.
- The experience reinforced my belief of being a leader amongst leaders.
- This was the busiest chat they had held at OTalk to date.
- There were over a million impressions (retweets and sharing from a range of countries, from the UK to Canada and New Zealand).

The response we had to the online chat on leadership was inspiring and stimulating; it left me in no doubt of the need to discuss and debate leadership in occupational therapy. In the hour-long discussion, and beyond, ideas were shared, and opinions expressed, with an easy to access international community of colleagues. Perhaps at next year's conference, a couple of the workshops will receive questions only by Twitter, presenting a real opportunity for occupational therapists to engage with wider and more diverse audiences.

My leadership journey continues in a new strategic leadership role in partnership with the Scottish Government and Alzheimer Scotland, as the Allied Health Professions Consultant, Alzheimer Scotland. Alzheimer Scotland is the leading dementia organisation in Scotland and has a key vision of 'making sure no-one goes through dementia on their own' (Alzheimer Scotland 2012). Dementia is one of the foremost public health challenges worldwide; I can also confidently predict that the majority of occupational therapists will work with someone who has dementia or will know someone who has dementia and have their own personal story to tell. I know I do.

What an opportunity a post like mine offers, to put into practice the role described by COT — as a consultant, to be pivotal in providing strategic leadership, to work across traditional boundaries and to drive strategy and service change using research (COT 2007), with the ultimate goal of improving access to occupational therapy for people with dementia and increasing public understanding of how we can assist in 'helping people to live life their way' (COT 2011b).

In Scotland we have a new dementia strategy (Scottish Government 2013) outlining 17 commitments to be delivered over the next 3 years. Importantly, one of the commitments targets allied health professionals; as occupational therapists we have a real opportunity to lead on this agenda:

> Commitment 4: We will commission Alzheimer Scotland to produce an evidence-based policy document outlining the contributions of AHPs to ensuring implementation of the 8-pillar model (Scottish Government 2013, p10).

In the next 12 months I will be leading the delivery of this commitment, writing the evidence-based policy document outlining the contribution of AHPs to an integrated community support model called the '8 Pillars' (Alzheimer Scotland 2012). I will do this by capturing people's narrative, maximising the evidence base, integrating data and building a community of influence.

At last year's conference there was a workshop that asked 'Is leadership an important quality for the development of the occupational therapy profession in the 3rd sector?' (Treseder et al 2013). My answer would be 'yes' — so 'watch this space'.

## Conclusion

To be a transformational leader you have to welcome new ideas and:

- Embrace chaos
- Set a new course with motivated, engaged staff
- Be willing to be a lifelong learner
- Harness all our creativity to find new ways of working.

In moving forwards we must retain the best of occupational therapy, implement what we already know works and not be afraid to let go of the practices that do not have an evidence base and are not true to the principles of the founders of the profession (Craik 2008), and which may have formed our 'professional habit track' — and let us imagine a track, leading onwards, towards 'becoming what we have the potential to become' (Wilcock 1999, p7).

The rate of change in services will continue at an accelerating pace, making leadership critical. Engaging transformational leaders must emerge in occupational therapy to develop new ways of working, with a focus on measuring outcomes and impact. Of equal importance is our ability to engage with the public, so bringing about a greater awareness of our role and contribution to health and wellbeing.

Leadership skills need to be constantly developed, practiced and nurtured with ongoing support, mentoring and action learning. Through accessing all three I have developed a deep understanding of the strengths I already have, using these strengths to their full capacity. To be a transformational leader you need to be self-aware, authentic and, also, to 'just be yourself'. In addition, you need to be bold, resilient and courageous — although being courageous does not mean there is an absence of fear. I have suggested to you, today, that the most effective leaders always invest in strengths, surround themselves with the right people, and then maximise their team's strengths. I have shared my personal perspective to outline habits and routines of transformational leadership with the ultimate goal of leading change, integrating the research and opinions as best I could. However, it is not an exhaustive list, and you will already have your own.

For those of you who are already our profession's transformational leaders, I invite you to reflect on your own leadership journey, considering how you, too, can share it with our next generation of leaders. For those of you who are our profession's managers, our transactional leaders, I invite you to consider your own leadership model and to ask yourself if you are truly engaging in your leadership. For our next generation of leaders, I hope that by sharing my leadership journey I have inspired you to know that, one day, you could be delivering the Elizabeth Casson Memorial Lecture.

We all face many challenges in our day-to-day work; however, these challenges can present opportunities. We need

occupational therapy leaders to locate these opportunities for, and with, us. We have reason to be proud: occupational therapists are doing amazing work. We can all be leaders — we should embrace this.

At an Elizabeth Casson Memorial Lecture there is no opportunity for audience questions. However, let me put one to you: **what would you do tomorrow if you knew you could not fail?** Let me propose this: when I presented my three key messages at the beginning of this lecture, I invited you to consider your own, as you listened to my lecture. What, then, if you transcribed your three key messages into 140 characters and shared them on Twitter (my Twitter handle is @elaineahpmh)? That might even lead to over 33,837 of us debating leadership, and would assist the vision of 'making the invisible visible'.


### Acknowledgments

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### References


Alimo-Metcalfe B, Alban-Metcalfe J, Bradley M, Mariathasan J, Samele C (2007) *The impact of leadership factors in implementing change in complex health and social care environments: NHS plan clinical priority for mental health crisis resolution teams (CRTs).* London: Department of Health.

Alimo-Metcalfe B, Alban-Metcalfe J (2008) *Engaging leadership: creating organisations that maximise the potential of their people.* London: Chartered Institute of Personnel and Development.

Alzheimer Scotland (2012) *The 8 pillars model of community support.* Edinburgh: Alzheimer Scotland. Available at: *http://www.alzscot.org/assets/0000/4613/FULL_REPORT_8_Pillars_Model_of_Community_Support.pdf* Accessed 29.07.13.

Bannigan K, Birleson A (2007) Getting to grips with evidence-based practice: the ten commandments. *British Journal of Occupational Therapy, 70(8),* 345-48.

Bass BM (1985) *Leadership and performance beyond expectations.* New York: Free Press.

British Columbia Patient Safety and Quality Council (2013) *Twitter for health care professionals: an introductory guide: learn how to tweet and why you should consider doing so.* Vancouver: BCPSQC. Available at: *http://bcpsqc.ca/documents/2012/11/Twitter-For-HealthCare-Professionals.pdf* Accessed 29.07.13.

Burns JM (2010) *Leadership (Harper Perennial political classics).* New York: HarperPerennial.

Butler J (2004) The Casson Memorial Lecture 2004: The fascination of the difficult. *British Journal of Occupational Therapy, 67(7),* 286-92.

Care Quality Commission (2011) *Care Quality Commission review of Castlebeck Group Services.* Available at: *http://www.cqc.org.uk/sites/default/files/media/documents/20110726_castlebeck_summary.doc* Accessed 29.07.13.

College of Occupational Therapists (2007) *Consultant occupational therapist. COT/BAOT Briefings.* London: COT.

College of Occupational Therapists (2011a) *Cost savings for commissioners of occupational therapy services. Fact sheet.* London: COT. Available at: *http://www.cot.co.uk/sites/default/files/commissioning_ot/public/Cost-savings-commissioners.pdf* Accessed 25.07.11.

College of Occupational Therapists (2011b) *Occupational therapy, supporting people living in care homes. Fact sheet.* London: COT. Available at: *http://www.cot.co.uk/sites/default/files/marketing_materials/public/OT%20care%20homes.pdf* Accessed 30.07.13.

College of Occupational Therapists (2013) *Clinical leadership. Occasional paper.* London: COT.

Corcoran M (2005) Leadership through scholarship in occupational therapy. *American Journal of Occupational Therapy, 59(6),* 607-08.

Covey SR (2004) *The 7 habits of highly effective people: powerful lessons in personal change. 15th ed.* New York: Free Press.

Craik C (2008) Future prospects for occupational therapy in mental health. In: EA McKay, C Craik, KH Lim, G Richards, eds. *Advancing occupational therapy in mental health practice.* Oxford: Wiley-Blackwell Publishing.

Curnow E (2012) Realising potential workshops achieve potential. *OTnews, 20(3),* 45.

Diogenes Laërtius (1925) *Lives of the eminent philosophers.* Translated by Robert Drew Hicks for Loeb Classical Library. Harvard: Harvard University Press.

Drummond A (2010) The Elizabeth Casson Memorial Lecture 2010: 'Jack of all trades and master of none': the future of occupational therapy? *British Journal of Occupational Therapy, 73(7),* 292-99.

Duncan EAS, Murray J (2012) The barriers and facilitators to routine outcome measurement by allied health professionals in practice: a systematic review. *BMC Health Services Research, 12,* 96.

Ellis M (1987) The Casson Memorial Lecture 1987. Quality: who cares? *British Journal of Occupational Therapy, 50(6),* 195-200.

Ferguson M, Agnew G, Flower S, McKelvie J (2011) Realising the potential of allied health professionals in mental health. *OTnews, 19(6),* 47.

Findlay L (1988) *Occupational therapy practice in psychiatry.* London: Croom Helm.

Firestone DT (2010) A study of leadership behaviours among chairpersons in allied health programs. *Journal of Allied Health, 39(1),* 34-42.

Gitlin LN, Winter L, Earland TV, Herge EA, Chernett NL, Piersol CV, Burke JP (2009) The tailored activity program to reduce behavioral symptoms in individuals with dementia: feasibility, acceptability, and replication potential. *The Gerontologist, 49(3),* 428-39.

Gitlin NL, Hodgson N, Jutkowitz E, Pizzi L (2010) The cost-effectiveness of a nonpharmacologic intervention for individuals with dementia and family caregivers: the Tailored Activity Program. *American Journal of Geriatric Psychiatry, 18(6),* 510-19.

Gough P (2009) What is policy? *CURUM Scotland Cares,* Spring 2009, 26-27.

Groom MH (2005) Facing challenges: reflections on the Casson Memorial Lecture 2005. *British Journal of Occupational Therapy, 68(7),* 289.

Hardacre J, Cragg R, Shapiro J, Spurgeon P, Flanagan H (2011) *What's leadership got to do with it? Exploring links between quality improvement and leadership in the NHS.* London: The Health Foundation.

Hawkins P, Smith N (2006) *Coaching, mentoring and organizational consultancy: supervision and development.* Berkshire: Open University Press.

Holdsworth LK, Douglas L, Hunter E, Mcdonald C (2013) Social media: raising the profile of AHPs. *British Journal of Healthcare Management, 19(2),* 85-92.

Hunter EP (2013) *Making the invisible visible (blog).* Available at: *www.elaineahpmh.wordpress.com* Accessed 29.07.13.

Hunter EP (1991) *Staff support and supervision for occupational therapy staff working in the clinical area of mental health.* (Unpublished undergraduate dissertation). Queen Margaret College, Edinburgh.

Hunter EP (2007) *Evidence and practice: an exploration of the AHP manager's perception and understanding of their role as a facilitator in implementing evidence based practice.* (Unpublished master's dissertation). Queen Margaret College, Edinburgh.

Hunter EP, Blair SEE (1999) Staff supervision for occupational therapists. *British Journal of Occupational Therapy, 62(8),* 344-50.

Hutcheson C (2013) Realising potential in physical activity. *OTnews, 21(6),* 18.

Marquardt MJ (2005) *Leading with questions: how leaders find the right solutions by knowing what to ask.* New York: John Wiley & Sons.

Marshall ES (2011) *Transformational leadership in nursing: from expert clinician to influential leader.* New York: Springer Publishing Company.

Mickel A (2012) Powerful questions, powerful results. *OTnews, 20(8),* 26-27.

Middleton K (2007) Forward. In: NHS Alliance. *Clinical leadership for NHS commissioning: exploring how allied health and other health professionals lead change through and beyond commissioning for a patient led NHS.* Nottingham: NHS Alliance.

Millward LJ, Bryan K (2005) Clinical leadership in health care: a position statement. *International Journal of Health Care Quality Assurance Incorporating Leadership in Health Services, 18(2-3),* xiii-xxv.

Mountain G (2005) The Casson Memorial Lecture 2005: Challenge — to confront, defy, face up to; a difficulty that stimulates interest or effort. *British Journal of Occupational Therapy, 68(7),* 290-300.

Naylor C, Imison C, Addicott R, Buck D, Goodwin N, Harrison T, Ross S, Sonola L, Tian Y, Curry N (2013) *Transforming our health care system — ten priorities for commissioners.* Revised ed. London: The King's Fund.

NHS Centre for Reviews and Dissemination (1999) Bulletin on the effectiveness of health service interventions for decision makers. *Effective health care: getting evidence into practice, 5(1),* 1-16.

OTnews (2012) Members debate the strategic direction of profession. *OTnews, 20(7),* 14.

OTtalk (2013) *Transcript of online discussion.* Available at: *http://otalkocchats.wordpress.com/2013/06/03/leadership-otalk-with-elaineahpmh/* Accessed 29.07.13.

Paterson CF (1998) Occupational therapy and the National Health Service, 1948-1998. *British Journal of Occupational Therapy, 61(7),* 311-15.

Paterson CF (2007) 75th anniversary of the founding of the Scottish Association of Occupational Therapists. *British Journal of Occupational Therapy, 70(12),* 537-40.

Paterson CF (2010) *Opportunities not prescriptions: the development of occupational therapy in Scotland 1900-1960. Aberdeen History of Medicine Publications, No 3.* Aberdeen: Aberdeen History of Medicine Publications.

Paterson CF (2012) Who do you think you are? *OTnews, 20(6),* 22-23.

Project Ghandi (2012) Available at: *www.projectgandhi.co.uk* Accessed 29.07.13.

Scottish Government (2009) *Delivering quality through leadership: NHS Scotland leadership development strategy.* Edinburgh: Scottish Government. Available at: *http://www.scotland.gov.uk/Publications/2009/10/29131424/0* Accessed 29.07.13.

Scottish Government (2010) *Realising potential: an action plan for allied health professionals in mental health.* Edinburgh: Scottish Government. Available at: *http://www.scotland.gov.uk/Publications/2010/06/15133341/0* Accessed 27.07.13.

Scottish Government (2011) *Realising work potential: defining the contribution of allied health professionals to vocational rehabilitation in mental health services: the way forward.* Edinburgh: Scottish Government. Available at: *http://www.scotland.gov.uk/Resource/Doc/365435/0124266.pdf* Accessed 30.07.13.

Scottish Government (2012a) *AHPs as agents of change in health and social care: the national delivery plan for the allied health professions in Scotland, 2012-2015.* Edinburgh: Scottish Government. Available at: *http://www.scotland.gov.uk/Publications/2012/06/9095/downloads* Accessed 30.07.13.

Scottish Government (2012b) *Mental Health Strategy for Scotland: 2012-2015.* Available at: *http://www.scotland.gov.uk/Publications/2012/08/9714/downloads* Accessed 30.07.13.

Scottish Government (2012c) *Professionalism in nursing, midwifery and the allied health professions in Scotland: a report to the coordinating council for the NMAHP contribution to the healthcare quality strategy for NHSScotland.* Edinburgh: Scottish Government. Available at: *http://www.scotland.gov.uk/Publications/2012/07/7338/downloads* Accessed 30.07.13.

Scottish Government (2013) *Scotland's national dementia strategy 2013-2016.* Edinburgh: Scottish Government. Available at: *http://www.scotland.gov.uk/Topics/Health/Services/Mental-Health/Dementia/DementiaStrategy1316* Accessed 30.07.13.

Smith G (2006) The Casson Memorial Lecture 2006: Telling tales — how stories and narratives co-create change. *British Journal of Occupational Therapy, 69(7),* 304-11.

Smyth G (2010) Collaborating for change. *OTnews, 18(5),* 48.

Stewart LSP (2007) Pressure to lead: what can we learn from the theory? *British Journal of Occupational Therapy, 70(6),* 228-34.

Taylor MC (2007) The Casson Memorial Lecture 2007: Diversity amongst occupational therapists — rhetoric or reality. *British Journal of Occupational Therapy, 70(7),* 276-83.

The King's Fund (2011) *The future of leadership and management in the NHS: no more heroes.* London: The King's Fund.

The King's Fund (2012) *Leadership and engagement for improvement in the NHS: together we can.* London: The King's Fund.

The King's Fund (2013) *Patient-centred leadership: rediscovering our purpose.* London: The King's Fund.

Treseder R, Buchett N, Nurse I (2013) Why the third sector needs OTs. *OTnews, 21(4),* 38-39.

Unsworth CA (2011) Evidence-based practice depends on the routine use of outcome measures. *British Journal of Occupational Therapy, 74(5),* 209.

Vogt EE, Brown J, Isaacs D (2003) *The art of powerful questions: catalyzing insight, innovation and action (CEM).* California: Whole Systems Associates.

Washington JM, ed (2003) *A testament of hope: the essential writings and speeches of Martin Luther King, Jr.* Reprint. New York: HarperCollins.

West MA, Dawson JF (2012) *Employee engagement and NHS performance.* London: The Kings Fund.

West M, Alimo-Metcalfe B, Dawson J, El Ansari W, Glasby J, Hardy G, Hartley G, Lyubovnikova J, Middleton H, Naylor PB, Onyett S, Richter A (2012) *Effectiveness of multi-professional team working (MPTW) in mental health care.* London: HMSO.

Whitney D, Trosten-Bloom A, Radar K (2010) *Appreciative leadership. Focus on what works to drive winning performance and build a thriving organisation.* New York: McGraw Hill.

Wilcock AA (1999) Reflections on doing, being and becoming. *Australian Occupational Therapy Journal, 46(1),* 1-11.

Wilcock AA (2001) *Occupation for Health Volume 1: a journey from self-health to prescription.* London: College of Occupational Therapists.

Wimpenny K, Forsyth K, Jones C, Matheson L, Colley J (2010) Implementing the Model of Human Occupation across a mental health occupational therapy service: communities of practice and a participatory change process. *British Journal of Occupational Therapy, 73(11),* 507-16.

Williams H, Bannigan K (2008) A simple trick to market ourselves. *British Journal of Occupational Therapy, 71(6),* 225.

Wylie DA (2009) *Leadership in the allied health professions in Scotland: a review of the literature within NHS Scotland context.* Available at: *http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4003765/Leadership%20in%20AHP%20-%20review%20of%20lit%20David%20Wylie.pdf* Accessed 29.07.14.

Wylie DA, Gallagher HL (2009) Transformational leadership behaviors in allied health professions. *Journal of Allied Health, 38(2),* 65-73.