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# The Dr Elizabeth Casson Memorial Lecture 2019: Shifting our focus. Fostering the potential of occupation and occupational therapy in a complex world.

## Abstract

Challenges to health promoting occupation are experienced by many people in the UK today. It is suggested that the way we currently think about and so organise our practice may make it difficult to address some of these occupational needs. An alternative lens is proposed, drawing on the work of P. Cilliers and his discussions of the implications of thinking in terms of complex systems. Taking on an 'attitude of complexity' allows us to reconsider our work within the systems we are part of and encourages us not only to acknowledge but also to embrace the richness and diversity of our complex world. The discussion will focus on how occupational therapists can become part of, or strengthen their existing part, in change within these systems, developing their contribution as experts in occupation. This lecture is about 'shifting our focus', about fostering the potential of occupational therapy and contributing to individual and social transformation through occupation that will support the health of the population.

## Keywords

Systems thinking, social transformation, occupational needs, P.Cilliers,

## Introduction

It is a very exciting opportunity and a huge honour to present the Dr Elizabeth Casson Memorial Lecture at this, the 43rd conference of the Royal College of Occupational Therapists (RCOT) and I would like to thank my nominee and the RCOT council for giving me this opportunity. For me, it is a particularly meaningful year as the UK negotiates its changing relationship with Europe. My family is bi-cultural and bi-lingual, I have spent over half my working life in Europe, and major influences on my work continue to be my colleagues from across Europe, their practices and their conceptualisations, particularly via the Erasmus programme, the European Network of Occupational Therapy in Higher Education (ENOTHE) and Occupational Science Europe. My life journey means that I am in the privileged position of having had the opportunity

to experience occupational therapy beyond national borders as it has developed across Europe and beyond.

One of the privileges and challenges of working in many different places is that I find myself frequently asking the question why. Why is occupation or daily life as it is; who does what, where, when and why? Why is occupational therapy like it is in this country and what are the influences on that? And that inevitably leads to the question: Is it enough, is occupational therapy addressing the occupational challenges facing the particular population?

And this is the question I bring to us today: Is the way we do contemporary occupational therapy in the UK enough? Are we addressing the challenges to health-promoting occupation facing the population? My perception is that at this time the answer is 'no'; at best we can say that we are partially addressing the occupational needs of society today. This is a problem for the people of the UK in that we are not fulfilling the expectations of a profession constructed to meet those needs. It is also a problem for us as a profession as we are limiting our potential for growth.

Therefore, this lecture is about 'shifting our focus', about fostering the potential of occupational therapy and contributing to individual and social change through occupation that will support the health of the population. And, here I want to emphasise that I consider that we do therapy very well. However, the complexity of occupation, and working to ensure health promoting occupation for all, requires much more. The vision I want to share with you is of much more; not only to expand our work in those places where we are already located, but also occupational therapists in government policy and city planning departments, managing care homes, in partnership with neighbourhoods to develop green spaces and play areas, promoting occupation in leisure centres, public libraries and GP surgeries, working to develop employment and leisure opportunities for all, and so on. As discussed by Carmel Borg, a keynote speaker at the ENOTHE conference in 2018 "occupational therapy is an ethical, moral and social act as much as it is a technical act" (Borg, 2018:4). I suggest that we have an ethical, moral and social responsibility to recognize the complexity of daily life and the full extent of the occupational needs of the population. Perhaps we also need to work through what Friere described as a fatalistic attitude to what we perceive that we cannot change (Rossatto, 2004). With today's lecture I wish to contribute to this, challenging us to 'shift our focus'.

In order to explore this idea of 'shifting our focus' I will develop my argument in three stages:

First, I will identify in brief some of the contemporary challenges to health in terms of the occupational needs experienced by people in the UK today that I suggest we are not addressing sufficiently. Secondly, I will propose that the way we currently think about and thereby organise our practice, may make it difficult to address these challenges. I will draw on thinking about complex systems to suggest an alternative lens. Thirdly, I will discuss how we, as occupational therapists, can become part of, or strengthen our existing part, in change within these systems, with the aim of increasing the health-promoting occupation of the people of the UK.

Core to any discussion is a need to briefly define key terms. I have spent a good deal of my professional life working to understand occupation, through my own research and through the developing scholarship of occupational science. Occupation is complex, multifaceted, including understanding it "as the ordinary and extraordinary things that people do everyday" (Watson, 2004: 3), that it is both "the active process and outcome of living" (Whiteford et al., 2000: 64), and is a means of "personal and community transformation" (Wilcock and Townsend, 2000: 86). This view of occupation allows a good deal of diversity around what we do during our everyday lives and why, while also does not frame it only as positive and health-promoting.

In defining health, I support a move away from an individualised focus on the body and mind. With our increasing understanding of the intricate interlinking of person and environment (for example, the adverse effects of air pollution and plastics entering the food chain), health can only be perceived in terms of the person (their genetic makeup and their behaviours) and the social and physical environments together, expressed in what people are able to do and be. In addition, given the vast inequalities in health it is important that health is understood within a perspective of human rights and as a matter of social justice (Venkatapuram, 2010).

Therefore, and as our literature discusses (see Stewart et al., 2015), we can see that occupation and health are intertwined. Occupation may support our health to varying degrees, while our health is expressed in our occupation, and both are inextricably interlinked with the contexts of our lives. We can see these iterative relationships in many of the contemporary challenges of our society today resulting in a range of occupational needs.

## Contemporary challenges for health promoting occupation.

I will not undertake a comprehensive review of the challenges to health promoting occupation in the UK, but rather I want to indicate the nature and extent of these through a brief review of four key areas of occupational need: experiences of occupational deprivation; violent and dangerous occupations in homes and communities; occupations that have become addictive; and the link between occupation and contemporary environmental challenges.

## Experiences of occupational deprivation

It is widely recognized that many groups in society in the UK are excluded from health promoting occupation by structural conditions beyond their control. Framed conceptually as occupational deprivation (Durocher et al., 2014; Whiteford, 2010) these situations interact with each person in unique ways leading to a variety of possible outcomes (Crawford et al., 2016). Occupational deprivation includes not only restricted participation in certain occupations, but also changes in the form that occupations are taking with characteristics that challenge health. The changing nature of work, as well as unemployment, poverty, homelessness, and social isolation are all such contemporary issues, often interconnected. National statistics provide a clear picture of the extent of the issues.

Regarding employment, while currently the national employment rate is at around 76% (Office for National Statistics, 2019), we see much lower employment rates for certain groups of people. For example, the employment rate of persons with learning disabilities is 23.6% and for those for those with experience of mental health problems between 26.2% and 45.5% (TUC, 2017). Asylum seekers are only allowed to work when they have been in the UK for 12 months and then only if their skills are on the Shortage Occupational List (Home Office, 2017). At the same time there is a rise of mental illness in the workplace and of work-related illnesses. In 2017/18 there were a total of 1.3 million workers with new and long-standing cases of work-related ill health, of which 44% had stress, depression or anxiety, and 35 % musculoskeletal disorders (Health and Safety Executive, 2017).

In 2017, 22% of the population (14.3 million people) were reported to be living in poverty including pensioners and children. Of note is that 4 million of these people were in work and 4.3 million were disabled people (Joseph Rowntree Foundation, 2018). Poverty is linked to a range of occupational needs including poorer educational achievements, difficulties in maintaining a

home and having adequate nutrition, as well as to poorer physical and mental health and an overall decrease in life expectancy and healthy life years (Joseph Rowntree Foundation, 2018).

Homelessness is on the rise, in 2018 reaching 320.000 people, particularly affecting those from the private rented sector, and includes families, veterans, the employed as well as those with long term health issues (Shelter, 2018). Young people are finding it difficult to establish their own homes (Fitzpatrick et al., 2018), and so unable to engage in occupations around homemaking and other family occupation (Kantartzis and Molineux, 2014).

The human species has always operated as communal groups with skills in social cooperation (Fukuyama, 2012). Humans are social animals (Aristotle, n.d.) but currently 6% of the population report feeling lonely all or most of the time, with the highest percentage in the 16-34 age group (Department for Digital, Culture, Media, Sport, 2019). The impact is significant with not only loneliness, but also social isolation and living alone all identified to independently increase mortality risk by almost 30% (Holt-Lunstad et al., 2015).

### Criminal and violent occupations in homes and communities.

Increasingly we understand that not all occupation is positive or health promoting (Kiepek et al., 2018), and at an extreme we see people engaging in occupations that may inflict harm, injury and even death, as well as forms of occupation that include abuse and violence (Twinley, 2013). While exact figures are not known, it is reported that in England 27,000 children are gang members, some of whom are involved in crime and may become involved in criminal networks (Childrens' Commissioner, 2019). In 2017-18 there were 40,100 knife crime offences with 268 fatalities (Allen and Audickas, 2018). Serious knife crime offences have increased over the past ten years, with a 99% increase in threats to kill and a 76% increase in sexual assault (Allen and Audickas, 2018). Living in violent neighbourhoods is not only an immediate threat of injury or death, but also impacts on the daily occupations of many members of the community, for example restricting opportunities for children's play due to parents' fears of safety (Jacoby, 2018).

There is also a concerning number of people whose everyday occupations, such as making a meal or watching television, take a form that includes abuse. While underreporting is recognised, it is estimated that across the population 26% of all women and 15% of all men

aged 16 to 59 are estimated to having experienced some form of domestic abuse since the age of 16 (Strikland and Allen, 2018). However, for some the rate is much higher, with an estimated 1 in 2 disabled women experiencing abuse (Breckenridge, 2018; European Union Agency for Fundamental Rights, 2014).

## Potentially addictive occupations

A number of occupations are potentially addictive, and we are coming to recognise the central place in many people's lives of occupations around alcohol, drugs, gambling, eating and gaming (Kiepek and Magalhães, 2011; Wasmuth et al., 2016). Other occupations in which people may begin to engage in addictive ways, include sex, shopping, work, exercise (Kiepek and Magalhães, 2011), and social networking (Kuss and Griffiths, 2017). Identifying that we may have traditionally referred to such occupations as behaviours (Stewart et al., 2016), recognizing them as often non-sanctioned (Kiepek et al., 2018), enables us to consider the social determinants as well as the meaning and routines, the roles and the relationships, that go to sustaining these, despite their risk to health.

### Occupations and sustainability

We see the fundamental importance of how we live our lives to the well-being of our planet. As the World Health Organisation (2018) has noted, climate change overwhelming will have an adverse effect on our health and wellbeing, through increases in natural disasters, reduced food and water supplies, and changes in patterns of infections and disease. Air pollution and problems caused by our extensive use of plastics are further issues that require our urgent attention. As recently noted by the World Federation of Occupational Therapists (2018: 13) "The environment is the crucible within which meaningful occupational participation can be nurtured…[and]… it is recognized that climate change threatens the very ecological framework that not only sustains life but makes meaningful occupational participation and health possible." Again, here we see the iterative relationship between occupation and context as central to these issues is how we do our occupations and the materials we use for these.

These occupational needs, experienced by large numbers of people in the UK, emerge as part of complex issues recognised beyond both professional and national boundaries. For example, the Sustainable Development Goals of the United Nations (2015), with the central message

‘Leave No One Behind’, identify core issues such as poverty, education, equality, work and living conditions as fundamental to our development as individuals and as societies. The European Union’s European Pillar of Social Rights (2017) supports principles of social inclusion, social justice, equality and protection, in order to fight exclusion, discrimination and poverty through action aimed at employment, education, housing and welfare support. The World Health Organisation’s (2008) discussion of the social determinants of health have expanded our understandings of health inequalities and causes of these. The challenges are enormous, constructed within unequal power relationships, embedded in our social and economic histories as well as in our contemporary realities. And as we have seen, many of these issues have occupation at their core, in their expression, and in their ongoing re-construction. From this brief discussion and the figures presented it is reasonable to presume that the majority of the individuals we work with in health or social care settings will be facing at least one of these challenges. So should we, can we, address them?

The World Federation of Occupational Therapists (2016) clearly recognizes that we need to address these issues in our practice as well as our education, noting in the recently revised minimum standards for education the aim of such standards to include to:

> “Reach out proactively to partner with communities and other stakeholders to develop services and funding sources to help populations, communities and individuals to live well, particularly those who struggle with addictions, chronic disease, developmental challenges, disability, old age, ethnic oppression, poverty and other social challenges that limit their participation, as valued and respected citizens, in necessary and desired occupations” (WFOT, 2016:11).

We can see here strong support for our expertise in occupation to contribute to working towards change, to developing occupational opportunities, and to ensuring that our society supports the health of all.

## The lens we look through shapes the world we see.

So, the question arises - why are these issues, these occupational needs, not core to our practice as occupational therapists? I suggest that the way we think about occupational needs, including where we understand the problem to be located and what solutions might be, has led to how we organize our work around them within existing health and social care services.

It is said that traditional scientific thought has shaped the way most people think about the world and how it works (Heylighen et al., 2006) and thereby has driven how much of health care is organized. This is based on an understanding that there is an external, objective world that we can 'know'. We have believed in a search for universal truths, and that by reducing complicated situations to ever smaller elements we can ultimately discover a single pre-determined cause and understand how they work, so leading to a solution. This has led to dysjunction - the isolation and separation of complex cognitive problems with increased specialisation between disciplines to deal with each part separately (Cilliers, 1995; Heylighen et al., 2006; Morin, 2008).

However, it is suggested that there are limitations to this way of thinking if we hope to understand complex phenomena such as language, art, and society (Cilliers, 1995), including some of the challenging issues we are facing today. It is proposed that thinking critically within a systems perspective may enable us to understand the complex world in alternative ways (Cilliers, 1995; Morin, 2008; Woermann et al., 2018).

In proposing this alternative lens, or way of seeing the world, I will particularly draw on the work of Paul Cilliers (Cilliers, 1998; Preiser, 2016), noted as "one of the first authors to approach the understanding of complex systems from a philosophical perspective" and specifically a post-structural position (Preiser and Woermann, 2016:1). Cilliers encourages us to challenge the traditional role of science in how it relates to larger societal questions as well as think about how we should live, be human, and "engage with the rich and diverse wonders of our complex world" (Preiser and Woermann, 2016:18)

In considering what it might look like to think with a systems lens, let us consider an example. In 2007 the UK Government's Foresight Programme published a report that included an 'obesity systems atlas', mapping out the multiple interdependent factors that comprise the system that is obesity and the feedback loops between the elements. The atlas identifies a range of factors grouped thematically, including: media, psychological, social, economic, food, activity, infrastructure, developmental, biological, and medical factors (Vandenbroeck et al., 2007). This viewpoint challenges typical interventions for obesity that focus on health education and change in the individual's behaviour, that perceive the problem of obesity as lying within the individual and their patterns of food consumption versus energy requirements; approaches critiqued as having low reach and impact, requiring considerable individual agency and even a tendency to

widen health inequalities (Rutter, 2017; Maclean et al., 2010). This atlas invites us to reflect on where might we, traditionally, have located our practice? Which of the multiple elements making up the situation and their numerous interactions and feedback loops (Cilliers, 1995) would usually we take into account?

This atlas suggests that to understand and work with issues such as obesity, we need to think and understand a whole range of factors, as a system. This is a change not primarily in how we deal with the world, how we conduct our practice with our methods and our techniques, but more fundamentally in how we understand the world, our ontological position (Heylighen et al., 2006). Thinking critically in terms of complexity and systems, adopting what Cilliers would describe as an "an attitude of complexity" (Priser and Woermann, 2016: 1), is more aligned to the complex situations that we are discussing here and that we are experiencing in the world around us. This attitude invites us to adopt a particular way of thinking not only about how these complex situations arise, are maintained and can change, but also thinking about our own place in the system, recognising our own influences on it, including the importance of the choices we make about where we choose to focus our attention and our practice. To continue this discussion, we can look in a little more detail at the nature of complex systems.

## The nature of complex systems.

We saw with the example from obesity, that we can think of a system as being made up of the interaction between multiple and varied elements (Dekkers, 2017; Holden, 2005); people in all sorts of places, doing all sorts of things – families and shop keepers, journalists, politicians, farmers, food manufacturers and many more. These interactions are ongoing and dynamic, changing all the time, so such complex systems are neither solid nor permanent.

The elements, people, interact in many and varied ways, each influencing but also being influenced by many others. However, no-one is in direct contact with everyone else in the system. Nobody knows what everyone else is doing and neither is everyone working to an overarching plan; there is no overall intention to 'create' a problem of obesity, or any of the other occupational issues introduced, such consequences are emergent (Heylighen et al., 2006) from the system as a whole. We can consider these issues, as unintended consequences of local ways of relating and doing (Paley and Eva, 2011).

Here we begin to see the limitation of only focusing on one element or one person, as we cannot understand the problem or issue by only analyzing one part of the system. For example, a family's shopping and food consumption patterns tells us very little about how the media is portraying obesity, and both give us only a partial understanding about the obesity system in the UK. Any complex system cannot be compressed (Cilliers, 2000a); we cannot understand complex systems by a reductionist process (Morin, 2008).

Systems also have histories, and a system's history is important, co-responsible for, its behavior today, for the nature of the system. Any analysis of a system must include attention to its development through time (Cilliers, 1995; 2000b). We also see that complex systems are not closed with clear boundaries, but are open, interacting with the environment (Cilliers, 1995). Elements of one system may connect to another, for example, a neighbourhood where violent crime is increasing, may interact with systems of racial discrimination and of class, but also with institutional systems of policing, welfare and health (Walby, 2007).

Many social systems are complex and share these features. We can see how the occupational needs we are discussing emerge from the relationships of people in neighbourhoods, communities, schools, workplaces, amongst collectives (Foster-Fishman and Behrens, 2007). They emerge where policy meets law enforcement agencies, housing developments, health services, educational institutions and people living in particular locations. And where one system comes up against another, such as with multiple intersecting social inequalities such as gender and class (Walby, 2007). Such complex systems incorporate diverse elements across multiple dimensions from the individual to the societal, influencing the continually evolving nature of the needs. So let us look now in a little more detail at the processes of change in such complex systems, so that we can begin to consider how we might contribute to such change.

## Change in complex systems

In complex systems change occurs in the interaction *between* the elements within the system and as well as between the system and its environment (Human and Cilliers, 2013). This is very different from the change *within* elements that we often focus on as occupational therapists, for example change internal to a person or change to their environment. In understanding (and potentially transforming) the system the dynamic relationships between elements are of key importance (Foster-Fishman and Behrens, 2007).

Change within the system is ongoing, diffusing throughout the system (Dekkers, 2017). Changes may arise from within the system (for example, the introduction of sugar tax or a local shop keeper's decision to stock fresh fruit), or external to it (for example, the global economic crisis or Brexit). The same action may have multiple effects across the system at different times, but also feed back into the starting conditions (Heylighen et al., 2006). These feedback loops can be both positive (enhancing, stimulating) and negative (detracting, inhibiting) (Cilliers, 1995). Returning to the example from the obesity map and one that we will have seen in our own practice, it was noted that as people want more convenient food it is likely that more convenience food will be produced and sold. As consumption of convenience food increases, cooking skills will be lost, meal-time patterns will change, leading to further increased demand for convenience food and so-on (Vandenbroeck et al., 2007). We can see how we have become part of this system as our own work has come to include meal preparation skills for a wide variety of people. With such change occurring dynamically throughout the system, we can also see how reversing  any change to return to original conditions or a previous state is not possible, that is, the characteristic of irreversibility of complex systems (Morin, 2008), and therefore the need to work towards new interactions within the system.

As already discussed, change in complex systems is not a linear process of a cause leading to a proportionate effect. There are numerous and simultaneous 'causes', as the elements of the system continually interact and respond to shifting conditions, and so no centralized point of control that can be the focus for change. We also cannot predict the size of the change, as we have come to expect with change in linear processes (Heylighen et al., 2006). A small change in the relationship between two elements of the system may lead to a major shift in the pattern of the system (and vice versa), often without us being able to predict it, or even to identify the original cause of the change (Human and Cilliers, 2013). In addition, we cannot be sure of the speed of change; although there may be rapid changes, more generally change in systems is slow as the system works to maintain itself (Manson, 2001; Rihani, 2002).

Therefore, we can therefore begin to see why attempts to intervene in systems may lead to unexpected results in size and focus, some undesired and unplanned (Reynolds and Holwell, 2010). However, it is important to recognise that this unpredictability and inconsistency are characteristics of such systems. If we try to reduce the system to the predictable and the rational, we are effectively returning to traditional linear ways of viewing the world (Cilliers, 2000b; Humans and Cilliers, 2013).

### Our place in the system

And what about our place in systems, as occupational therapists and our practices? If we take on an 'attitude of complexity' we are constructing a particular view of the way the world works and how we can understand it. This is not a view of an objective reality to which we are passive observers, but rather we are part of the system and therefore influence how much we can see or understand it (Woermann et al., 2018). Due to the complexity of systems, we cannot know in full all the elements that make up a system or map out all the possible connections and relationships (Cilliers, 2005; Humans and Cilliers, 2013). Working to understand an issue will always be limited to some degree by where we draw the boundaries to the system, or what we include in our discussion of relevant elements, and this depends on our positions and perceptions. These are ethical decisions (Cilliers, 2004). We are continually making choices about what we see, where we place the focus of our practice. Alongside acknowledging the focus of our practice, we also need to be aware of the inevitable limitations in our knowledge and understanding of the issues (Cilliers, 2005).

We also recognise that these decisions about where we focus our practice will contribute to the nature of the system, due to our own positions as elements in the system, interrelated with many others. Our decisions and our actions have consequences, both planned and unexpected. The consequences of our actions, as part of the system, have been described by Morin (2008:21) as the "ecology of action", he notes that "from the moment an action enters a given environment, it escapes from the will and intention of that which created it…"

So, a question for us becomes: which part of the system are we currently seeing? And this leads on to questions about how might we shift our focus to see a different part of the system, or more of it, and what might be the effect of doing that on our practice and in turn on the system we are part of?

## Developing our practice to contribute to processes of change addressing contemporary occupational needs

If we agree that many people in the UK face occupational challenges, that systems thinking may help us to understand these complex issues, and that occupational therapy should be contributing to processes of change around these issues, we can then begin to explore what

our contribution might be. This is not to deny the importance of our work that focuses on the person and the development of their performance, and indeed this may take place within an understanding of the complexity of their situation (Woermann et al., 2018).

In the UK there is currently an increasing interest in systems thinking, understanding health in terms of systems, as well as systems science research in public health (for example Carey et al., 2015). In the occupational therapy literature, a number of scholars (for example Creek, 2003, 2010; Whiteford and Wright-St.Clair, 2005) have introduced ideas of complexity to the profession, taking a range of approaches to complexity theory. This thinking also aligns with our recent work for the Royal College of Occupational Therapists on occupation and complexity, particularly in its reference to the view that occupational therapy can be seen to be working to intervene in complex systems (Pentland et al., 2018).

While a range of systems approaches and methodologies are discussed in the literature (see Jackson 1992; Foster-Fishman et al., 2007; Reynolds and Holwell, 2010), discussing each of these and their relative merits and applications is beyond the scope of this lecture. Rather I consider it most useful at this time to provide some signposts to how expanding our thinking in terms of systems can begin to suggest and guide our future actions.

But where to begin? The preceding discussion of systems thinking raises a number of questions, and perhaps one that comes to mind first is – if systems are complex and made up of so many interactions that we can never know a systems in its entirety  and that often we cannot know the direction and effect of change (Cilliers, 2000b), then how can we work with systems and what can we hope to achieve? Cilliers (2005) is clear that we should not see these challenges as something negative, but rather that recognizing them allows us a realistic and "modest" (Cilliers, 2005: 256) position, where we can acknowledge the uncertainties of working with the reality of the complex world. We can work from a position where we understand that there is not 'a' problem to be solved, but rather a problem-situation, and how that may be resolved (rather than 'solved') will not be clear at the outset (Reynolds and Holwell, 2010).

This, however, does not mean that we should ignore these issues, regard them as insolvable, or beyond the scope of our practice. So, a first important message from a system thinking perspective, is to see uncertainty and flexibility as inherent to our work.

## Attend to the systems of which we are part

A further piece in this jigsaw of thinking of our work as intervention in systems (Hawe et al., 2009) is that we pay attention to the system that we are working within. For example, there has been criticism of the focus in the National Health Service (NHS) towards identified targets caused by specific actions, with quick results that demonstrate economic benefits (Reynolds and Holwell, 2010; Sterman, 2006), and on individual life-style factors in many instances of ill-health at the expense of a systemic understanding the social determinants of health (Salway and Green, 2017). Such criticism, which is not restricted to the UK, has been framed within an individualization of health within neo-liberal discourse (Gerlach et al., 2018), with it noted that this "ideological position …locates the roots of disadvantage with individual traits and diverts attention away from policy solutions that are unpalatable to those in powerful positions" (Salway and Green, 2017: 524).

So, we need to apply a critical lens to the systems we work within and in continuation to our roles as occupational therapists as they have developed over time within those systems. It may be useful to reflect on our own responses to the following questions:

- Does the current location of our practice, predominantly within the ill-health and care systems, provide us with opportunities to work with occupation to the benefit of the health of the population, across sectors and dimensions? Where else should and could we be located? As already mentioned, there are numerous possibilities, not only GP surgeries, but libraries, town planning offices, job centres and many more.

- What are the current boundaries of our practice? How can we ensure that all our partners are at the table, including those who traditionally may be excluded or silenced? How do ideas about professionalism, expertise and client-centred practice impact on our work with our fellow citizens for change in our common, shared society? How does our position in hierarchies of power influence perceived possibilities for practice and change? (Fransen et al., 2015; Gerlach et al., 2018; Pollard et al., 2019).

- Are we constrained by current expectations for our practice, for example a need to present accurate goals and time scales to achieve these (Rihani, 2002), although we may recognize the importance of a certain slowness in facilitating our understanding of the system and consequent possibilities for change (Cilliers, 2006)?

- Do our existing models of practice describe the processes of change that we see in complex systems? In the literature it is acknowledged there are still limitations to all disciplines knowledge and tools of how to intervene in systems. Training and clear guidelines are required if we are to avoid reverting to our previous experience of delivering multicomponent reductionist-style interventions (Sautkina et al., 2014) and the idea that practice can be learnt by breaking it down into its component parts (Whiteford et al., 2005). While there has been work to push the boundaries of our current professional reasoning, with discussion, for example, of strategic, creative, and collaborative reasoning (Cole and Creek, 2016), what further practice and educational opportunities do we need to develop?

- Does the current dominance of evidence-based interventions reflect the reality of working with systems, where the situation is constantly changing and context dependent, possible solutions may not be identified from the outset, and where we recognise that the whole system may not be known or understood (Whiteford, 2005)?

An alternative view asks whether the reality of needing to maintain a “modest attitude” (Cilliers, 2005: 256) regarding our expertise is recognized? Is our critical attitude and curiosity to explore further, to work towards resolutions, celebrated by our managers and leaders? Do we recognize the artistry of our practice, using our professional reasoning to improvise and be creative in the messy and unpredictable situations that we encounter, and particularly as experts in the art of occupation? (Whiteford et al., 2005)

Many questions arise regarding the systems of which we are part. Change may be needed if we are to effectively work with complex issues, and these will be fueled by ongoing future debates. However, we will look at two key areas in a little more detail.

## Develop strategic partnerships.

It is evident that we need to move away from mono-disciplinary perspectives (Fransen et al., 2015; Whiteford et al.,2005) created in an attempt to reduce and ‘solve’ problems and move towards trans-disciplinary approaches with multiple groups and disciplines (Bernstein, 2015). We may need to work with politicians and gardeners, artists and town planners, teachers and allied health professionals and particularly with the people directly affected by the issues. We

need to use multiple approaches, both horizontal (across sectors and disciplines for example) and vertical (from citizens groups to local municipalities and to central government) (MacLean et al., 2010). In considering our partnerships, I invite you to consider the setting that you are working in today, what are the issues that you are aware of and would like to work with more, who should be your partners, how can you meet and open conversations with them?

As we begin to think of our work as work in systems, it is useful to remember that pragmatically, we will only be able to work with a part of the system. However, this means that we need to maintain a critical awareness of how we identify the boundaries of the system, including how the problem is defined and in continuation who is included in work to resolve the issues (Cilliers, 2001; Foster-Fishman and Behran, 2007). As an example, we may be interested in working around issues of loneliness for the elderly people with whom we work. Our current boundaries may be primarily the acute setting; how can we widen the boundaries to involve the local community, town councilors, GPs and other AHPs, the elderly, their families, carers and neighbours, schools and universities, seeing it as an issue that is part of the fabric of our society, not only important for the elderly but for all ages and across all groups.

We need to ensure that all those identified as partners in the process are able to engage in open discourse and debate. Emancipation and pluralism are vitally important in supporting change in systems (Watson and Watson, 2011). We need to work to open spaces that include those who traditionally are not considered to be experts and whose voices may be hidden or ignored. We need to address power differentials, “to enable ordinary people to determine which problems they wish to address, how the problems should be tackled, and by whom” (Rihani, 2002: 238).

Such discourse in the public sphere, incorporating many elements from civil society, also facilitates important discussions around what is normal and what is good, and who decides. Such ethical debates in complex situations will be ongoing, requiring continual attention as we gain new understandings as we work with the system over time (Cilliers, 2004). In addition, these discussions offer opportunities for change in the mental maps and world views of participants that guide their decision making and action (Foster-Fishman and Behran, 2007), helping to identify in what directions and in what ways the problem situation might be resolved.

When considering occupational needs from a systems perspective, we see that top-down approaches to control or change behavior, to 'solve' the issue will not be successful (Dekkers, 2012). Programmes that are achieving success are involving multiple partnerships. For example, Amsterdam's Healthy Weight Programme is a whole city approach to working on childhood obesity, placing child and adolescent health at the centre of all policies and involving collaboration among political parties in areas such as food, transport, and sport (Amsterdam City, 2019; Sheldon, 2018). Glasgow's approach to treating knife crime as a public health issue has also reported success, again with multiple approaches and partnerships (Torjesen, 2018). And as an example of an organization involving occupational therapists, Alzheimer Scotland (2019, Maclean et al., 2019) is engaging across sectors and from grass root to policy level, with multiple initiatives to raise awareness of dementia and to facilitate policy and practice change

So, to summarize, occupational therapists - we - need to join the conversation. We are well positioned - crossing boundaries between the arts and sciences, bio-medical and social sciences, supporting a holistic view of people and their situations - to play an active role in bringing together or joining, all those people who are part of the system either directly or indirectly. So, having joined the people in the room, we can turn to our significant contribution, that is, our unique understanding of occupation.

## Develop our contribution as experts in occupation

Characteristic of work that explores social change as change in systems is the understanding that optimal change occurs in the relationship between the systems constitutive elements rather than within any particular element (Dekkers, 2012; Holden, 2005; Stroh, 2015). Change occurs in policies, routines, relationship, resources, power structures and values (Foster-Fishman et al., 2007). And what is occupation if not one of the key ways though which people interact, collaborate, communicate, shape their everyday lives together? Occupation happens in the spaces between people (Kantartzis, 2017; Sakellariou and Pollard, 2017).

We see this in our theories where occupation is positioned between people and their environments, including, for example, from a transactional perspective (Cutchin et al., 2013; Law et al., 1996) and from complexity theory (Creek, 2003, 2010; Whiteford et al., 2005). However, while traditionally our focus has been more towards the individual and their occupation, we can see from our discussions today the importance of focusing on occupation

itself as a key relational element in the system we are working to change. It is not sufficient to empower people to return to the occupations of their everyday lives, when, as we have seen, those occupations are characterised by deprivation, violence, or addiction for example. Therefore in focusing on occupation, also we are recognizing that occupation is shaped within the interactions of the elements of the system, or in other words, that it is determined by the social world (Farias et al., 2016; Hocking and Whiteford, 2012; Laliberte Rudman, 2010; van Bruggen, 2017).

However, at the same time we can see that occupation also holds the potential to contribute to change in the system. If we can enable change in occupation, developing health promoting occupation, we may be able to contribute to the transformation of our social world (Hocking and Whiteford, 2012; Watson and Swartz, 2004).

The focus of our practice therefore becomes change in occupation. Here we are particularly focusing on the occupation of the social and public world, and we can draw on work that discusses occupation and citizenship (Fransen et al., 2015; Pollard et al., 2019) and collective occupation (Kantartzis and Molineux, 2017; Ramagundo and Kronenberg, 2015). Collective occupation, occupation that occurs when multiple people come together, shapes both the possibilities of individuals and the nature of the social world (Kantartzis and Molineux, 2017; Ramagundo and Kronenberg, 2015). The shape (nature) of occupation in our communities, between people, occurs as an outcome of the interaction of the elements of the system. We therefore need to look critically at the shape or nature of occupation in our collectives and communities, and how we may facilitate change in this, utilizing the power of the collective to drive change.

What is the shape of daily occupation in our communities? Informal daily encounters, meetings with others in our common public places of interaction (Francis et al., 2012), lead to networks of occupation in our neighbourhoods and communities (Kantartzis and Molineux, 2017). Going to our local shops, library, hairdresser, cafe and pub are important occupations, providing opportunities to be recognized (Frazer and Honneth, 2003) and to maintain and develop our sense of belonging (Francis et al., 2012). What possibilities for casual, daily encounters are there for all those living in your local area? Are there places and opportunities for you all to meet? And who is not there and why? For example, what physical barriers including

accessibility and transport, and social barriers such as stigmatising attitudes or financial requirements are present?

Further to these daily encounters, special occasions, collective events such as parties, sports matches, concerts, parades and memorials, allow experiences of heightened emotions with others, again facilitating a sense of collective belonging, meaning and connections. If people coming together, as a collective, to organize these events themselves there is an increased sense of ownership, control and power, pride in the community, as well as opportunities for the development and use of skills perhaps not required in day to day living and working (Kantartzis and Molineux, 2017).

Other important forms of collective occupation are organisations and associations, whether local, such as a movement to support a green space; national, such as our own Royal College of Occupational Therapists; or international, such as on-line professional networks, created and maintained as people to come together. They are important for citizenship and political action (Fransen et al., 2016) and may lead to engagement with policy change at local, national or even international levels.

As our focus today is on those situations where occupation is not supporting the health of the population and needs are not met, how can we facilitate change in existing occupation?
As already discussed, participatory processes, developing relationships with community members and local leadership, is important for enabling engagement in occupation (O,Neill, 2017) and to ensure local issues are addressed through such community-centred practice (Hyett et al., 2018; Lauckner et al., 2019; WFOT, 2019). Principles of community development may also be useful to support our thinking and our practice, working with communities to identify their strengths and needs, to build capacity and to develop opportunities for culturally relevant collective occupation (Carra et al., 2019; van Bruggen, 2017). This may include the development of employment opportunities, of shared caring and other essential occupations. The idea of “occupational reconstructions” (Frank, 2017; Frank and Muriithi, 2015) is particularly important, as central to the process is the power of people coming together to drive change in their occupation. People change the shape of their everyday lives, explore new ways of doing, in response to a problematic situation, building on their “occupational capacity” both as individuals and as organisations (Frank, 2013: 237).

Within the systems we have been considering, the community or meso level is only one point at which change may need to occur. Systems are generally seen to be resistant to change, operating to continually respond to changing conditions (Foster-Fisherman and Behran, 2007), and influenced by their history and particular context (Cilliers, 2000b). Effective change in systems has been seen to occur when the leverage applied to effect change is tightly linked with multiple other points of change at various levels (Foster-Fishman and Behran, 2007). Therefore, it is important to consider the level of our intervention (micro, meso macro) and possible interactions between levels. For example, as well as working for change in occupation at the community level, it is useful to work for such change through intervention at a policy level, working towards change in the structures and processes that influence opportunities for communities (Lauckner et al., 2019; van Bruggen, 2017). Advocacy for occupation needs to become central to our practice (Kirsh, 2015). Change may also spread out from one level to another, for example as local movements around a particular issue gain national attention, and we can be alert to facilitating such opportunities.

These ideas all underpin the idea of change beyond individual change, changing, even transforming, our social world through change in occupations, understanding occupation as "actions that rearrange and reconstruct the world we live in" (Frank, 2013: 213). Examples exist in the literature of occupational therapists around the world working to develop such occupational opportunities and to address social injustices (see Kronenberg et al., 2005, 2011; Sakellariou and Pollard, 2017). Social occupational therapy has developed in Brazil with the specific intention of practicing where people's lives are shaped by structural conditions (see Malfitano et al., 2014). In South Africa the Occupational based Community Development Framework (ObCD) has been developed to support a critical approach to using occupation to promote community development (Galvaan and Peters, 2017). The International Social Transformation through Occupation Network is developing case studies illustrating these processes, as well as offering opportunities for exchange and development of practice (Laliberte Rudman et al., 2019).

However, despite these examples, and our title as occupational therapists, we seem reluctant to regularly engage with occupation as a change agent and particularly in terms of systems change in the UK. It is important for us to reflect on our own understanding of occupation. Do we see occupation as an agent of change? And change for who or in what? Beyond the profession we see numerous examples of occupations being used as catalysts for change in

communities and neighbourhoods; including football (Street Soccer Scotland, n.d.); table tennis (Walker, 2019), gardening; knitting and crochet (Social Transformation through Occupation, in press); and crafting (Diamond and Gordon, 2017). Earlier in the year we saw the development of social prescribing in GP surgeries. However, we seem to be lagging behind this growing public perception of the importance of occupation. This increasing awareness of the importance of occupation is to be celebrated, and as occupational therapists we can add to these initiatives our knowledge of the power of occupation for transformation, but also characteristics of occupation for health, such as the importance of choice and the socially situated nature of that (Gallagher et al., 2015; Galvvan, 2015), naming occupation strategically to raise public awareness of issues around occupation and health (Townsend and Wilcock, 2004). But we need to consider, are we champions of occupation? Are we silent and reluctant (Maclean and Breckenridge, 2015; Turner and Knight, 2015), or do we actively fight to ensure that the power of occupation is recognized (both for creating ill health as well as supporting it)? Do we take the concept of occupation with us, spread the word, recognize when people do not have the opportunities they need and when their occupational needs are unmet?

## Concluding remarks

I opened this lecture with a question: Is contemporary occupational therapy in the UK enough? Are we a socially and ethically responsible profession addressing the occupational needs of the population? In responding to that question, I have aimed to share with you some of the challenges that I see we face in engaging with the pressing problems of our society today. I have suggested that traditional ways of thinking and thereby practicing, may be limiting our potential to contribute to their resolution, and that understanding these problems from a systems perspective may be useful to enable us to see ways that we can contribute, utilizing the power of occupation for transformation.

Systems thinking supports understanding that complex issues of occupational need are made up of inter-related elements across multiple levels, from the individual to the global. The response is not to impose a traditional reductionistic and linear approach to one part of the system in an attempt to provide ‘a solution’, but to recognize that working towards change in systems will entail working with multiple partners towards trying to identify possible resolutions to problems. It means that we will need to tolerate our uncertainties about the size of change we can expect and those unexpected consequences. It may include our uncertainty about why

occupation works for change and how, even though we recognize its potential. It invites us to be creative and imaginative about the better futures that we are hoping for and working towards (Cilliers, 2005).

At this time there is a good deal of interest in applying systems approaches within the health system (The Health Foundation, 2010) and in applying systems thinking to complex issues, such as those we have discussed (Carey et al., 2016), However, at the same time it has been suggested that some of these are rather sweeping claims, less well supported theoretically (Paley and Eva, 2011), and that there is limited evidence demonstrating the effectiveness of interventions based on these theories (Carey et al., 2016). But, as Cilliers (2005: 256) notes, "the failure to acknowledge the complexity of a certain situation is not merely a technical error, it is also an ethical one". I believe a failure to act is not only a technical issue regarding our knowledge and skills for practice with complex problems, but also an ethical and moral issue regarding our willingness to acknowledge the occupational needs of contemporary UK society and our responsibility to work to address those.

So I invite us to 'shift our focus', look with courage at those problems which we believe we cannot change or that we do not know how to work with. We must join the conversations, embrace the power of occupation to be part of the processes of change, and work towards the transformation of our society towards health for all.

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