This article offers an overview of Wilcock's theories, from the field of occupational science, and relates them to the community care of people with severe mental health problems. Wilcock's occupational risk factors – imbalance, deprivation and alienation – are described and are seen to be reinforced both by the adaptive nature of this client group's problems and by the difficulties experienced by community-based services as they evolve to address the unfolding complexity of clients' needs. The potential for chronicity to be compounded and deepened in this way is highlighted, with particular reference to vocational and social disability, and the possible implications of a wider acknowledgement of occupational risk factors are discussed in relation to day-to-day practice and service configuration.

Occupational Science and Community Mental Health: Using Occupational Risk Factors as a Framework for Exploring Chronicity

Jon Fieldhouse

Introduction

Occupational science is an academic discipline that focuses on the form, function and meaning of human occupation (Clark et al 1998). It is 'a new, interdisciplinary synthesis of basic knowledge concerning the human as an occupational being' (Yerxa 1993, p3), whose nature and behaviour, in all its complexity, can only be fully appreciated by drawing on sources such as evolutionary biology, anthropology, social and developmental psychology, political science and economics (Yerxa 1993). As such, occupational science is a discipline that integrates biological and social sciences with a single construct: human occupation.

In the United Kingdom, occupational science is said to have permeated occupational therapy and become embedded in it, influencing the profession's thinking, education and research (Mounter and Ilott 1997). However, the question of how knowledge from occupational science (a basic science) can be organised for clinical use in occupational therapy (an applied science) (Kielhofner 1997) is a pertinent one.

This article intends to demonstrate the applicability of occupational science ideas to the day-to-day practice of occupational therapists, within the context of national mental health policy.

Defining the client group

The need for mental health services to prioritise people with severe mental health problems has generated several definitions of 'severe', among which there is no real consensus (Slade et al 1996), and the terminology used has itself become a subject for debate. The user movement challenges the medical preference for terms such as 'chronic' and the concept of 'illness' on the grounds that it perpetuates stigma and fails to acknowledge periods of 'wellness' when clients are more self-determining (Morgan 1996).

This article uses the Department of Health's (1996) 'framework definition' of severe mental illness which emphasises that the term 'severity' has several dimensions: disability, diagnosis (typically schizophrenia or major affective disorder), duration of the condition, safety issues and the need for informal or formal care.

The phenomenon central to this article is 'chronicity', or the persistence of symptoms and the increasingly impaired performance over time experienced by many individuals (Warner 1994, Lloyd and Samra 1996), and it is approached from the perspective of vocational and social disability.

Wilcock's theories

Wilcock's theories encompass human biology, the evolutionary path this biology has enabled our species to forge, and the activity spectrum or stream that we have developed over time. She suggested that the size and structure of the human brain (6.3 times larger than that expected for our body size compared with other mammals)

(Wilcock 1995) is both a stimulus to and a product of our occupations. It motivates, organises and enables our actions to meet bodily, social and cultural needs, while continuously developing itself through use in this way. This is seen to have been a continuing process, in response to changing environmental demands, since earliest pre-mammalian times (Wilcock 1995).

Humans have been built by and for occupation. We are beings for whom 'being', 'doing' and 'becoming' are synonymous (Wilcock 1999). This link between nature and behaviour, or between biology and occupation, means that we have powerful systems within us that permit us to live only in certain ways.

Appreciation of this fact is not the preserve of occupational scientists. Geneticists have noted that the success of a species depends on the survival of genes down the ages and that this occurs 'only if they are good at living and reproducing in the particular way of life chosen by the species' (Dawkins 1996, p6). Far from being a reductionist view, occupational science suggests that the human organism maintains and develops itself through the exercise of personal capacities which can only be fully understood in the context of the individual's biology, physiology, environment, family, society, culture and personal constructs of meaning (Wilcock 1993a, Yerxa 1993).

Wilcock (1993a, 1995) has argued that the link between capacities, occupation and health is becoming obscured by the gradual process of enculturalisation, whereby complex socioculturally determined values and demands are now shaping our occupations and, by implication, what we ourselves are becoming. This process may outstrip our biologies and alienate us from our more anciently derived occupational natures, causing chronic disease and stress-related illness, so that we are both the products and the victims of our own society (Wilcock 1995). Many occupational therapists undertake anxiety management with their clients (Craik et al 1998) and chronic anxiety may provide a familiar illustration of this point. If the chronic tension cycle is acknowledged as a conflict between the primitive and involuntary 'fight or flight' response of the lower brain, and the restraint attempted by the higher, 'newer', cortical brain in seeking to interpret modern stressors (Keable 1997), then it is clear that our older biological reaction offers us too narrow a repertoire of responses or is inappropriately elicited. It has been 'outstripped'.

Occupational risk factors

Occupational risk factors may be understood as symptoms of the loss of harmony between lifestyle and the environment that humans evolved within and which ensured the healthy continuation of all capacities. Wilcock (1998a) has suggested that the current complexity of occupational behaviour, and the very arbitrariness of its divisions according to present-day sociocultural values, may conceal detrimental effects of occupation. She gave the example that defining what is 'work' or 'play' is now a social, rather than a biological, construct.

Wilcock (1998a) proposed that at local, national and international levels, occupational institutions and activities impinge on the individual through the operation of risk factors. In order to understand the implications of these for people with severe mental health problems, it may be helpful to describe them in some detail.

Occupational imbalance refers to a loss of balance between work, rest and play; and between those occupations that we choose and those that we are obliged to engage in (Wilcock et al 1997). It is regarded as being strongly sanctioned in the job market of post-industrial society. *Occupational deprivation* is the denial of opportunity for expressing one's occupational nature because of technologisation, the division of labour, poverty, non-availability of services, inequality of access, discrimination or disability (Wilcock 1998a). It means that an individual cannot be fully part of the world around him or her and, through diminished interaction with that world, is less able to make sense of it and himself or herself (Whiteford 1995). *Occupational alienation* describes the more complex existential concept of separateness from the harmonious, ecological relationship between occupation, health and the environment that our biopsychosocial selves evolved within. It involves estrangement from that self and its capacities and is related to activity at a societal and institutional level that many individuals are not empowered to influence or even able to acknowledge (Wilcock 1998a).

The outcome of these risk factors is continuing unresolved stress (Wilcock 1998b). This manifests itself directly in boredom, burnout, depression, sleep disturbance and anxiety states, which are themselves precursors to disease, disability and death; or can lead to health risk behaviours such as alcoholism and substance misuse (Wilcock 1998a). These disorders and behaviours can disrupt engagement in occupations prompting the loss or abandonment of skills, and of roles as in the negative syndrome of schizophrenia; but, equally, they can trigger the onset or relapse of positive psychotic symptoms. Schizophrenia has been considered as 'a biological disorder that is stress-related' (Falloon and Shanahan 1990, p62) and a low threshold to stressors is recognised as a principal distinguishing feature of severe mental health problems generally (Lloyd and Samra 1996). Occupational risk factors offer a framework, then, for linking clients' occupational performance, and its impairment by both positive and negative symptoms, to their exposure and vulnerability to environmental stressors.

Mental illness and society

Littlewood and Lipsedge (1997) have noted that while poverty and mental illness have been observed to coexist, the precise nature of the relationship has been harder to determine. Wilcock (1998b) described the emergence of social, economic and political systems as features of human occupational behaviour at individual and societal levels over time. Consequently, the notion of occupational risk factors

arguably offers the mental health practitioner a framework for understanding the *processes* within the relationship, not the mere coexistence of phenomena.

It has been shown that however important particular symptoms might be for diagnosing schizophrenia, they are a less significant factor in prognosis than the country where the patient lives, with people in developing countries being less likely to remain ill over a 2-year follow-up period than those in Europe and the USA (Littlewood and Lipsedge 1997). It has been suggested that the better prognosis in non-industrial countries is related to the greater similarities that exist between the family and social milieux (Cooper and Sartorius 1977, Stevens and Price 1996) and that a more balanced use of capacities results from being socialised into selecting occupations conducive to health (Wilcock 1998a).

Sociocultural and economic factors contribute to the social drift of vulnerable people with severe mental health problems to cheaper, more anonymous accommodation (Dalgard and Tambs 1997, Littlewood and Lipsedge 1997); and in deprived areas psychiatric hospital admissions are three times the national average (Mental Health Foundation 1993). Wilcock (1998a) has suggested that the population concentration in urban areas exhausts human beings' social nature through sheer overabundance of potential contacts, prompting individuals to become alienated, isolated and more prone to aggression, and to curtail simple activities like going out for a walk. It is interesting to note that general practitioners in Southwark have been 'prescribing' walks for patients with mental health problems (Bloomfield 1999) and that physical, psychological and social benefits are reported by participants in a coordinated scheme of group walks in Sonning, Oxfordshire (Bartlett et al 1996).

People with severe mental health problems are a disadvantaged group in society and 'the stigma associated with being mentally ill has caused fear, misunderstanding and discrimination' (Mental Health Foundation 1993, p51). This is a factor in occupational deprivation in so far as it limits access to resources and mainstream social contact. The long-term effects of this are yet to be determined but it is significant that occupational deprivation among special needs prisoners, in an environment intended to ensure safety and minimise the exacerbation of psychiatric symptoms, was seen to make these phenomena more likely (Whiteford 1997). In addition, comparisons between the patterns of behaviour associated with the negative syndrome of schizophrenia, long-term custody and long-term unemployment have been made (Watkins 1996).

Society itself (the economy and the culture) may be an important factor, then, in producing chronic mental health problems (Littlewood and Lipsedge 1997) and, if the correlation between effective rehabilitation and periods of high national employment (Kiesler 1992, Freeman 1993, Warner 1994) is acknowledged, it may also be seen as a factor determining treatment outcomes.

Occupational risk factors offer a structure that enable the therapist's focus to move smoothly from broad issues such as these to the particular factors that impinge on the wellbeing of individual clients, whose difficulties go beyond symptomatology and extend to problems of adaptation to their environment: the community.

Adaptation in the community

The closure of the large psychiatric hospitals has only effectively taken place since the late 1980s (Freeman 1993, Holloway and Faulkner 1994) and the community has a relatively new role as the principal environment in which people with severe mental health problems live and receive the bulk of their care. This newness means that services have encountered the changing presentation by clients in the community for only a relatively short period of time and are now evolving in response to a gradual unfolding of the depth and complexity of clients' needs.

The recognition of the problems of institutionalisation, innovations in psychosocial treatments, the anti-psychotic drug revolution and mental health service reform have all contributed to the decline of the asylums (Thornicroft and Tansella 1999). However, while the discovery of neuroleptics provided an impetus for treatment outside hospital (Freeman 1993), chronicity was not abolished (Lockie 1989). It can be argued that their wide use fostered an overexclusive focus on symptom reduction as the key to successful community living and on medication as the means of facilitating it (Curson et al 1988). The complex array of determinants of healthy living could not, however, be adequately framed by a form of inquiry borrowed from the physical sciences. Wiersma (1996) has noted, for example, that psychiatric symptomatology and social dysfunction may vary independently and that the latter may be a more reliable indicator of community survival.

It was specifically to address the anomalies and problems of reductionism that Kielhofner and Burke (1977) used general systems theory to re-focus therapists on 'occupation' as a mechanism for adaptation. Adaptation is taken here to mean the acquisition of skills that enable a person to achieve a new dynamic order for himself or herself in response to changing circumstances and environmental conditions (Kielhofner and Forsyth 1997) and requires the unified action of all capacities.

It has been observed that the fragmentation of care associated with deinstitutionalisation prevented many people with severe mental health problems from managing in the community at all (Ryan et al 1991). The effective exclusion from mainstream opportunities for clients to express their occupational natures, thus limiting the potential for adaptation, is arguably a factor in this. A closer look at vocational and social disability may help to illustrate this point.

Vocational disability

Although case management, care management and the Care Programme Approach (Department of Health 1990) have evolved to address the fragmentation of care in the community, certain features of institutional care are now absent from the

community landscape altogether. The sophisticated work schemes developed in the large institutions, for example, have not been translated into anything comparable, although recognition of the psychological and social value of work (or 'the moral equivalent of work', Yerxa 1998, p417) as a reintegrative force in the lives of people with severe mental health problems is wide and has a long history (Oxley 1995, Durham 1997).

Leff and Trieman (1997) have suggested that the division between health and social care, and consequent confusion over who should initiate and fund such enterprises, hinders their development. Local initiatives have shown that supported employment can enable people with severe mental health problems to access and sustain mainstream employment (Perkins et al 1997). Occupational therapists, who have demonstrated the positive impact of sheltered work opportunities on readmission rates and burdens on traditional day facilities, have argued that the onus is on the National Health Service to embrace this function again as part of a comprehensive community mental health service (Creegan and Williams 1997).

It is significant that in the USA, the Fountain House transitional employment programme for severely disabled psychiatric patients (a model now extended worldwide) attributes its success to making vocational rehabilitation into a function of the normal working community, rather than a sheltered facility (Beard et al 1982). The shelter is provided by the organisation taking collective responsibility for meeting the requirements of specific jobs while individuals acclimatise to the work. Mental illness is not seen as the only, or even main, explanation for vocational disability; rather, it is the individual's personal exclusion from work experiences and consequent failure to acquire adaptive skills.

Practitioners extending the parameters of their practice in this way and exploring the potential continuum between statutory and voluntary services, and between services and the mainstream community, can be supported and informed by occupational science. It underpins concepts already familiar to therapists, such as normalisation or social role valorisation. If living in the community is to be restorative (in ways that living in a hospital cannot be), there must be genuine access points, for people with severe mental health problems, to the features of mainstream community life that sustain health in the general population.

The new millennium, anticipated as an era of increased chronicity and increasing complexity of daily life (Yerxa 1994), will see work and social roles change rapidly (Jones 1993, Wilcock 1993b, 1998a, Steward 1997). The scope exists for people with chronic conditions to live in a more 'negotiated reality' (Field and Taylor 1998, p8) since the hegemony of the medical profession, in managing and defining chronicity, has necessarily given ground to the disability and user movements (Field and Taylor 1998). If there is, indeed, more room now for negotiation of this kind, it can be argued that occupational therapists should be accompanying their clients into that negotiating space to provide them with the most effective, and perhaps most acceptable, service.

Social disability

Wilcock (1998b, 1998c) described how communities have been developed through the expression of human occupational nature to meet occupational needs, which in turn sustains wellbeing. From this it follows that social contact is intrinsic to human health, and that occupations are the key mechanisms by which individuals shape and maintain their own social networks and validate their own social identity.

The significance of social networks to the wellbeing of people with severe mental health problems is described in numerous studies (Nolan 1995, Becker et al 1997, Langford et al 1997). The interdependence between an individual's social network, sense of self, occupational forms engaged in and general wellbeing means that the possibility of accessing this matrix, and using it as a vehicle for clients' psychosocial adaptation, is of obvious relevance to occupational therapists. Indeed, the value of community-based group work in enabling clients to maintain their own networks has already been described (Brewer et al 1994, Bryant 1995) and people with schizophrenia have described 'social connectedness' as a factor in their enjoyment of occupations (Emerson et al 1998), suggesting that it may be an intrinsic motivator of engagement.

Linking adaptation with a naturally occurring support network that is already deeply woven into the everyday lives of individuals is in keeping with a health promotion ethos (Wilcock 1998a, b) and is supported by the enhanced adaptive potential afforded by skill acquisition in 'real life' situations (Yerxa 1994). Interventions of this kind automatically avoid the pitfalls of context-less 'activities' that therapists have been cautioned against using (Golledge 1998a, b).

Social contacts can be mechanisms for sustaining health, but they may also contain an increased risk of exacerbating mental health problems where there is stress or a high level of expressed emotion within families (Avison 1996). This risk factor is linked to the closeness of relations in a family and is frequently bound up with the dynamics that occur when an individual's social network is limited and mediated by a key relative or carer (Nolan 1995). When an individual forges a personal network for himself or herself, it is often a unique configuration of support that cuts across family boundaries (Mitchell and Trickett 1980). Engagement in occupations can be instrumental in this process by enabling individuals to develop and sustain social contacts for themselves, which are consequently more likely to be reciprocal.

The person-environment link is recognised as an important determinant in health beyond occupational therapy. A study of community mental health nurses' views of the community they worked in found that the most helpful conceptualisations used a systems approach acknowledging clients' networks (St John 1998). What occupational therapy does uniquely possess, however, is a range of models that have evolved from an appreciation of this connectedness and its relationship to adaptation, and which conceptualise the community as a tool for therapy. It

is this practice that occupational science can now readily infuse and inform, as Yerxa (1994) suggested:

> Occupational therapists who provide a service in real life environments are not only practical but are employing the most sophisticated form of intervention supported by neurobiology, evolutionary biology, and anthropology (pp587-588).

An extended practice paradigm

Wilcock has advocated a form of clinical practice, methodologies in research and a shift in public health emphasis that recognise the role of occupation as a determinant in health (Wilcock 1993a, 1995, 1998a, 1998b). She observed that occupational therapists are frequently too distracted by their traditional tools to take the broader view that this recognition requires and argued that the 'unique but repressed history' (Wilcock 1998c, p12) of the profession has seen therapists using whatever aspects of 'divided occupation' have been sanctioned by, or are in vogue with, medicine or borrowed theory.

Wilcock (1998b) suggested that an extended practice paradigm which refocuses day-to-day practice on the connection between occupation and health would necessarily prompt therapists to consider their work on a macro level of public health, as well as the micro level of hands-on clinical practice. This potentially offers occupational therapists a more 'complementary' role to medicine than the current 'supplementary' role, which she saw as being problematical because of its dependence on others' domains of concern. As community mental health teams explore their roles and parameters (Finlay 1997) and the fluidity of changing times gives service providers the opportunity to effect change for themselves (Creek 1998), the scope now exists for occupational therapists to develop their practice in this way.

Baum and Law (1997) have suggested that one milestone on this journey is an openness to new collaborative working partnerships in the community; and the efficacy of using normal, community-based venues as sites for occupational therapy has been described (Brewer et al 1994, Bryant 1995). Occupational therapists' familiarity with occupational forms in the mainstream community make them ideally suited to being a conduit for this opening-up process in their multiprofessional teams. The Care Programme Approach (Department of Health 1990) provides the therapist/keyworker with the machinery for tapping this potential through a holistic assessment of needs, the brokering of a range of services (statutory and non-statutory) and inter-agency working. Indeed, practice of this kind is endorsed by the National Service Framework for Mental Health (Department of Health 1999) which takes a broadly health promotional stance, reflects a biopsychosocial approach to mental health problems, and emphasises the maintenance of occupational and social roles as ways of improving the quality of life and clinical outcomes of service users (Ormston 1999).

Health promotion

The public health approach to mental health acknowledges that 'the mental health of individuals is integrally linked with the wider social and economic health of their communities' (Thornicroft and Tansella 1999, p16). Wilcock (1998b) has advocated a 'health promotion' perspective (based on a *health* ideology) as opposed to a 'prevention of illness' perspective (based on a *healing* ideology); and has argued that medical science, to which notions about public health are conceptually tied, remains focused on the latter. This was echoed in the direction and range of most health research, which consequently lacked the scope to deal with the complex matrix of health determinants that existed (Wilcock 1998a). This wider arena is, perhaps, the only valid context for developing our understanding of schizophrenia, for example, and seeking answers to the questions being asked about the role played in its incidence by social class, ethnicity, the economy and industrialisation (Warner 1994).

Conclusion

Most mental health services are now provided in the community and this has great restorative and preventative potential for work with clients with severe mental health problems. However, it also holds the potential for compounding clients' problems by exposing them to fragmented community services and effectively excluding them from the mainstream community. The consequent breakdown of the interaction (through occupations) between the person and his or her environment has implications for the maintenance and development of adaptive skills and, so, for community survival.

Implicit in the framework of occupational risk factors is an analysis of this problem and a suggested solution. It allows the therapist to see chronicity as a phenomenon in its entirety: one created by intrapersonal, social and societal processes, acting synergistically. It also informs therapists' day-to-day practice with individuals in their communities, supports broader work aimed at creating a more accepting community for them, and reaffirms the relevance of occupation and occupational therapy to current national mental health policy.

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