What Do We Need To Know To Practice Occupational Therapy in the Community?

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One of the main challenges to occupational therapists in community practice is applying our existing knowledge base to support a different kind of practice in the community. This article explores the theory base in occupational therapy that informs three models of community practice: client-centered, community-based rehabilitation, and independent living. It defines these three preferred models of service delivery for community practice and looks at the knowledge requirements for each. Using a taxonomy developed to classify occupational therapy theory, the article examines existing theory and gaps in the theory base for occupational therapy in community practice. Finally, the article challenges practicing therapists, educators, and researchers to examine their use of theory and their underlying assumptions for meeting the challenge of community practice.

Occupational therapists have been talking about the inevitability of a transition to community practice for at least 20 years. As an undergraduate in the 1970s, I believed that most of us would practice in the community and that we were on the brink of a revolution in health care. Yet, 20 years later, statistics tell us that only 37% of occupational therapists in the health sector are working in the community (Canadian Association of Occupational Therapists, 1996).

One of the main challenges to occupational therapists in contemplating a major shift to community practice is the extent to which our existing knowledge base supports a different kind of practice in a different kind of environment. Until now, traditional institutional occupational therapy practice has been supported by basic knowledge in the medical and biological sciences. Although this knowledge base serves us adequately in institutional practice, it will not serve us well in the community. Instead, we need basic knowledge about the nature and distribution of disability and occupation and about the determinants of successful community living with a disability.

Therefore, we need to evaluate the knowledge base in occupational therapy for applicability to community practice, to organize this knowledge around issues that are pertinent to community practice, and to identify areas for knowledge development. This article explores the theory base in occupational therapy that informs community practice. It offers a taxonomy for theory that is based on occupation and models of service in the community. It begins by defining three preferred models of service delivery for community practice and looks at the knowledge requirements for each. Using a taxonomy developed to classify occupational therapy theory, the article examines existing theory and gaps in the theory base for occupational therapy in community practice. In so doing, it challenges educators and researchers to examine their respective roles in preparing occupational therapists for the challenge of community practice.

Models of Service Delivery in Community Occupational Therapy

In institutional settings, occupational therapists have traditionally functioned within a biomedical model of rehabilitation, meaning "a goal-oriented and time-limited process aimed at enabling an impaired person to reach an optimum mental, physical and/or social functional level" (United Nations, 1983, p. 10). Although this model may have served therapists and clients well in such institutional settings, there are a number of discussions of its inappropriateness for providing service to persons with dis-

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abilities living in the community (Hahn, 1984; Schlaff, 1993; Verbrugge & Jette, 1994). For example, the biomedical model assumes that people will get better and can be freed of social obligations until they do. This is clearly not an appropriate assumption for a person with a life-long disability. Instead, three alternative models of rehabilitation services have been outlined for community practice: client-centered, community-based rehabilitation (CBR), and independent living (McColl, Gerein, & Valentine, 1997).

Client-centered rehabilitation was originally defined by Rogers (1942) to mean a non-directive approach to therapy, where the therapist’s role is to create an environment of trust and support, furnishing clients with the opportunity to utilize their own problem-solving capacities to realize their therapeutic goals (p. 9). According to this model, clients seek a therapist; explain their problems; and, in an environment of understanding, trust, and acceptance, pursue change toward their goals (Burnard & Morrison, 1991; Herzberg, 1990; Patterson & Marks, 1992). Thus, client-centered practice is based on micro-level theory, focusing on a person in his or her micro-environment. The micro-environment includes the person and spaces closest to the client. It usually consists of his or her living situation and the persons that share it, such as family members, roommates, and intimates (Bronfenbrenner, 1979; McColl & Bickenbach, in press).

CBR uses a community development approach to achieve equalization of opportunities and social integration of all people with disabilities. CBR is implemented through the combined efforts of people with disabilities themselves, their families and communities, and the appropriate health, education, vocational and social services (International Labour Organization, United Nations Educational, Scientific and Cultural Organization, & World Health Organization, 1994, p. 3). In CBR, the community is the target of intervention, although persons with disabilities themselves are primary beneficiaries (Lyssack & Kaufert, 1994). CBR may be considered a health promotion approach to providing community services to persons with disabilities, focusing on mobilizing community supports and resources to improve health (Epp, 1986). Thus, we may consider CBR to be based on meso-level theory, focusing on meso-level environments (Bronfenbrenner, 1979). The meso-environment consists of one’s community and the persons in it, such as neighborhood and neighbors, workplace and work colleagues, school and schoolmates, friends and their homes, parks, stores, and offices (McColl & Bickenbach, in press).

Independent living is a concept, a policy, a set of community-based services and programs, and a civil rights movement. It is the freedom to participate in the community fully and to have access to housing, transportation, health care, employment and education. It is reflective of a self-determined and self-directed lifestyle that permits the individual to make meaningful choices (Denson, 1988, p. 18)

Independent living is a social movement that developed out of the collective political action of persons with disabilities (Dejong, 1979; Driedger, 1989; Oliver, 1990). It is a movement of and for persons with disabilities, offering self-help, peer support, research, service, referral, and advocacy (Canadian Association of Independent Living Centres, 1989; Dejong, 1979; DeLoach, Wilkins, & Walker, 1983). It is based on macro-level theory, focusing on persons with disabilities in society and the macro-level structures that affect their lives. The macro-environment is the broader society within which one lives. It includes structures, policies, and attitudes that define the society and its relationship to persons within it. The boundaries among the micro-environment, meso-environment, and macro-environment are not fixed, but they offer a way of thinking about the environment and how persons interact with it (McColl & Bickenbach, in press).

Knowledge Base for Practice

In a discipline such as occupational therapy, knowledge and theory exist not only to explain the world around us, but also to guide professional intervention. Thus, the knowledge base consists of conceptual models, which help us to analyze and understand occupation, and practice models, which help us to know what to do to promote and improve occupation. McColl, Law, and Stewart (1992) offered a way of conceptualizing occupational therapy’s body of knowledge, which helps to classify similar ideas together. The approach begins with a model of occupation, which characterizes occupation as a function of environmental, developmental, and personal factors (see Figure 1).

Environmental factors consist of aspects of the physical, social, political, economic, institutional, and cultural environment. These factors may be either hostile or friendly toward occupation; in other words, the environment may either hamper or facilitate function.

Developmental factors refer to the extent to which previous environments have afforded the supports and challenges that lead to adaptation and development. The developmental level of a person may either be adequate or inadequate to support particular occupations.

Personal factors consist of physical, psychological–emotional, cognitive–perceptual, and sociocultural factors. Physical factors include strength, range of motion (ROM), endurance, and other musculoskeletal capacities. Psychological–emotional factors refer to feelings and thoughts and intrinsic and learned responses to internal and external stimuli. Cognitive–perceptual factors refer to the abilities of persons to analyze or process incoming
Factors Affecting Occupation

- Development Factors
  - self-care
  - productivity
  - leisure

- Environment Factors
  - physical
  - psychological-emotional
  - cognitive-perceptual
  - sociocultural

- Person Factors
  - physical
  - psychological-emotional
  - cognitive-perceptual
  - sociocultural

Figure 1. Model of occupation. Note. From Theoretical Basis of Occupational Therapy (p. 5), by M. A. McColl, M. Law, & D. Stewart, 1992, Thorofare, NJ: Slack. Copyright 1992 by Slack. Adapted with permission.

Knowledge About Occupation

Level I: Definition of Occupation

- Occupation

Level II: Determinants of Occupation

- Environment Factors
- Development Factors
- Person Factors

Level III: Understanding Human Function

- Architecture
- Geography
- Economics
- Sociology
- History
- Basic and Human Clinical Sciences

Figure 2. A taxonomy of occupational therapy theory. Note. From Theoretical Basis of Occupational Therapy (p. 7), by M. A. McColl, M. Law, & D. Stewart, 1992, Thorofare, NJ: Slack. Copyright 1992 by Slack. Adapted with permission.

Information, including external information, such as sensory or verbal information, and internal information, such as vestibular or kinesthetic information. These factors differ from psychological-emotional factors in that they involve a level of processing, integrating, computing, or understanding of stimuli. Sociocultural factors include internalized values, beliefs, attitudes, roles, and behaviors that result from a person's socialization or upbringing (McColl et al., 1992).

According to the model, occupational functioning may be enabled or obstructed by the presence or absence of environmental, developmental, or personal factors. Each factor represents a way of understanding occupational function or dysfunction, a way of analyzing occupation, a way of identifying potentially remediable deficits that contribute to occupational dysfunction, and an area for occupational therapy theory. Hence, these three theory areas provide the basis for a taxonomy that organizes theory of occupation into recognizable areas for therapists (see Figure 2).

The taxonomy has three levels. Level I contains definitions and conceptualizations of the central construct of occupation. Theories classified at Level I are those that define and describe occupation. Level I theory includes such concepts as the occupational nature of humans, the need for meaningful occupation, and the essence of balanced occupational functioning for health. These basic ideas about occupation are equally pertinent to therapists working in institutions or community environments and to therapists whose practice is based on any of the three theory areas. Nelson's (1997) discussion on the use of occupation as a therapeutic modality is an example of Level I theory.

Level II contains the three theory areas previously described (i.e., environmental, developmental, personal). These theory areas attempt to explain occupation as a function of a particular model. Examples of Level II theory in each of the three areas follow in the next section.

The environmental theory area is concerned with how the environment either facilitates or impedes occupation. Theorists contributing to this area understand occupation in terms of the environmental forces that act upon it. They interpret occupational dysfunction as a result of an inadequate, an overly controlling, a hostile, or perhaps simply an indifferent environment. Changing occupational functioning within this framework is predicated on changes in the environment.

The developmental theory area is based on the belief that occupation is learned in a developmental sequence as part of the overall process of development. Proponents of the developmental approach understand occupational dysfunction as a result of faulty or incomplete development in a particular area. They evaluate occupational dysfunction by attempting to discern the stage at which occupational development had become arrested. Remediation then begins at that stage and consists of tasks and challenges aimed at stimulating development through succeeding stages.

The personal theory area explains occupational function and dysfunction on the basis of physical, psychological-emotional, cognitive-perceptual, and sociocultural factors. The physical approach is based on the belief that problems of occupation are a function of the person's physical abilities and deficits (i.e., strength, ROM, en-
durance). Thus, occupational functioning is promoted through the person's adaptation and compensation for his or her physical deficits, using interventions such as exercise, work simplification, energy conservation, adaptive technology, adapted methods, and ergonomics to overcome physical barriers to occupation.

The psychological–emotional approach is based on the belief that successful occupational performance is predicated on healthy psychological and emotional responses toward occupation. Within this framework, occupation is analyzed in terms of feelings, attitudes, motivation, and coping resources for occupation. Remediation includes analysis of the inherent meaning of occupation; overcoming psychological obstacles to occupational function; and the development of coping skills, social skills, and cognitive strategies.

The cognitive–perceptual approach upholds the belief that cognitive and perceptual integration of input is essential to one's ability to carry out occupation with success and satisfaction. According to this approach, inability to perform occupation may be explained and addressed in terms of the person's inability to experience, process, and apply incoming information. Successful occupational functioning depends on sensory, perceptual, neurological, and cognitive capabilities. Both intrinsic and extrinsic input must be meaningfully interpreted to allow appropriate occupational responses.

The sociocultural approach understands occupation as a function of the socialization and acculturation of persons throughout their lives. Society and culture convey beliefs, attitudes, and values that become internalized and influence how persons engage in occupation. Roles, uses of time, attitudes about work and leisure, values, and beliefs about occupation are all examples of our constructed reality. According to this approach, these socially constructed messages have the potential to influence occupation. Therefore, evaluation and remediation of occupation according to this approach are aimed at understanding the values and beliefs that affect occupation and rationalizing expectations, demands, and roles to enhance occupational success.

This article focuses particularly on Level II theory. That is, it focuses on each of these three theory areas that helps occupational therapists understand factors affecting occupation for their clients living in the community.

Level III contains those theories, usually derived from other disciplines, that occupational therapists use to understand humans, their development, and their environments. Level III theories do not specifically relate to occupation itself; rather, they give us background knowledge that provides a basis for the occupational therapy theories found in Level II. Other disciplines whose theory supports occupational therapy theory include anatomy, anthropology, architecture, biomechanics, economics, neuroanatomy, neurophysiology, neuropsychology, psychology, politics, psychiatry, psychology, and sociology, to name a few.

Theory and Service

The two topics discussed thus far—models of service and areas of theory—offer us a way of looking at knowledge and service in community practice. Knowledge has been classified into three categories corresponding to factors affecting occupation (i.e., environment, development, person), and four models for providing service in the community have been discussed (i.e., biomedical, client-centered, CBR, independent living). If these two topics are combined into a matrix, we can systematically examine the knowledge base supporting occupational therapy in the community. The remainder of the discussion will focus on the three models of service most pertinent to community practice (client-centered, CBR, independent living) and the information, knowledge, and theory that support practice according to each.

Client-Centered Model

Client-centered occupational therapy is supported by knowledge and theory from each of the three theory areas. Therapists working from an environmental theory base focus on the client in his or her immediate home environment, that is, the micro-environment. They understand problems of occupation as a result of factors in the home and family and seek to remediate occupation by modifying the tools the client uses, the accessibility of the home, and the supports offered in the family or living situation. The Person–Environment–Occupation Model is an example of micro-level environmental theory (Law & Dunn, 1993; Law et al., 1996; Letts et al., 1994). Additionally, Barri's (1982, 1986) work on occupation as person–environment interaction is another good example.

Developmental theory supporting a client-centered model of practice focuses on the occupational development of the person. Problems of occupational performance are seen as faulty or inadequate development of occupation itself (Level II) or of the physical, cognitive, emotional, or social aptitudes supporting occupation (Level III). Remediation is aimed at presenting the client with the appropriate tasks, challenges, and supports to facilitate development of the needed occupational skills. Some of the best examples of the theory base supporting this approach to practice in the community are those dealing with occupational choice (Black, 1976; Webster, 1980).

Theory relating the personal factors to occupation is pertinent only to the biomedical and client-centered approaches to service delivery in the community. Because
the other two models (CBR, independent living) focus on the community and the society as the locus of intervention, it would not be logical to use theory explaining occupation as a function of personal factors for either model. 

Level II physical theory supporting the client-centered approach to problems of community living for persons with disabilities includes knowledge about the physical requirements of community-living occupations (i.e., strength, ROM, endurance). Therapists practicing from this perspective understand occupational dysfunction largely on the basis of knowledge from the basic sciences. Level II theory in the psychological--emotional area is dominated by the psychiatric rehabilitation approach, which applies the ideas of disability and handicap to persons with mental health impairments (Anthony, Cohen, & Farkas, 1990; Anthony & Lieberman, 1986). 

Level II theory in the cognitive--perceptual area includes knowledge about the sensory, cognitive, and perceptual requirements of occupation in the community. Although our theory base is well developed to understand the requirements of basic institutional self-care occupations, such as dressing, bed mobility, and ambulation, we know little about the information-processing requirements of more complex community occupations. Thus, occupational therapists working with persons with cognitive or neurological problems living in the community are left to practice with a dearth of theory to support their activities. An example is the area of organizational functions for persons returning to the community after an acquired brain injury. Therapists use a variety of technologies and strategies for assisting these persons with organizing their time, keeping their appointments, remembering important numbers, and finding their way around, but little of this activity has an explicit theoretical base to support it. Level II theory in the sociocultural area includes an understanding of the roles persons fulfill in the community, the requirements of those roles, the allocation of time to various aspects of occupation, the way values and attitudes affect performance, and the way values and beliefs are modified.

**CBR Model**

CBR is supported by environmental and developmental theories. According to the environmental perspective, a community-based approach focuses on the meso-environment, or the community, as the locus of occupational dysfunction. Therapists using environmental theory within a community-based model understand occupational dysfunction as a result of barriers to full participation in the community and intervene by seeking change in the community. That is, they identify opportunities for increasing equality and access in the workplace, the neighborhood, and the local businesses as the means to promote increased occupational functioning for their clients. They use the process of advocacy to assist community members to recognize inequities for persons with disabilities as a problem and to marshal community resources to address the problem. Grady's (1995) description of communities for persons with disabilities is an example of our evolving knowledge base in this area.

Developmental theory supporting a CBR model of practice includes theories of community development. Problems of occupation are understood in the context of inadequate community development such that a community is unable to offer occupational opportunities to its members with disabilities. To practice from this perspective, occupational therapists require a knowledge base that allows them to understand communities as "organic," dynamic entities that grow and change in much the same way that individuals do. To facilitate remediation from a community development perspective, therapists need to understand how to help communities develop to a point where they are able to offer equal opportunities to members with disabilities. Thus, the therapist acts as a catalyst to community development by increasing community awareness of the needs of its members with disabilities and assisting communities to marshal resources and
evolve solutions. A number of authors have contributed to our understanding of how communities grow and change. McKnight (1988) wrote extensively on the concept of community and community development (Level III) and contributed to our understanding of how communities develop to provide opportunities for occupation. Examples from the rehabilitation literature include Bewley and Glendenning (1994), representing a North American perspective, and Ingstad (1990), representing a developing world perspective.

Independent Living Model

Therapists applying an independent living model of service also find knowledge and theory to support their practice in the developmental and environmental areas. Environmental theory supporting the independent living approach focuses on the macro-environment as the locus of occupational dysfunction. Of particular interest are issues of citizenship, housing, employment, transportation, education, and the extent to which societal structures afford persons with disabilities opportunities to be occupationally successful. Over the two decades since its inception, the Independent Living Movement (Dejong, 1979) has evolved from a position of antagonism against professionals to a recognition of the potential contribution of professionals to the initiatives of persons with disabilities (Dejong, 1993). However, occupational therapists working within an independent living model must recognize the limits of their professional role. One of the basic tenets of independent living is that persons with disabilities have the resources and abilities at their disposal to make structural changes that will lead to full participation. Thus, professionals assume a supporting role relative to the initiatives of persons with disabilities or advocacy groups. Two examples that represent the macro-environmental approach to occupational therapy include Jongbloed and Crichton’s (1990) discussion of implications of independent living ideology for social policy and Polataiko’s (1994) discussion about occupational therapy in the next millennium.

Occupational therapists working from an independent living model of service also find theoretical support in the developmental area. Therapists need to understand social development in the broadest sense. They need to understand how societies develop from a primitive state, where each person must fend for himself or herself, through philanthropic societies, where more fortunate persons adopt a charitable stance toward less fortunate persons, to cooperative societies, where members are uniquely valued for their contributions and where different mediums of reciprocity are understood. This approach requires therapists to have some appreciation of history, anthropology, and sociology (Level III) as well as an understanding of the development of specific societal responses to persons with disabilities and their need for occupation (Level II) (Driedger, 1989). Therapists practicing from an independent living model within a developmental framework understand problems of occupation as inadequate societal development to support persons with disabilities. The role of the therapist is that of an advocate supporting the initiatives of persons with disabilities in order to promote social development that would result in an institutional, political, and social framework that supports clients’ full participation in occupation. The therapist might contribute knowledge of social development and the disability rights movement, as well as knowledge of the kind of policy environment that best supports occupation, toward the development of strategy by groups representing persons with disabilities. This type of practice requires the development of a knowledge base that is considerably beyond what most occupational therapy students are currently offered or what most occupational therapy researchers currently address.

Conclusion

This article has described three models for providing service to persons with disabilities in the community. These models serve as alternatives to the traditional hierarchical, professionally dominated biomedical model that pervades most institutional practice. Further, the article has described three areas of theory in occupational therapy and has explored each for ideas pertinent to practice in three models of community service. These theory areas need not be mutually exclusive. In some instances, a single theory area may adequately explain occupational function. In other instances, the combination of two or more theory areas may be required to explain occupational function, particularly in instances of multifaceted or complex occupations, such as those usually encountered in community practice.

The obvious need for theory development to support community practice in occupational therapy may be one reason why the past two decades have seen so little real progress in the development of community occupational therapy. Although we advocate community practice at every opportunity, without a solid knowledge base, it is difficult for therapists to make the transition to community-based models of service delivery. Armed only with knowledge developed for institutional practice models, therapists working in the community are left to their own devices to adapt these theories to community practice. The result is that many occupational therapy services in the community simply apply institutional or biomedical perspectives to practice rather than adopting one of the community practice models discussed earlier.
From the perspective of education, it seems essential that we prepare occupational therapy students to work with communities and with organizations of persons with disabilities and not simply with individuals. Students need to understand what a community is; how communities and organizations form and identify themselves; how they are governed, both formally and informally; how to identify resources in a community; and how to facilitate change in a community and a society. Further, we need to cultivate fieldwork experiences that offer models of successful community practice from a variety of models and perspectives. This requires that we officially acknowledge and professionally recognize the experiences that may be gained in fieldwork outside of traditional settings.

From the perspective of research, the article points to several areas where occupational therapy’s knowledge base could be developed to better support practice in alternative models of service in the community. A commitment to service delivery in the community must be accompanied by a commitment of research resources and investigation of community-based research questions. Given a presumably fixed pool of research resources, this may require the profession to shift some of the focus of research efforts away from topics concerned with the validation of institutional practice toward topics concerned with how persons with disabilities live in the community, how they develop and pursue occupations, and the supports and barriers experienced in these pursuits.

Occupational therapists understand the importance of community, both intuitively and scientifically. The challenge in the current, rapidly evolving health care system is to translate this understanding beyond rhetoric into knowledge and practice that provides for a meaningful relationship with persons with disabilities living in the community. ▲

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17


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