Social Justice and Resource Utilization in a Community-Based Organization: A Case Illustration of the Role of the Occupational Therapist

Brent Braveman and Yolanda Suarez-Balcazar

Social justice and occupational justice have received increased attention in the occupational therapy literature. This evolving discourse has focused on establishing a connection between the effects of social injustice and the resulting negative influences on occupational participation. This literature has also addressed the role of occupational therapists in responding to social injustice at the societal, population, or individual levels. We examine the two most well-known theories of social justice to understand the responsibility of organizations, institutions, or governments in providing for people who have experienced difficulties in maintaining self-sufficiency. We use two case examples to illustrate how community-based organizations act as brokers of human, financial, and other resources and the challenges they face in distributing these resources in a manner consistent with social justice concepts. Finally, we suggest how an occupational therapist might assist such organizations in fairly distributing resources by applying occupational therapy paradigmatic knowledge and skills.


Social justice is a broad term that encompasses several interrelated concepts, such as equality, empowerment, fairness in the relationship between people and the government, equal opportunity, and equal access to resources and goods (Abberley, 1995; Beverly & McSweeney, 1987; Fondacaro & Weinberg, 2002; Longres & Scanlon, 2001; Townsend, 1993, 2003; Townsend & Wilcock, 2004; Young, 1990). In addition, the concept of human rights has been considered a global value that lies at the core of social justice (Austin, 2001). Some of the roots of the notion of social justice date back to the early teachings of the Catholic Church as well as philosophers such as St. Thomas Aquinas, John Locke, David Hume, and Jean-Jacques Rousseau (Bowring, 2002). From the time of the early philosophers, the concept of social justice has focused on the moral and philosophical meaning of individual rights, free society, and free will. Social justice also encompasses the study of the relationships between society and government and the accountability of the masses (Lowery, 1998). More recently, the Liberation Theology movement (Gutierrez, 1990) has propelled the concept of social justice as it relates to the struggle for workers’ rights and the rights of the poor (Young, 1990). Many of these concepts are congruent with the roots and underlying philosophies of occupational therapy, such as the moral treatment movement and the humanitarian approach to people with mental illness (Schwartz, 2003, p. 5).

Scholars often discuss justice using one of two terms: social justice or economic justice. From a social point of view, scholars have studied human rights, women’s rights, violence, poverty, access to social services, and group and individual empowerment, among other concepts. The study of economic justice focuses on economic

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distribution, occupation (including employment), economic inequalities, and economic access to goods. Given these, Marxism provides the most comprehensive theoretical and philosophical critique of the capital mode of production while strongly advocating for a just distribution of economic resources (Marx, 1980).

We examined the two most well-known theories of social justice and concepts assigned to it to understand the responsibility of organizations, institutions, or governments in providing for people who have experienced difficulties in maintaining self-sufficiency. We address the requisite skills, motivation, and habits that are rooted in Western values of individuality and self-sufficiency. We describe how service-oriented community-based organizations act as brokers of human, financial, and other types of resources and the challenges they face in distributing these resources in an efficient and equitable manner. Finally, we suggest how an occupational therapist might assist such organizations in effectively and fairly distributing resources through the application of occupational therapy–paradigmatic knowledge and skills.

Social Justice Theories

The most well-known theories of social justice are the distributive justice theory and the processual justice theory (Longes & Scanlon, 2001). The distributive justice theory “refers to the way economic and social goods and services are distributed in a society” (Rawls, 1971, p. 448). It also discusses provision of resources, access to resources, and economic opportunities. The processual justice theory (also commonly referred to as procedural justice) considers the decision-making process as it describes the relationships between dominant and subordinate groups and the participation level of people within larger societal structures. This theory articulates that principles and laws that govern the relationships between dominant and subordinate groups lead to decisions about the distribution of resources (Young, 1990). Distributive and processual justice can complement each other. A person might be able to increase distributive justice by participating in the decision-making process about the use of available resources (processual justice). These two theories have been studied across disciplines in connection with the concepts of human rights, empowerment, and occupational justice. These three concepts are discussed in the next section of this article in more detail because they affect our views about the personal responsibility of the individual and the responsibility of society in assisting people in pursuing social justice from an occupational therapy perspective.

Human Rights

The concept of social justice has been closely related and studied in connection with human rights (Bowring, 2002; Lowery, 1998). Indeed, this is the concept that has received the most attention in the literature related to social justice (Austin, 2001; Fondacaro & Weinberg, 2002). Smith (1998), a proponent of the protection of human rights, asserted that governments have a legal and moral responsibility to provide for the basic needs of their citizens, including the preservation of liberties and protection from harm. According to Austin (2001), “the central assumption of the rights paradigm is that every person can make certain claims based solely on their humanness” (p. 184). Much discourse addresses what the notion of human rights encompasses, including intellectual rights, rights to freedom, reproductive rights of women, and health rights, among other issues.

Bowring (2002) explored three strategies used in the relationship between human rights and social justice: confrontation, mediation, and mutual realization. For instance, an individual with a disability might experience that his or her rights have been violated if he or she is lacking accommodations and accessibility in the workplace. This person might advocate for social justice by confronting his or her employer about his or her needs. Mediation might take place as he or she negotiates the required accommodations, and mutual realization might be the end product of compliance between the employer and the employee. They may identify the advantages of complying with the necessary accommodations, such as increased productivity and a higher level of job satisfaction. Conversely, an employee might be faced with an employer who refuses to make the necessary accommodations that might lead to an unfair and unjust occupational situation.

Distributive and processual justice play an important role in the context of human rights. Some societies provide their citizens with opportunities to have access to resources (distributive justice) and opportunities to voice their opinions and make decisions (processual justice), while at the same time protecting their human rights (e.g., intellectual rights, freedom of speech), such as in the case of democratic societies.

Empowerment

A second concept often related to social justice is the concept of empowerment, which was introduced into the social sciences literature by Rappaport in 1977. Empowerment is the process of giving voice and participation to people regarding the decisions that affect their lives. Although the
empowerment tradition emphasizes the individual’s responsibility to control his or her own life and resources, those in positions of power—such as the government, agencies, and organizations that hold resources—can facilitate opportunities for people to control their own lives (Fawcett et al., 1994). According to Fawcett et al.’s (1994) contextual model of empowerment, the interaction between environmental and personal factors can either facilitate or limit empowerment outcomes. According to Fondacaro and Weinberg (2002), empowerment is mostly rooted in the principles of processual justice; however, an empowerment outcome might refer to distributive justice (e.g., access to resources), which is attained through processual justice (e.g., making decisions). For example, a minority individual living with HIV may have the skills and motivation to search for employment; however, he might face discrimination and lack of information about adequate jobs, whereas another individual with the same condition might have a support network when searching for a job and might be more likely to find employment. Finding employment in this case is the outcome that is followed by making decisions and gaining increased power on how to use available resources.

Empowerment theory is rooted in the assumption that people value the opportunity to be involved in making decisions that affect their lives because participation affects their psychological well-being (Zimmerman, 2000), increases the possibility that they will gain control of their own resources (Fawcett et al., 1994), and motivates actions directed toward improving their own conditions and fulfilling their goals (Balcazar, Keys, & Suarez-Balcazar, 2001). Empowerment can be achieved by increasing an individual’s skill level, knowledge, and capabilities and providing support systems or removing barriers that reduce marginalization (Fawcett et al., 1994; Suarez-Balcazar, 2005). According to Fondacaro and Weinberg (2002), although early work on empowerment was mostly concentrated on individualistic notions of autonomy, self-control, personal responsibility, and psychological issues, later studies and conceptualizations of empowerment concentrated on systemic factors, issues of distributive justice, and social responsibility at the group and systemic level (Riger, 1993). The emphasis on systemic factors came from the realization that often people in disadvantaged situations (e.g., people with HIV, people with disabilities) may lack empowerment, in part because of experiences of oppression and marginalization (i.e., lack of distributive justice and processual justice).

Occupational therapists have studied empowerment approaches in their work with people with disabilities (see Boyce & Lysack, 2000; Cockburn & Trentham, 2002; Redick, McClain, & Brown, 1999; Rogers & Palmer-Erbs, 1994; Townsend, Birch, Langley, & Langile, 2000). Within these studies, the approaches described emphasize building the capacity of people with disabilities to make decisions, learn critical life skills, and set their own goals for change.

Occupational Justice

Social justice has been discussed within the occupational therapy literature as it relates to oppression or systematic limitations to participation in occupation of people with disabilities and people with chronic health conditions. Terms such as occupational justice or occupational apartheid have been used to describe these phenomena (Abelenda, Kielhofner, Suarez-Balcazar, & Kielhofner, 2005). Wilcock (1998) introduced the concept of occupational justice, which was further expanded by Wilcock and Townsend (2000). This term was meant to reflect the belief that societies should provide opportunities for people to engage in meaningful occupations that allow them to develop their potential and participate in their communities (Jakobsen, 2004; Wilcock, 1998; Wilcock & Townsend, 2000). Their conceptualization urged a society that can support and promote the satisfaction of people’s occupational needs (Townsend & Wilcock, 2004).

Occupational justice is based on the premise that the role of a society includes the provision of adequate occupational opportunities for all. These occupational opportunities may also involve meaningful employment, leisure, skill development, hobbies, and other forms of occupation (Abelenda et al., 2005). People with disabilities and other minority groups may experience several barriers and obstacles in the pursuit of occupational justice (Jakobsen, 2004). In the context of distributive and processual justice, current statistics show that people with disabilities and chronic health conditions, and in particular ethnic minorities with disabilities, experience a high rate of unemployment (Balcazar & Hall, 2005). This unemployment results in decreased access to resources and opportunities for meeting individual and family needs (distributive justice) and decreased access to participation in the decision-making process about distribution of resources (processual justice).

Putting It All Together

Analysis of the concepts of human rights, empowerment, and occupational justice broaches the responsibility given to government, systems, or institutions to provide for their members versus the responsibility placed on the individual for becoming self-sufficient. For example, according to Sarason (1990), one of the purposes of any educational system is to "produce responsible, self-sufficient citizens who
possess the self-determination, initiative, skills, and wisdom to continue individual growth and pursue knowledge” (p. 163). However, from a social justice perspective, one may argue that some systems are inefficient in providing citizens with the skills, supports, and abilities to pursue meaningful lives, and instead they may experience discrimination, marginalization, and oppression. As such, people who share common predicaments and conditions, such as living with HIV/AIDS, having a disability, or being a racial minority, often experience situations of oppression and discrimination more so than people without these conditions. Given that, many assert that self-determination is a critical skill for producing responsible adults (Wehmeyer, Palmer, Agran, Mithaug, & Martin, 2000; Wehmeyer & Schwartz, 1997). As such, the following questions may be posed:

• Is our society adequately supporting people with disabilities or those experiencing chronic health conditions to achieve self-sufficiency and self-determination when faced with challenges to occupational participation (access to resources—distributive justice)?

• Are service organizations making effective decisions to promote full participation and self-determination (processual justice) through effective distribution of resources and services (distributive justice)?

Part of the paradox that some people with disabilities and people with chronic health conditions may experience is that despite enduring oppressive circumstances (e.g., discrimination, lack of opportunities), our society expects them to exert self-sufficiency and self-determination, which are core values of the U.S. culture (Dalton, Elias, & Wandersman, 2001). Essentially, our society expects its people to exert control by making their own decisions, taking care of themselves, and becoming independent or interdependent. However, people experiencing oppression might need support systems in place to enable their independence and to protect their own rights. Consider, for instance, the predicament of people living with HIV/AIDS who might need the assistance of an agency or social services system to facilitate equal access to employment, adequate and affordable housing, and health care. Many social services programs in this country are designed to create access to resources for people in need by building skills; increasing personal capacity; and increasing access to resources to promote empowerment, self-sufficiency, and self-determination. However, one’s ability to make use of available resources might be a function of the relationship between individual characteristics (e.g., abilities, skills, motivation, volition—interest and values—and sense of self-efficacy) and environmental characteristics (e.g., support systems, accessibility, availability of resources).

Unfortunately, our social services system in general is experiencing many challenges, including budget cuts, frequent staff turnover, and staff overload (Suarez-Balcazar, Harper, & Lewis, 2005) and cannot always protect individuals’ rights and provide the optimal support and resources needed for people to exert their self-determination and self-sufficiency. Moreover, it must be recognized that the social services system in the United States faces some limitations. It has difficulty distinguishing between people who fail to be self-sufficient because of a lack of well-developed skills or habits but seek to do just that and those who do not fully use their resources to maximize independence and minimize reliance. One could also argue that oppression and discrimination can lead to helplessness and passivity about the individual sense of capacity to transform one’s own social reality and exert self-determination. Therefore, despite providing the necessary support, some people may lack the motivation (because of either personal issues or oppression) to pursue their goals, whereas others might have the optimal level of motivation and are ready to capitalize on any assistance they are provided with to pursue self-sufficiency and self-determination. This situation places social services staff in a difficult situation in terms of making decisions about how to best use their resources and how to appraise people’s needs, skill level, and motivation to provide the necessary assistance.

In conclusion, the discourse on human rights, empowerment, and occupational justice—all concepts associated with social justice—has emphasized the interaction between facilitative societal factors (e.g., human rights policies, occupational opportunities, building capacity) and a person’s ability and motivation that influences personal control over resources and outcomes important to people. Therefore, some scholars believe that both society and people are responsible for pursuing social justice.

Role of Occupational Therapy in Addressing Issues of Social Justice

Organizations as Brokers of Societal Resources

In the United States, the distribution of human, financial, and other resources to people who have experienced some difficulty in remaining self-sufficient is typically administered through some form of human services organization. Such organizations would be governmental agencies such as the Social Security Administration and nongovernmental and nonprofit community-based organizations. These organizations garner resources and in turn provide services to people in need. Most nonprofit organizations receive funding from a variety of sources, including government funding, foundation support, corporate sponsorship, fundraising efforts, and individual donations.
Despite a growing world economy, most human service organizations struggle to find the resources necessary to maintain the services they provide, and a few would claim to be able to serve anyone who requests assistance. Rather, most organizations are in the position of having to make choices about how to distribute limited resources and, as a result, which people receive which services, if they receive assistance at all. Organizations, therefore, are faced with finding some logic or principles to use to guide resource distribution in a manner that supports self-sufficiency in those with limited capacity. At the same time, they must prevent the inefficient use of resources that results when people who are capable of being more self-sufficient choose not to be and take advantage of the organizations’ resources for their personal gain. Occupational therapy practitioners are well suited to assist organizations in the effective distribution of resources by virtue of their skills in assessing the match among the individual, his or her needs, and the demands of the environment.

In the remainder of this article, we use two case examples of organizations serving people living with HIV/AIDS to illustrate how occupational therapy practitioners may play a role in assisting organizations with effective resource distribution, therefore promoting social justice. The application of paradigmatic occupational therapy knowledge is highlighted throughout the presentation of two cases in which the staff of an organization providing services to people living with HIV/AIDS struggled with decisions regarding allocation of human and financial resources. We discuss these two examples in light of the theories and concepts of social justice discussed earlier.

**Supportive Living and HIV/AIDS**

At a rate of more than 40,000 new cases per year, more than 1 million people were estimated to be living with HIV/AIDS in the United States by 2007 (Centers for Disease Control and Prevention [CDC], 2004, Table 17). People living with HIV/AIDS range from those who are asymptomatic to those who experience severe neurological, cognitive, musculoskeletal, psychological, and emotional impairments. Increasingly, people living with HIV/AIDS include women (26.6%) and people of color (64%; CDC, 2004). Those people most affected by HIV/AIDS are also likely to struggle with drug and alcohol abuse or mental illness and face homelessness or the risk of homelessness at some point in their lives. Consequently, people with HIV/AIDS experience discrimination; oppression; stigmatization; and many social, health, and economic barriers in pursuing self-sufficiency and self-determination.

Supportive living facilities for people living with HIV/AIDS exist in many major cities across the United States (U.S. Department of Housing and Urban Development [HUD], 2008). Services provided at these facilities often include housing, nutritional services, case management, drug and alcohol counseling, spiritual care, and independent living services. In Chicago, the University of Illinois at Chicago (UIC) Department of Occupational Therapy has collaborated with several nonprofit organizations that provide supportive living to further develop services to promote self-sufficiency of residents, including return to more independent living in the community, paid employment, and further education or training (UIC, 2005). Like most social services organizations, these organizations struggle to find the necessary financial resources to allow them to survive and provide needed services to their clients in a time when funding streams are constantly shifting and shrinking.

For example, the federally funded program Housing Opportunities for Persons With AIDS, or HOPWA, established by HUD to address the specific needs of people living with HIV/AIDS and their families, experienced a $13 million budget cut from the previous year in 2005. HOPWA makes grants to local communities, states, and nonprofit organizations for projects that benefit low-income people medically diagnosed with HIV/AIDS and their families. The effect of these cuts on people living with HIV/AIDS who struggle to find and maintain independent living and on the agencies that serve them is significant. For instance, the AIDS Foundation of Chicago, which administers the HOPWA program in Chicago, closed its housing assistance program (HAP) to new clients. As a result, more than half of the existing HAP clients experienced annual losses in income ranging from $1,150 to $1,500. Given this situation, it became essential that decisions regarding the distribution of resources and providing services to residents be made in ways that best support their transition toward independence.

**Offering Residency: Determining Who Will Be Served and How Resources Will Be Used**

To determine whether an individual is offered residency and to establish their eligibility for services, representatives of an interdisciplinary team typically assess applicants and make the appropriate recommendations to the full programs and services team. Services offered include housing, nutritional services, case management, life skills training, and employment preparation, among others. The recommendation to extend an offer of residency is based on the interdisciplinary team’s assessment of the potential of the individual to achieve relative independence and self-sufficiency. Once residency is offered, the resident and the team must develop an intervention plan that in essence determines the expectations for the
“balance” between the responsibility of the organization and the responsibility of the individual. Both the resident and the organization must be willing to contribute to the development of the individual’s self-sufficiency. Once an intervention plan is determined, the team acts as a broker to distribute financial, human, and social capital to support the resident’s attempt at achieving the predetermined outcomes. As such, an occupational therapist can help the team distribute resources more effectively by applying paradigmatic knowledge such as the Model of Human Occupation (MOHO) and by helping establish clear and appropriate expectations necessary for the promotion of independence and self-determination among the residents.

Model of Human Occupation
MOHO is an example of occupational therapy–paradigmatic knowledge that may be used to assess an individual’s self-sufficiency as well as environmental limitations to attaining independence (Kielhofner, 2002). MOHO conceptualizes occupational behavior as a function of volition, habituation, performance capacity, and environmental impact. Volition includes the worker’s values, interests, and personal causation. Habituation includes internalized social roles and habits. Performance capacity is conceptualized as the underlying capacities of the individual, such as cognitive and motor abilities. The environment includes both physical factors (objects and places) and social factors (groups and occupational forms). Because MOHO addresses the full range of personal factors thought to influence occupational performance and considers the influence of the environment as well, it is useful in assessing the potential for people such as those living with HIV/AIDS in supportive housing to become self-sufficient. MOHO also helps determine the level of support that they may need from an AIDS services organization. MOHO has been used in several interventions with people living with HIV/AIDS and is presented in the following examples as the framework on which the occupational therapy intervention was designed (Kielhofner et al., 2004; Paul-Ward, Kielhofner, Braveman, & Levin, 2005; Pizzi, 1992).

The following two case examples illustrate situations that nonprofit organizations typically encounter while attempting to serve an increasing number of clients, namely ethnic minorities with HIV/AIDS who lack employment, housing, and health care. The names used in the cases are fictional to protect the residents’ confidentiality.

Case 1: Craig, “A Sure Thing”
Craig is a 28-year-old White man living with HIV/AIDS who was recommended for consideration for residency at one supportive living facility. Craig had experienced recent homelessness after a hospitalization for a lung infection. He had a history of consistent full-time employment and had maintained his own apartment since finishing an associate’s degree. Craig was independent in his activities of daily living (ADLs), community mobility, and his instrumental activities of daily living (IADLs). He was a body builder who valued his health, physical fitness, and appearance, and he stated that he had an active and supportive social network of friends and family. During the interdisciplinary team meeting held to discuss Craig’s residency, the team members decided to offer him residency because he was viewed as “a sure thing,” according to one staff member. Although the team discussed the extent of his needs given his health and capacities, they noted that he “just needed a short time to get his stuff together and could get back to his previous life.”

An occupational therapy assessment was completed with Craig using the Occupational Performance History Interview (OPHI–II), the Worker Role Interview (WRI), and Occupational Self-Assessment (OSA; Baron, Kielhofner, Iyenger, Goldhammer, & Wolenski, 2006; Braveman et al., 2005; Kielhofner et al., 1997). The OPHI–II is a life history interview that allows the therapist to elicit a narrative account of the client’s life history and includes three scales: (1) Occupational Identity (i.e., how people see themselves and see opportunities for participating in occupational forms that are culturally recognized and named activities), (2) Occupational Competence (i.e., one’s perceptions of ability to sustain a pattern of occupational behavior that is productive and satisfying), and (3) Occupational Behavior Settings (i.e., perceptions of the various environments with which people interact). The WRI is a semistructured interview and rating scale initially developed at the University of Illinois at Chicago as part of an effort to identify psychosocial variables related to return to work (Velozo, 1991). The original WRI focused on assessment of the injured worker and included a 17-item scale based on the results of an interview and other available information about the client’s physical status and functional performance. The interview was revised in 2005 to include formats appropriate for the worker with longstanding illness or disability (Braveman et al., 2005). The WRI may be used to assess the likelihood of return to a specific job or to work in general. The OPHI–II and the WRI overlap because they relate to eliciting information on a client’s life history. Therefore, they may be conducted together to save administration time by adding a few work-related questions to the OPHI–II. The OSA is designed to capture clients’ perceptions of their own occupational competence on their occupational adaptation. Clients are provided with a list of everyday occupations and assess their level of ability when participating in a given occupation and their value for that occupation.
The occupational therapy assessment of Craig revealed that he had experienced relatively little difficulty with occupational performance. He had successfully performed several roles, including worker and home maintainer, denied any physical problems, and was independent in all ADL and IADL tasks. The OSA revealed that Craig had some difficulty managing his finances. Because his illness prevented him from maintaining a steady source of income, he had incurred some credit card debt. Consequently, he arranged a reduced payment plan with his credit card company, which would stay in effect until he found steady employment. Despite his successful work history, Craig stated he did not plan to return to work and asked for assistance only with the process of appealing the denial of Social Security Disability Insurance (SSDI) payments.

Occupational therapy intervention with Craig focused on strategies to help him identify short-term goals and strategies for reaching them. Although Craig stated he had no plans to return to work and wanted to focus on qualifying for SSDI, the team at the supportive living facility thought that his goal conflicted with their mission to help residents move back to independence as quickly as possible. Initially, the occupational therapist attempted to involve Craig in activities that would highlight his skills and capacities, such as groups on résumés or employment interviews, to build his confidence and to refocus him on attaining employment and independent living in the community. To establish a relationship with Craig and to support self-determination, the occupational therapist provided guidance to Craig about the process of appealing his SSDI but refused to provide the documentation of functional limitations that Craig requested. Other members of the team assisted Craig with his requests to support self-determination but continued to challenge Craig to reconsider returning to work over the 10 months that Craig resided at the supportive living facility.

Outcomes of the interdisciplinary intervention were that Craig won his appeal for SSDI benefits and was eventually accepted in a residence that offered permanent subsidized housing for persons with disabilities. During a follow-up interview 1 month after completion of the intervention, Craig identified that his primary occupations included weight lifting, travel, and spending time at the beach and coffee shop. In retrospect, the team discussed whether residency in supportive living was the most appropriate placement for this client and expressed concern that the considerable resources used might have been more appropriately used with another potential resident.

Case 2: Karen, “A Long Shot”

Karen was a 32-year-old Black woman living with HIV/AIDS recommended for consideration for residency. She had a history of severe substance abuse and homelessness and had also suffered a stroke as a complication of toxoplasmosis. She had an inconsistent work history for the past 10 years because of heroin and cocaine use. Karen was independent in her ADLs but limited in community mobility and IADLs. She was a parent of two children in foster care but stated that she had no plans to seek custody. She did wish to establish a more effective relationship with her children, and this plan was supported by the children’s foster parent. Although the interdisciplinary team chose to offer Karen residency, it was done with the assumption that her residency would be relatively short term and focused on finding a permanent supported living setting. On the basis of her assessment results, the team did not view Karen as a good candidate for referral to vocationally related services because she would likely not participate in services focused on helping her achieve independent living in the community.

The occupational therapy assessment of Karen also included the administration of the OPHI–II, the WRI, and the OSA. Karen had a limited and unsuccessful work history because of her substance abuse. She adamantly believed that leaving her children in foster care would benefit them the most. However, one of her primary goals was to establish a healthy relationship with them and serve as a positive guiding influence on their development. In addition, because Karen had had a stroke, she was observed performing several IADL tasks such as washing her clothes and traveling to a doctor’s appointment in the community. Minor deficits in motor performance, planning of tasks, and problem solving were noted, and she required minimal assistance to complete some tasks. A significant problem identified through the OPHI–II and the OSA was that Karen had a low level of volition and did not see herself having the skills and capacities to ever become independent. She noted that she would probably live at the supportive living residence until she was old enough to be placed in a nursing home.

On the basis of the interdisciplinary team assessment, intervention with Karen initially focused on increasing her confidence for community mobility, improving her adherence to her HIV/AIDS medication schedule, and finding her permanent housing. Initially, the team members, including the occupational therapist, were reticent to use resources related to helping Karen become more financially independent; therefore, occupational therapy focused on her goal of increasing her skills as a parent. However, through what might be considered standard occupational therapy intervention (e.g., meal planning and preparation, laundry), Karen encountered a series of success experiences that began to affect her level of volition. She became more engaged in the occupational therapy process and, after a period of several months, began to identify new occupations that she wished
to perform independently. Slowly, Karen experienced what Balcazar (1999) referred to as the process of conscientization, or moving from a state of naïve awareness that overemphasizes the past and accepts mythical explanations for events to critical awareness by delving into problems, exploring new ideas, facing real causes, and increasing dialogue. From an empowerment perspective, given the intervention and support she was receiving from the occupational therapist and the agency (e.g., increasing specific skills, removing barriers), she may have experienced increased confidence in her personal ability to change her reality. Karen began to reject the assumption that she had shared with the team that she could not be self-sufficient. In the early months of intervention, the team was skeptical of both Karen’s and the occupational therapist’s increased attention to involvement in occupations related to living independently and even some work-related tasks. However, when Karen surprised the entire team by finding a volunteer position in the community on her own and performing the role successfully, the team members began to wonder if they should have invested more resources in her goal of achieving independence earlier and had higher expectations for Karen for becoming self-sufficient.

After almost 2 years of intervention, the outcomes of intervention with Karen were surprising. Karen was successful in obtaining two different part-time paid jobs and became independent in community mobility. She became fully independent in IADLs and, with the assistance of a case manager, found an apartment in which she lived independently in the community. Karen’s goal of establishing an effective relationship with her children was realized, and her children regularly visited her home, including occasional overnight stays. During a follow-up, the team discussed how they could have underestimated Karen’s capacities so severely. The occupational therapist introduced the team to the concepts of volition and knowledge of capacity and why Karen might have come to underestimate her own abilities.

Table 1 presents a summary of the occupational therapy assessment findings, the focus of intervention, and the intervention outcomes achieved with Craig and Karen.

Discussion

Craig and Karen represent two typical case examples of the types of dilemmas faced by interdisciplinary teams in supportive living facilities for people living with HIV/AIDS. Generally speaking, the individual occupational therapy assessments, interventions, and intervention outcomes processes may become second nature to experienced occupational therapy personnel. Similarly, it may be expected that organizations will struggle with the discussion of how to best allocate their resources with clients who have varied levels of capacity and motivation. However, what may be novel and worth further consideration and discussion is the role that occupational therapy personnel can play in helping an organization to solve its processual justice dilemmas through the application of paradigmatic occupational therapy knowledge such as MOHO.

In the cases of Craig and Karen, the team made initial judgments about how to distribute organizational resources and established expectations for Craig and Karen’s involvement in achieving self-sufficiency. These expectations were based almost solely on the face value of the narrative told by the potential residents and other historical assessment data and observations. These narratives were perceived in the context of the organizational mission, which was to support the residents’ transition to living independently in the community. On examining Craig and Karen’s work and life histories, Craig appeared to be capable of returning to work and living independently, whereas Karen did not. However, initially, little in-depth assessment or discussion occurred regarding their level of volition and the accuracy of their self-perception of their capacities. Although members of the team began to question why intervention with each of the residents was not resulting in the expected outcomes, they held fast to their initial intervention plans long after the clients had abandoned them, if the clients were ever onboard with those plans. Again, this in itself may not appear notable; however, the significance of these case examples lies in the fact that the teams moved beyond focusing on individual residents and began to question the larger issue of who deserved residency and how their efforts should best be used. Moreover, the team members began to discuss how they should decide where to best place their energy and to spend organizational resources. This dilemma provided an opportunity for occupational therapists to assume a valuable role in helping organizations to solve processual social justice dilemmas through application of occupational therapy knowledge and skills.

We might also argue that, given the discussion of social justice concepts presented in this article, perhaps the occupational therapist could have tried to explore the clients’ previous experiences of oppression and marginalization as these were cases of social injustice. One might assume that Karen’s experiences of oppression precluded her ability to attain self-sufficiency; however, it was Craig who preemptively resigned himself to inaction with regard to achieving independence. Essentially, the occupational therapist’s support and intervention served as an impetus for Karen’s improved self-confidence and newfound awareness of her personal capacity. This awareness, which is a key component of volition, may in turn contribute to the development of self-empowerment.
### Table 1. Occupational Therapy Intervention With Craig and Karen

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<th>Assessment</th>
<th>Intervention</th>
<th>Outcomes</th>
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<tr>
<td><strong>Craig</strong></td>
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<tr>
<td>Occupational Performance History Interview—</td>
<td>Encouraged him to participate in groups related to establishing goals and</td>
<td>Won his appeal for SSDI benefits</td>
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<td>Has maintained several roles with success including student, worker,</td>
<td>action plans</td>
<td>Moved into permanent subsidized housing</td>
</tr>
<tr>
<td>homemaker, significant other</td>
<td>Emphasized strategies and resources to assist with return to work or</td>
<td>Primary occupations include weight lifting, travel, and spending time</td>
</tr>
<tr>
<td>No indication of deficits in cognition, perception, communication/</td>
<td>educational settings, skill development, and independent living</td>
<td>at the beach and coffee shop</td>
</tr>
<tr>
<td>interaction skills, or motor function</td>
<td>strategies</td>
<td>In retrospect, the team discussed whether residency in supportive living</td>
</tr>
<tr>
<td>Occupational Self-Assessment—</td>
<td>Preparation of documentation to appeal denial of SSDI benefits and application</td>
<td>was the most appropriate placement for this client</td>
</tr>
<tr>
<td>Identifies “managing my finances” and “having a satisfying routine” as</td>
<td>for permanent subsidized housing but refused to provide documentation of</td>
<td></td>
</tr>
<tr>
<td>his highest priorities</td>
<td>functional impairment</td>
<td></td>
</tr>
<tr>
<td>States he has no immediate plans to return to work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wants help to appeal his denial for Social Security Disability Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(SSDI) benefits and on applications or interviews for permanent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>subsidized housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Karen</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational therapy assessment revealed real functional deficits in motor</td>
<td>Success experiences in basic activities of daily living (e.g., laundry, meal</td>
<td>Independent in instrumental activities of daily living and community</td>
</tr>
<tr>
<td>and process skills</td>
<td>preparation), mobility and interaction in the community, and socialization</td>
<td>mobility</td>
</tr>
<tr>
<td>Limited by educational level and poor work history</td>
<td>Conscientization to transfer from naïve awareness overemphasizing the past</td>
<td>Integrated the role of volunteer, then paid employee into daily activities</td>
</tr>
<tr>
<td>No expectation of return to work or independent living</td>
<td>and accepting mythical explanations for events to critical awareness by</td>
<td>Moved to her own apartment and permanent work with decreased reliance</td>
</tr>
<tr>
<td>Most significant limiting factor was low level of volition and inaccurate</td>
<td>delving into problems, exploring new ideas, facing real causes, and</td>
<td>on public benefits</td>
</tr>
<tr>
<td>knowledge of capacity</td>
<td>increasing dialogue (Balcazar, 1999)</td>
<td></td>
</tr>
<tr>
<td>Team was reticent to focus efforts of intervention on vocational or independent</td>
<td>Reintegration of multiple roles of home manager, mother, volunteer, and</td>
<td>In retrospect, the team discussed the need to differentiate low levels</td>
</tr>
<tr>
<td>living skills and considered focusing on moving client to a long-term</td>
<td>eventually paid worker</td>
<td>of “motivation” caused by inaccurate knowledge of capacity, poor</td>
</tr>
<tr>
<td>placement as soon as possible</td>
<td></td>
<td>self-esteem, and lowered self-efficacy from overdependence on the system</td>
</tr>
</tbody>
</table>

The process of assessing potential residents and working with those accepted for residency is complex. Increasing one’s self-sufficiency and self-determination depends on the interaction of multiple personal and environmental factors. From a processual justice perspective, organizations must manage these factors to ensure equal access and equal opportunity for involvement in occupations that empower them to achieve their goals. According to the concept of distributive justice, by empowering them and giving them the skills to make decisions, the possibility of access to resources (e.g., employment) increases. As previously noted, successful empowerment strategies assume that people value the opportunity to participate in the decisions that affect their lives and they are motivated to engage in actions directed toward improving their own conditions. Craig and Karen are two examples that are representative of the varying level of motivation exhibited by people receiving services to achieve independence. The complexity of the situation is further confounded when a person’s level of motivation is influenced by an inaccurate self-assessment of his or her own capacities.

Occupational therapists are well suited to use paradigmatic occupational therapy knowledge such as the MOHO to aid organizations and their staffs to distribute resources fairly and justly by assessing the true capacities and potential of the people they serve. Moreover, through the application of occupational therapy processes, occupational therapy personnel are positioned to guide organizations to support people to achieve self-sufficiency and self-determination, concurrently establishing reasonable expectations for people to contribute to this process. ▲

### References


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