The Issue Is

Community-Based Practice

The opinions presented in this paper are based on material generated by participants at the Directions for the Future Symposium held in San Diego in January 1990, as well as my own thoughts about what some of the features of occupational therapy practice based in the community might be like in the future.

Occupational therapy practice continues to be in transition from acute care settings to the community. Data comparing primary employment settings for occupational therapists in 1973 and 1990 indicate the greatest single decrease in hospital employment to be that in psychiatric hospitals, from 13.8% to 4.6%; and for occupational therapy assistants, from 22.6% to 6.6%. The area of greatest expansion within a community program was in the school system, with employment of occupational therapists increasing from 11.0% to 18.5%, and of occupational therapy assistants, from 3.6% to 17.0% (American Occupational Therapy Association [AOTA], 1991). Community programs that provide the much needed continuity of care for discharged patients do not exist in many places. With acknowledgment of the many differences between the psychiatric hospital and school system settings and their patient and student populations, as viewed from the perspective of availability for treatment, occupational therapy intervention has a better opportunity to be effective within 9 to 12 months, as opposed to 7 to 10 days. This, of course, is one of the attractions of community-based practice; the pressure for productivity in community programs is generally not less than the occupational therapist experiences in acute care settings, but the patient's availability may be less restrictive in community settings. For many patients, the benefits gained from having time to integrate insights and gains between treatments and having treatments over a longer period of time are preferable to intense, frequent treatment sessions. Additionally, a comprehensive, holistic treatment approach, including family involvement and education, is often more easily accomplished when the treatment is spread over a longer period of time rather than when it occurs within 10 to 14 days. The message to therapists will continue to be to do more and to do it better for less, and in the future, as now, innovative community programming will provide part of the response to this societal expectation.

Treatment Population

We are aware of the graying of America, of the increasing rate of survival of infants with congenital impairments, and of the increase in incidence and prevalence of chronic diseases.

Mortality is decreasing, while morbidity and disability are increasing. In all age groups, the prevalence of disability is increasing faster than population growth... In terms of prevalence and cost, disability ranks as this Nation's largest health problem. (National Institutes of Health, 1990, p. 24)

Between 1959 and 1984, persons between the ages of 18 and 44 years experienced the largest increase in severe disabilities, defined as "those that prevent individuals from carrying out their major activities" (National Institutes of Health, 1990, pp. 24-25). The performance dysfunctions represented by these disabilities are compounded and magnified by the lack of societal supports and attitudes that could act as enablers for those persons who have worked to overcome these dysfunctions and want to take their places in the mainstream activities of daily life. The Americans With Disabilities Act of 1990 (Public Law 101-336) is designed to assist with the removal of many of the architectural, economic, and societal barriers currently existing for persons with a physical or mental disability.

Persons with severe disabilities constitute the population with whom occupational therapists have always been involved through treatment, advocacy, the development of support groups and service provision systems, and other areas. We are going to be doing more and doing it better, but perhaps not with less, because this is one of the populations that will fill future employment gaps in the workplace, at least in this decade (Naisbitt & Aburdene, 1990). This population represents a largely untapped personnel resource. Disabilities are tremendously costly to this country. The lower birth rates of the 1960s and 1970s continue to have a direct effect on the number of workers available to enter the job market. As the shortage of entry-level semiskilled and skilled workers increases, the development of the support needed (e.g., public transportation and access to place of employment) to assist persons with disabilities in the work force and in the community will increase. Demands for creative and innovative approaches to where and how work is done will also increase, such as flex-time, shared, temporary, or part-time jobs, and working...
other systems (e.g., education, industry) will, because by enabling persons with disabilities to work, some systems will save money and others will earn money. Money is the major concern in this issue. Legislation may affect what we do and how we do it, but attitudes cannot be legislated. However, society generally values and rewards competence and ability. Continuing to expand and facilitate the use of the abilities of those who are disabled will change attitudes. Other sources of labor for the future workplace will include an increasing number of women, persons who have taken early retirement, immigrants, and younger adolescents, which would perhaps necessitate a revision of child labor laws (Naisbitt & Aburdene, 1990). An increased number of workers with disabilities will make even more visible the need for occupational therapy participation in providing wellness and prevention programming.

Service Provision

Occupational therapy personnel will continue to be involved in the movement and will provide much of the leadership needed to make it happen. We will be even more consumer-oriented than we are now, with a greater focus on holism, sensitivity to differences in values, ethical issues, and ethnic and cultural issues. This commitment to holistic treatment, regardless of the primary diagnosis, reflects the growing maturity of the occupational therapy profession. We will be much more involved than we are now in developing public policies in many areas of health and human services, including transportation systems, architectural changes supporting the disabled and elderly populations, and the design of services and their provision. Occupational therapists will form collaborative relationships with consumers and other professionals to effect these accommodations to consumers' needs in a manner that preserves the consumers' dignity and enhances their quality of life. Much more of our effort will be focused on the caregivers, joining with them in determining their needs, and developing training and provision systems in response to these needs.

The move to private practice, from 1.3% in 1973 to 7.7% in 1990 for occupational therapists and from 0.3% to 2.7% during the same time period for occupational therapy assistants, will steadily expand (AOTA, 1991). Hospitals, rehabilitation centers, and school systems are increasingly using contract services to provide occupational therapy. This presents the opportunity for a fairly stable financial base in the establishment of a private practice.

In the community, occupational therapy personnel who have maintained their skills as generalists will be in demand. In addition, the generalist may be a specialist in a particular area of practice, as the two are not mutually exclusive, and those therapists with expertise are also needed. However, the generalist can move freely between practice areas, thus stretching the health care dollar, and can make referrals to specialists when indicated. "Today's occupational therapists can work in many nontraditional roles, such as program administrator, independent living skills supervisor, and case manager" (Strickland, 1991, p. 106). Tomorrow's occupational therapists will be working in all of these roles and in many others yet to be discovered. If, as Naisbitt and Aburdene (1990) predicted, more and more Americans decide to improve their quality of life by moving to small towns and rural areas, made possible by the technology that links them to urban work sites, generalists will find yet another practice area of high demand.

The role of the occupational therapist as a consultant will expand. One area that will have increasing acceptance and use will be that of the gross screening of a defined population as possible recipients of service. The initial screening will not be done by occupational therapy personnel but by other professionals, indigenous community workers, a minimally trained worker, a robot, or a computer. The screening instrument may have been developed by or in consultation with occupational therapists. Assessment and indicated treatment for persons referred will then be provided by occupational therapy personnel.

Another direction for future community-based practice occurred in 1989, when the Health Care Financing Administration (HCFA) developed guidelines for outpatient occupational therapy. In these guidelines, HCFA recognized a person's need for cognitive assistance. Future occupational therapy practice will need to include cognitive assistance as a category separate from physical assistance. Although therapists are accustomed to demonstrating improvement in physical assistance, the most persistent and pervasive needs for assistance are with cognitive dysfunction. In both the present and the future, this provision by HCFA will allow occupational therapists to explain their services as helping clients adjust to these serious disabilities (M. Foto, personal communication, April 6, 1991).

Practice, Education, and Research

With decisions having been made, the development of hierarchies for education and practice, and the continuing studies on occupational science, occupational therapists' ability to define and articulate the frame of reference being used to guide their practice should be easier than it is now. We will reap the benefits of strengthened relationships between occupational therapy educators and clinicians as we work together in preparing students to meet current and future practice demands and as we collaborate on research projects. As we work together to determine the efficacy and effectiveness or outcomes of our interventions and as we collaborate with other professionals toward the same end, occupational therapy's contributors to the treatment of performance dysfunctions will gain wider understanding.

As this occurs, it will provide physicians, consumers, and payers with the ability to compare the results achieved by different therapies and different practitioners (Bezold, 1989). When outcome studies indicate the effectiveness of occupational therapy intervention and when this information is reported to other professionals and to the public, we may expect to receive reimbursement for our services from payers other than the health care system, including the consumers themselves. Our continuing studies in the area of clinical reasoning, which demonstrate the complexity of the process of occupational therapy, will contribute to the acceptance and valuation of our services.

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In the community, networking, service and programmatic linkages, and technological interfaces promise many changes in the services being provided. Advancing technology will make much of these changes possible. Sacks (1983) pleaded for physicians to avoid what Darwin has described, that is, a scientific medicine, which is too exclusive, and does not properly include "the emotional part of our nature." As physicians, we may be safe from this danger if, and only if, we have feeling for our patients. Such feeling does not stand in the way of scientific precision — each, I think, is the guarantor of the other. (p. 254)

As we strive to tie up the loose ends of continuing change and to quantify and justify what we do, let us continue to nurture the genuine warmth and regard we have for our patients and for ourselves, that we may keep in touch with the balance of it all.

References