Community Practice in Occupational Therapy: What Is It?

LEARNING OBJECTIVES

By the end of this chapter, the reader will be able to complete the following:

1. Describe the role of the occupational therapy practitioner in community practice.
2. Compare and contrast theoretical approaches to community practice in occupational therapy.
3. Reflect on the skills required to engage in community practice as an occupational therapy practitioner.

Key Terms

- Community
- Community-based participatory research (CBPR)
- Community-based practice
- Community-built practice
- Community capacity building
- Community-centered
- Community partnership
- Community practice
- Health
- Primary health promotion
- Secondary health promotion
- Tertiary health promotion

Overview

This chapter provides a basic introduction to community practice as a foundation for program development and grant writing for occupational therapy practitioners. The premise of this book is that successful grant proposals are based on sound program development. Throughout this book, many of the concepts introduced in this chapter are discussed in greater detail including application and examples. In this chapter, models of community occupational therapy practice are defined and described along with skills and challenges related to community practice. Important concepts of community

practice are described as are methods and strategies for building evidence in community practice.

Introduction

Occupations do not occur in a vacuum and, as outlined in the Occupational Therapy Practice Framework (OTPF), occupations are affected by the context in which people live (American Occupational Therapy Association [AOTA], 2008). **Community** is an important context that influences peoples' ability to engage in occupations. Communities can facilitate or inhibit occupational engagement of those with and without disabilities. In this book, the skills of grant writing are thoroughly discussed as applied to community occupational therapy practice. Occupational therapy **community practice** can be initiated and supported by external funding, including grants (Brownson, 1998). Prior to delving into the topic of grant writing, the question must be asked: What is community practice for occupational therapy practitioners?

What Is Community?

Communities provide a unique setting for occupational therapy practice. "Everyday life of a community, its mix of people, their needs, concerns, joys and struggles, offers an unparalleled opportunity to define [the occupational therapy] discipline, research its potential" (Fidler, 2001, p. 8). Communities are individuals tied together by occupational engagement and a collective sense of meaning. Communities are not simply defined by geographic location but refer to a "person's natural environment, that is, where the person works, plays, and performs other daily activities" (Brownson, 1998). Communities are the settings where people reside, build relationships, and engage in health practices (Brownson, 1998; Scaffa, 2001; Grady, 1995). Communities exist as a context in which people define their lives. For some people, identifying membership in a community may be challenging, yet everyone belongs to multiple communities.

LET'S STOP AND THINK

How do you define community? What communities do you belong to? Take some time to write down answers to these questions and reflect on your definition and the communities of importance to you.

The importance and relevance of community practice in occupational therapy have been discussed throughout the profession's history (McColl, 1998). In occupational therapy, an essential conception of community is one that considers groups of people engaged in a collective occupation. In other words, just as individuals have unique occupations, so do communities. The basis of a community is relationships, and communities of people come together "to do something that cannot be easily done in isolation" (Scaffa, 2001, p. 8). Based on this premise, communities have unique cultures, relationships, views of health, and occupations.

Health in the Context of Community

The World Health Organization defines **health** as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization [WHO], 1998). Health has been comprehensively defined in the profession of occupational therapy as

> the absence of illness, but not necessarily disability; a balance of physical, mental, and social well-being attained through socially valued and individually meaningful occupation; enhancement of capacity and opportunity to strive for individual potential; community cohesion and opportunity; social integration, support, and justice, all within and as part of a sustainable ecology. (Wilcock, 2006, p. 110)

Both definitions acknowledge that health is not only about disease state. These definitions incorporate a holistic view of well-being and the importance of quality of life as a significant component of health. In community practice, occupational therapy practitioners must retain a broad view of health in order to implement successful health-related programs because the extrinsic factors of health cannot be denied. For example, when conducting an occupational therapy evaluation in the home, the practitioner can explore the impact that the environment has on the client's occupational engagement and easily visualize the barriers to transfers or mobility that the client may face in the home.

In the community context of occupational therapy practice, the definition of health moves away from the medical definition. Health is viewed as the ability to engage in occupation (Baum & Law, 1998; Wilcock, 2006). Occupations "demonstrate a community's and an individual's culturally sanctioned intellectual, moral, social and physical attributes. It is only by what they do that people can demonstrate what they are or what they hope to be" (Wilcock, 2006, p. 9). The inability to engage in occupation, whether caused by physical, mental, social, or environmental challenges, leads to many problems with maintenance of health and well-being.

Wilcock (2006) says it best: "Health is remarkably simple and remarkably complex" (p. 3). Perhaps this perception of health can act as an appropriate mantra for occupational therapy practitioners working in the community. Health can be affected by simple factors, such as risk factors, in which people make conscious choices to engage in healthy and unhealthy behaviors that prevent or lead to disease. On the other hand, the health status of an individual and a community may be affected by forces beyond individual or group behaviors. External forces, such as transportation, socioeconomic status, and health disparities, greatly affect the health of a community.

Dr. Paul Farmer (2003), physician and medical anthropologist, discusses the impacts of social and political decisions on public health, acknowledging that these

larger systems affect the health of communities and entire countries. Many of the factors that affect the health of groups and communities are out of the autonomous control of the people affected. For example, many underserved communities find their health status affected by oppressive forces outside of their control (Farmer, 2003). Health disparities, unequal treatment of patients, and access to health insurance (including both the uninsured and underinsured) are sociopolitical factors that affect peoples' ability to access and respond to healthcare regimens and how community members define and engage in healthy behaviors.

For example, community members may not walk in the community for exercise because there are no sidewalks and residents fear for their safety when they have to walk in the streets. Although this may sound like an oversimplified problem, many times infrastructure and city planning issues, such as a lack of sidewalks, make community members feel like they are unable to practice healthy behaviors, like walking. In this example, the health determinant actually has nothing to do with the community members' physical ability to engage in health maintenance activities but demonstrates a simple barrier to health and well-being in a community setting. By considering factors such as these, occupational therapy practitioners can explore alternative methods for engaging community members in health maintenance because they understand the complexity of the human experience.

As experts in occupation, occupational therapy practitioners easily identify factors that prevent a person from healing. Skills in activity analysis provide occupational therapy practitioners with a basis for understanding engagement and how activities and occupations are impeded by physical factors. In a community practice setting, occupational therapy practitioners use these same clinical skills to explore the determinants of health beyond the physical by taking a systems approach to understanding health and disease (Wilcock, 2006; McColl, 1998; Scriven & Atwal, 2004). The role of the occupational therapy practitioner in community practice is to explore occupational engagement in a broad sense. Practitioners must apply to the community setting the same clinical skills they use to analyze an activity and how an individual can accomplish it despite a disability (McColl, 1998).

Occupational therapy practitioners must understand the context and conditions beyond physiologic problems that affect health status. Community characteristics, including but not limited to socioeconomic status, culture, political infrastructure, public transportation, availability of healthcare services, and geographic location, affect community health status. Occupational therapy practitioners practicing in the community setting need not fully understand all the factors that create community context but must acknowledge their existence and impact on the health status and well-being of the community and its members. Based on this complexity and interdependence of external factors on health status, occupational therapy practitioners are called to view health in a broader sense (Wilcock, 2006).

The Need for Community Practice

Occupational therapy practitioners recognize that "staying within the medical model deprives society of the full benefits of an occupational approach" (Miller & Nelson, 2004, p. 138). Community practice opens the door for the profession of occupational therapy to grow and apply occupation in its natural settings. Yet communities are complex and dynamic, and addressing health issues in communities is complicated by factors such as reimbursement, community-defined needs, and health disparities. Current healthcare systems lack the ability to adequately address community health issues, health disparities, health promotion, and health behaviors, which lays the ground work for occupational therapy practitioners to actively explore and define roles in community practice (Scaffa, 2001; Fazio, 2008). Because of these challenges in the healthcare system, occupational therapy practitioners can adopt

> a client-centered, community approach that requires practitioners to have the skills to work effectively in individual, dyadic, group, and community interactions to implement restorative as well as preventive and health maintenance programs that enhance the function and well-being of clients. (Baum & Law, 1998, p. 9)

With the drastic changes in healthcare services, the rising costs of health care, and the time constraints on providing health care caused by funding limitations, an increasing demand for community health programs has developed across the disciplines (Merryman, 2002; Fazio, 2008). To meet these demands, communities are turning to healthcare providers for assistance to meet the needs of community members (Baum & Law, 1998; Suarez-Balcazar, 2005). Furthermore, insurance costs have risen drastically, forcing individuals and employers that provide health insurance to explore the role of health maintenance and wellness as a method for reducing costs (Cover the Uninsured, 2008). All of these factors justify the need for occupational therapy practice in community settings.

The profession of occupational therapy is becoming more proactive in addressing health needs that arise, expanding outside a rehabilitation approach. Examples of this include fall prevention programs and driving programs (Dorne & Kurfuerst, 2008). Programs such as these demonstrate a shift in the profession from rehabilitating those who are ill or disabled to facilitating healthy living, aging in place, and quality of life for all. Most of these programs occur in a community setting.

Understanding Community Practice in Occupational Therapy

Defining community practice in occupational therapy is challenging because of its encompassing nature and its differences from traditional practice. In the community setting, occupational therapy practitioners "have no recipe for success in this

realm of practice, no standard treatment plans to follow, no scheduled times to perform activities of daily living treatments" (Loukas, 2000). Occupational therapy practice in community settings is broad, and programs are unique to each community and practitioner working in the community. Occupational therapy interventions move "beyond the individual treatment of a client to working with systems that affect the ability of an individual or group to achieve work, leisure, and social goals" (Brownson, 1998, p. 61). According to the Occupational Therapy Practice Framework (OTPF), occupational therapy practitioners must consider clients not only as individuals but also as both organizations and populations within a community (AOTA, 2008). Because communities are collective in nature, occupational therapy practitioners in community practice must explore innovative ways of practicing, not just new venues for practice (Brownson, 1998).

Community practice in occupational therapy explores "the role of occupation in the shaping of a society and a daily life" (Fidler, 2001, p. 7). McColl (1998) proposes that occupational therapy practitioners in community settings "need basic knowledge about the nature and distribution of disability and occupation and about the determinants of successful community living with a disability" (p. 11). But beyond understanding the experience of individuals with a disability living in the community, community practice involves understanding the collective whole. As discussed previously, communities are unique and exhibit collective occupations. Even when addressing individual clients, the impact of the community and relationships within it are instrumental to occupational engagement (Fazio, 2008). Wilcock (2006) suggests that "occupation provides a mechanism for social interaction and societal development and growth, forming the foundation of community" (p. 9). As individuals experience challenges to occupational engagement, so do communities. Occupational therapy practitioners must understand these concepts to apply them in a community setting.

Community practice provides a clear picture of the dynamics that affect a person's ability to practice healthy occupations. The difference between community practice and traditional medical practice is simple: "Community practice exists in the client's 'real life' and 'real world'" (Siebert, 2003, p. 2). In fact, all the aspects that affect health and occupational engagement must be considered in the community setting because this makes therapy more applicable and client-centered (Brownson, 1998). For example, when an occupational therapist completes a home safety assessment, the practitioner can easily view barriers and accessibility issues. Obviously, this approach has an advantage over simply interviewing the client in an inpatient setting about his or her perceived barriers and accessibility issues in the home. Client perceptions are valid and important, yet a discussion about home safety that is conducted in the inpatient setting is removed from the dynamic environment and community context in which the person engages daily. Practicing in community settings provides practitioners with a realistic view of the client's life and promotes better treatment outcomes because suggestions and therapy occur in context.

Fazio (2008) suggests that to engage in community practice successfully, the occupational therapy practitioner must adopt a systems approach (Gray, Kennedy, & Zemke, 1996a; Gray, Kennedy, & Zemke, 1996b). Occupational therapy practitioners are interested in occupation related to "the dynamics of this process within the larger system of environment/community" (Fazio, 2008, p. 25). Communities are complex, with multiple dynamics all interacting and interconnected. Occupational therapy practitioners must find a role that can facilitate positive health changes in this system (Fazio, 2008).

By being in a community, practitioners can perceive community members' barriers and challenges to healthy living. Many factors that affect health are not visible in clinical settings because the environment is controlled by the healthcare system. In the community, many factors affect an individual's ability to live healthily. For example, American Indians living on a reservation typically receive federal food commodities, which dictate food availability. Telling a client to eat healthy is simple, but obviously reservation-based American Indians may find it difficult to comply with this suggestion because of the limited food choices available. Clients are challenged by issues such as nutritional access, and practitioners must take into account these issues when working with communities. When providing services in community settings, practitioners must know the community in order to implement healthcare recommendations and treatments that meet the needs of the community members and that acknowledge challenges to basic health maintenance (Fazio, 2008). Factors such as food access affect the overall health of a community and imply the need for healthcare practitioners to understand the community context to facilitate healthy living.

Communities can be collectively healthy or unhealthy as a result of many factors. For example, in cities with reliable and accessible transportation systems, individuals with physical disabilities can get to work on time. Because of the accessible and reliable transportation system, these community members can make a societal contribution and are able to sustain a living income, which improves quality of life for all members of the community. In communities where transportation is not reliable or accessible, individuals with physical disabilities may not be able to maintain a job and cannot make a living wage. Because of lack of transportation services, individuals with physical disabilities are alienated and may experience a decreased quality of life. This example highlights the impact understanding the role community plays in occupational engagement.

The occupational therapy profession has identified practice settings in which occupational therapy practitioners can provide occupational therapy–related services (Scaffa, 2001); however, the concepts and framework of community practice in occupational therapy have not been formally outlined or accepted in the profession. Because of this lack of a collective professional definition of community practice, occupational therapy practitioners must begin to define community practice. Occupational therapy practitioners have the opportunity to explore the impact

of occupational therapy practice in communities and define the specific role the profession will play in community health.

The Roles of Occupational Therapy Practitioners in the Community

It is important for readers to have a basic understanding of the roles of occupational therapy practitioners in community settings. As mentioned, no specific standards for community practice exist; however, because of the nature of community practice, specific roles and responsibilities have emerged and are discussed in the literature. These roles are often not practice-based but describe the general characteristics a practitioner needs to be successful in community settings. These include advocacy, assessment skills, capacity building skills, and the ability to apply the principles of occupation in a community context. Obviously, these roles and responsibilities are broad and each community practitioner will find different activities associated with each of these generalized roles. The following subsections describe these characteristics further.

Advocacy

In community practice, occupational therapy practitioners are required to advocate for clients for multiple reasons. Advocacy is part of the principles and values of the profession (AOTA, 1993). Although advocacy is important in all occupational therapy practice settings, it takes on a unique role in community settings (Jensen & Royeen, 2002) where practitioners address health issues not typically covered by insurance providers and may work with an underserved population that cannot afford services. The practitioner must discover and explore feasible approaches to address health issues in the community, which requires advocacy on many levels, from educating community members on the role of occupational therapy practitioners to advocating for the needs of underserved communities (Herzberg & Finlayson, 2001). For example, identifying a health problem and developing a program to address this problem is a form of advocacy (King et al., 2002; Scaletti, 1999). Writing a grant to fund services is also a form of advocacy.

LET'S STOP AND THINK

Think of a community you belong to that is important to you. Brainstorm ways in which you would engage in advocacy for that community. Think of specific ways you could advocate both as a member of that community and as an occupational therapy practitioner.

Practitioners must also advocate for promotion of inclusion of all in the community (Grady, 1995) because community involvement is an important component of quality of life and self-esteem for individuals. Practitioners might sometimes need to advocate in regard to grant funding, especially when funding streams are eliminated or threatened as a result of political debate, economics, trends, or changes in administration (Jensen & Royeen, 2002). In community practice, an occupational therapy practitioner may be called to contact or communicate with political officials to voice support for initiatives.

TABLE 1-1 OCCUPATIONAL THERAPY ROLES IN ADVOCACY

- Education
- Addressing unmet health needs
- Serving the underserved through health-related programs
- Promoting inclusion
- Political advocacy

Assessment Skills

Occupational therapy practitioners in community practice require unique assessment skills. In community program development, most interventions are for a group and not for an individual; therefore occupational therapy practitioners in community practice must learn how to assess groups of people regarding occupational engagement and performance (Brownson, 1998; Fazio, 2008). Some practitioners may find this a challenge because it deviates from the traditional therapist–client relationship and delivery model. Furthermore, community assessment requires skills in multiple data collection methods and data analysis. It requires an understanding of epidemiology and how community data can be used in program development and grant writing (Fazio, 2008; Wilcock, 2006).

In addition to gathering initial assessment data, occupational therapy practitioners in the community must collect ongoing evaluation data. Knowledge and understanding of program evaluation methods are crucial to the success of any program (Suarez-Balcazar & Harper, 2003). Evaluation methods are vital to improve community programs and ensure that programs address their intended purposes. Assessment also helps to build evidence and science-driven approaches that are necessary to justify funding and development of community practice in the field of occupational therapy.

BEST PRACTICE HINT

Outcome data from assessment can be used in advocacy by demonstrating a need and justifying how a program can affect a community's health in a positive and effective way.

Gaining skills in assessment can be challenging to novice practitioners. Methods and strategies for developing these skills are discussed later in the text. Assessment not only provides feedback on a program's outcomes but can lead to external funding support and potential policy development (Suarez-Balcazar, 2005).

Building Community Capacity

Community capacity building can be defined as exploring and understanding a community's potential or ability to address health problems (Chino & DeBruyn, 2006; Goodman et al., 1998). Although all communities have needs, in underserved

communities where severe health disparities exist and issues such as access to care permeate, it can be challenging to explore community capacity. Although occupational therapy practitioners have been trained to identify problems or needs, in every community, they must look beyond need to identify capacity and assets for addressing health issues (Fazio, 2008).

To engage community capacity building, occupational therapy practitioners must be **community-centered** and apply client-centered practice to the community. In client-centered practice, practitioners seek to understand the goals of the community members in a similar way as to how they seek to understand the individual client in traditional therapist–client interactions (McColl, 1998). Community interventions that are based on and developed using community-identified needs build upon community strengths and have been successful (Kretzmann & McKnight, 1993; Elliott, O'Neal, & Velde, 2001). Occupational therapy practitioners must understand the occupational profile of the community to develop meaningful interventions that are based on occupational preferences (Brownson, 1998).

LET'S STOP AND THINK

Think of a community you belong to that is important to you. What does the community have to offer that is unique or beneficial? Write down what you identify and reflect on how these capacities could be used in the context of community occupational therapy practice.

Applying Occupation in the Community Context

Occupational therapy practitioners in the community must understand occupation in a community context (Fazio, 2008). Occupational therapy practitioners are experts on occupation and have argued that occupation is a "fundamental prerequisite of wellbeing and linked it to an individual's state of happiness, self-esteem and physical and mental health" (Scriven & Atwal, 2004, p. 427; Wilcock, 2006). However, in community practice, practitioners must understand occupations both on the individual and community levels. Because illness and health are affected by disease as well as external context and health infrastructure, occupational therapy practitioners must transform traditional beliefs about occupation to apply occupation on multiple levels. Occupation can be applied in the community context through program development and grant writing, the focus of this text.

Skills Required for Community Practice

Occupational therapy practitioners in the arenas of community health, public health, community-based practice, and community-built practice require a unique set of skills to achieve success. Fidler (2001) states that "responding to the varied needs, interests and welfare of a community will differ in orientation, attitudinal and knowledge base from the one that currently guides our education and practice" (p. 8). Despite this fact, some skills required for community practice transfer easily from the clinical setting to a community practice setting, whereas others require development and experience.

TABLE 1-2 COMMUNITY OCCUPATIONAL THERAPY PRACTITIONER SKILLS

- Consultancy
- Education
- Autonomy
- Client-centered practice
- Clinical reasoning
- Health promotion
- Networking
- Management skills
- Program evaluation skills
- Cultural awareness
- Team skills

According to a survey of community occupational therapists conducted by Mitchell and Unsworth (2004), community occupational therapists need to possess the following skills and characteristics: consultancy, education, autonomy, client-centered practice, clinical reasoning, and health promotion. A study by Lemorie and Paul (2001) indicates that community occupational therapy practitioners need to know how to do the following: network, navigate community resources, manage volunteers, evaluate programs, health promotion/disease prevention, and address multicultural practice issues. Fazio (2008) discusses skills required of occupational therapy practitioners including communication skills, ability to develop collaborative relationships, management skills, and leadership skills. Furthermore, occupational therapy practitioners in community settings need to be able to interact with an interprofessional team that includes both professionals and valued community members (Baum & Law, 1998; Paul & Peterson, 2001; Miller & Nelson, 2004).

BEST PRACTICE HINT

Many practitioners feel intimidated by community practice. A best practice hint is to seek out a mentor or support group of practitioners that work in the community. By participating in a network, practitioners can develop skills important to community practice.

Occupational therapy practitioners in community settings can find a role in consultancy (Mitchell & Unsworth, 2004; Lysack, Stadnyk, Krefting, Paterson, & McLeod, 1995). For example, an occupational therapy practitioner can serve on the board of directors for a health-related nonprofit or be an active member of a community coalition. In these roles, the occupational therapy practitioner provides advice as an expert in occupation or some other component of the profession. Even though the occupational therapy practitioner does not provide direct service or engage in direct program development, he or she acts as an advisor to these processes, which leads to professional development and knowledge about community practice.

BEST PRACTICE HINT

To explore community practice occupational therapy practitioners can join a board of directors or advisory board of a community organization. Serving in this capacity helps the practitioner learn about the processes of community organizations.

Education is a key component of community practice. Occupational therapy practitioners usually take on an educator role. According to Brownson (2001), community "programs are

distinguished from clinical services in that programs are primarily educational" (p. 96). Providing education is a significant component of community practice when practitioners explore health promotion and lifestyle modification. Occupational therapy practitioners in community settings need to have strong educative skills (Scaffa, 2001). Perhaps their most significant challenge is to tackle education in a manner that fits the needs of the community, gearing education to the culture and health literacy levels of the community members.

LET'S STOP AND THINK

Consider the multiple theoretical approaches that occupational therapy practitioners in community settings must employ (public health, epidemiology, systems theory, sociology, organizational psychology, and sociology). Identify which aspects from each theoretical approach occupational therapy practitioners might use in community practice.

The tenets of community practice draw from a variety of social sciences including public health, epidemiology, systems theory, sociology, organizational psychology, and sociology (Munoz, Provident, & Hansen, 2004). Occupational therapy practitioners can use elements from each source as tools for community practice. Practitioners in community practice must commit to lifelong learning and make ongoing efforts to experiment and strategize for success.

Models of Practice in the Community

In occupational therapy, there are two main approaches to practice: community-based practice and community-built practice. Occupational therapy practitioners must decide which approach works best for the needs of their practice and the community. In this section, each approach is explored and described as a valuable framework.

Community-Based Practice

Community-based practice is the location in which occupational therapy services are provided. In this model, specific locations within the community context are identified and the skills of and roles that occupational therapy practitioners can play in the setting are described. Examples include adult daycare programs, driving rehabilitation programs, and health promotion programs (Scaffa, 2001; McColl, 1998). According to Wittman and Velde (2001), community-based practice "refers to skilled services delivered by health practitioners using an interactive model with clients" (p. 3).

For community-based practice, occupational therapy practitioners must move away from the medical model and focus on a health promotion and disease prevention approach to healthcare delivery (Scaffa, 2001). Scaffa, Desmond, and Brownson (2001) encourage occupational therapy practitioners to adopt a role in health promotion program development by providing an occupation-based perspective or developing occupation-based programming to complement current health promotion programs.

Program development is a significant component of community practice. It can be compared to the occupational therapy process and includes the following steps:

TABLE 1-3 THEORETICAL FRAMEWORKS UTILIZED IN COMMUNITY-BASED PRACTICE

Occupational Therapy Theories	Theories Outside Occupational Therapy
Model of Human Occupation	Social Learning Theory
Ecology of Human Performance	Health Belief Model
Occupational Adaptation	Precede-Proceed Model
Person-Environment-Occupational Performance Model	Transtheoretical Model of Health Behavior Change

Source: Scaffa, M. (Ed.). (2001). *Occupational therapy in community-based practice settings.* Philadelphia: F. A. Davis.

preplanning, needs assessment, plan development, implementation, evaluation, and institutionalization (Brownson, 2001). Program development will be discussed in further detail in Chapter 2. Community-based practice has been widely accepted in occupational therapy. The community-based practice approach transfers practice skills from the clinical setting to a population-based program development model.

Community-Built Practice

Community-built occupational therapy programs are "open systems in constant interaction with their physical, natural, temporal, social and political environment" (Elliott et al., 2001, p. 106). The basis of the **community-built practice** model is collaboration with a strength-based approach and "ends when the client-defined community has effectively built the capacity for empowerment" (Wittman & Velde, 2001, p. 3). Community-built practice is founded on the following principles:

1. *Each community member and community has strengths.* In the community-built practice model, each community member and community is evaluated for strengths. Practice focuses on health promotion and wellness and recognizes the ability of each individual and community to build capacity for success. It is assumed that the community will embrace the practice and, at some self-defined point, no longer need the occupational therapy services.
2. *Community members are equal partners in program development, implementation, and evaluation.* According to the community-built practice model, community programs can be successful only if they receive the buy-in of community members and involve them in the program planning and implementation. Community members are the experts in the community's culture, dynamics, politics, and health issues and are the strongest resource of any community program. The community-built practice model recognizes this fact and uses it as a strategy for success (Wittman & Velde, 2001).

3. *Community members "own" the program.* The community program should not depend on experts or "outsiders" to be successful but should become embodied by the community. This process takes time and is not well defined in the community-built model because communities vary; but the ultimate goal of community-built practice is for the community to assume responsibility for the program.
4. *The occupational therapy practitioner must be culturally aware for the program to succeed* (Barnard et al., 2004; Wittman & Velde, 2001). In most cases, the occupational therapy practitioner comes from a cultural background different from the community members. Cultural awareness and cultural desire (Campinha-Bacote, 2001) are skills required of the practitioner for the program activities to have an impact.

Community-built practice is an emerging model in occupational therapy practice that is based on community- and capacity-building models in population-based and health promotion practice (Wittman & Velde, 2001).

Community-Based Practice versus Community-Built Practice

Both community-based practice and community-built practice are models used as frameworks for community practice. Although both models focus on community practice, they differ in their approaches and philosophies.

A community-based occupational therapy program takes place in the community context. It focuses on applying the concepts of occupational therapy practice to community settings to develop programs that address occupational needs. Braveman (2001) shares an example of a community-based program for addressing the work rehabilitation needs of individuals with HIV/AIDS. The program, based on the Model of Human Occupation and provided as part of the services offered by a community organization, provides four phases of intervention: Phase 1 focuses on self-assessment and exploration of roles and habits, phase 2 focuses on developing skills required for work, phase 3 includes employment placement with support, and phase 4 provides long-term follow-up and support in the new work role. To develop the program, Braveman (2001) followed a program development model proposed by Grossman and Bortone (1986) and implemented the program within a community context.

Community-built practice utilizes a collaboration model and focuses on the needs and capacities of the community and its members. The community-built model refers to this aspect in its title: *Community* is *built* with the occupational therapy practitioner as facilitator. Barnard and colleagues (2004) in "Wellness in Tillery" describe an example of a community-built model. Tillery is a small, rural town in North Carolina with a large African American population. Students in the East Carolina University Occupational Therapy program were assigned to develop programming following a community-built model. Students were asked to

immerse themselves in the community to learn about the people and to face their own biases about the community. Through building relationships, the students were able to collaborate with the older African Americans in the community to develop the Open-Minded Seniors Wellness Program, a program focused on physical activity, spirituality, nutrition education, and cognition activities. Through surveys and feedback, the program was able to increase senior wellness and improve overall quality of life among the community members involved. The program's success is attributed to the concepts of the community-built model, which include collaborative planning and implementation, equal partnerships in program implementation, and a sense of community ownership of the program.

Both models of community practice offer approaches and methods for the occupational therapy practitioner. The community-based model focuses on a variety of health promotion and program development approaches whereas the community-built model provides a structured way of viewing the community and program development. Occupational therapy practitioners must determine which approach best suits their clinical reasoning and the community they plan to partner with. Examples of community-based and community-built practice programs exist in the literature to aid the practitioner in picking a model best suited for practice.

BEST PRACTICE HINT

Explore the literature for models of community-based practice and community-built practice to identify which model best suits you.

Public Health and Occupational Therapy

According to Hildenbrand and Froehlich (2002), the aim of public health is to "mobilize resources to ensure health-supporting conditions for all persons." Wilcock (2006) argues that occupational therapists have a role in public health. On the other hand, Scriven and Atwal (2004) question "whether the profession has the competencies and capacity to join others in the public health workforce with upstream remits and responsibilities" (p. 428; Scaffa, Van Slyke, & Brownson, 2008). Despite the debate, the role of occupational therapy practitioners in community practice follows a traditional public health model.

BEST PRACTICE HINT

Many states have public health organizations similar to state occupational therapy associations. Explore membership in the public health organization of your state to learn more and to network with public health professionals.

Health promotion is a key component of public health. According to the World Health Organization (2008), health promotion is "the process of enabling people to increase control over their health and its determinants, and thereby improve their health." In general, the occupational therapy literature acknowledges that practitioners' roles in community practice are to "work with clients to promote health and overcome a range of physical, social and emotional barriers and problems to maximise the client's quality of life" (Mitchell & Unsworth, 2004, pp. 14–15). For many

occupational therapy practitioners, practice may delve into health promotion, which tightly aligns with the tenets of public health (Baum & Law, 1998).

Practitioners who are unfamiliar with the concepts of public health may find it difficult to transition to a public health framework. Hildenbrand and Froehlich (2002) argue that occupational therapy practitioners have a fundamental role to play in public health, including the promotion of health maintenance for individuals with or without disabilities, development of occupation-based community programs, and participation on teams of public health professionals involved in health promotion programming. They encourage occupational therapy practitioners to embrace a role in public health, stating that "public health arenas of health maintenance, disease prevention, and health promotion offer a new vision of opportunity for personal challenge, professional development, and discipline expansion."

According to *The Promotion of Health Statement and the Prevention of Disease and Disability* published by the American Occupational Therapy Association, occupational therapy practitioners can play a role in health promotion through the promotion of healthy living, use of occupation as a vehicle for healing and health maintenance, and the provision of interventions focused on both individuals and populations (Scaffa et al., 2008). The document goes on to state that "because of the inextricable and reciprocal links between people and their environments, larger groups, organizations, communities, populations, and government policymakers must also be considered for intervention" (p. 420).

In community practice, there are three main areas of health promotion as outlined by Scriven and Atwal (2004): primary health promotion, secondary health promotion, and tertiary health promotion. Following traditional definitions of prevention, **primary health promotion** is defined as "activities that target the well population and aim to prevent ill health and disability through, for example, health education and/or legislation." **Secondary health promotion** "is directed at individuals or groups in order to change health-damaging habits and/or to prevent ill health moving to a chronic or irreversible stage and, where possible, to restore people to their former state of health." **Tertiary health promotion** occurs "with individuals who have chronic conditions and/or are disabled and is concerned with making the most of their potential for healthy living" (Scriven & Atwal, 2004, p. 425). Each level of prevention/promotion focuses on a different subset of the population. Primary prevention explores health for all individuals whereas secondary prevention focuses on working with people who have identified risk factors and tertiary prevention focuses on those who already have an existing condition affecting their lives.

Occupational therapy practice is fueled by the belief that wellness and health derive from engagement in occupation (Fazio, 2008). This very fundamental principle defines the role of occupational therapy practitioners in public health and prevention in community settings.

TABLE 1-4 EXAMPLES OF PREVENTION

Primary Prevention	Secondary Prevention	Tertiary Prevention
• Wearing helmet while cycling • Obtaining immunizations • Wearing a seatbelt while driving • Rehabilitation	• Health screenings including cholesterol and blood pressure	• Medications for existing disease

Source: Fitzgerald, M. A. (2008). Primary, secondary, and tertiary prevention: Important in certification and practice. Retrieved July 10, 2008, from http://www.fhea.com/certificationcols/level_prevention.shtml

Building Evidence in Community Practice

Community programming in occupational therapy, though at this point not thoroughly researched, has demonstrated a positive impact (Dunn, 2000; Loisel et al., 2003; Scaffa, 2001; Fazio, 2008). Because evidence-based practice is emphasized as a key component for achieving the science-driven goals of the profession, exploring evidence in community practice is crucial. Furthermore, occupational therapy practitioners must continue to add to and develop this evidence.

According to Horowitz and Chang (2004), "preventative community-based occupational therapy lifestyle redesign programs have been found to provide significant benefits in promoting quality of life, physical functioning, and mental health" (p. 48). These community programs have demonstrated an impact not only on physical well-being but the whole person, which is the ultimate goal of authentic occupational therapy.

Much of the evidence regarding community practice actually refers to education of occupational therapy students and exploration of successful strategies for teaching the skills necessary to practice in the community (Lemorie & Paul, 2001; Munoz, Provident, & Hanson, 2004; Miller & Nelson, 2004; Eggers, Munoz, Sciulli, & Crist, 2006; Perrin & Wittman, 2001). In most examples, students have been required to engage in a service learning project with a community partner or to participate in level I fieldwork experiences in a community setting. Students have the opportunity to learn basic community practice skills such as conducting assessments, program development, grant writing, case management, identifying occupations common to the community or population, and basic community-based participatory research (Perrin & Wittman, 2001; Munoz et al., 2004).

Aging in place is an area of practice that uses a health promotion model. Programs such as the Well Elderly Study exemplify the importance of occupational engagement in health promotion programs (Mandel, Jackson, Zemke, Nelson, & Clark, 1999). Community programs targeted at older adults including driving programs and fall prevention programs have evidenced success (Dorne & Kurfuerst, 2008; Siebert, 2003). Evidence is a crucial component of community practice. Occupational therapy practitioners should integrate and disseminate evidence-based approaches when they write grants and develop programs.

Community-Based Participatory Research

In the field of public health, **community-based participatory research (CBPR)** is used to demonstrate the effectiveness of programs that affect communities. The beauty of CBPR is that the framework itself acknowledges the unique needs and values of each community. According to Israel, Eng, Schulz, and Parker (2005), community members and researchers need "jointly to decide on the core values and guiding principles that reflect their collective vision and basis for decision making." Practitioners in the community setting must understand that collaboration is the key to success (Brownson, 1998; Fazio, 2008).

Although CBPR has guiding principles, it allows for the community to drive the research. In most cases, the research team acts as a facilitator, guiding the community toward addressing its own health issues. CBPR empowers communities because it assumes that community members are the experts on their own experience. In a sense, CBPR closely aligns with the occupational therapy principle of client-centered care and provides a forum for using evidence-based practice in the community. CBPR is covered in more detail later in the text.

Challenges to Community Practice

Occupational therapy practitioners face many challenges in working directly with and in communities. First, occupational therapy community practice is not well defined. Currently, resources name the skills required for working in community settings, but a collective definition of community practice for occupational therapy practitioners has not been created. Occupational therapy practitioners in community practice are to "acquire new skills, fill new roles, and use a client-centered approach to treatment" (Lemorie & Paul, 2001, p. 34).

Another significant obstacle to overcome in community practice and program development is funding (Brownson, 1998). In many cases, programs cannot be funded by third parties because the programs and services provided are not considered reimbursable by third-party payers, and the community members being served may not be able to pay for services. Unfortunately, very few planning grants exist and most funders expect infrastructure to be in place so that program implementation can occur upon receipt of funding. For newly developed programs, a

lack of external funding can be a challenge and practitioners must realize that work might need to be done without financial support.

Program sustainability is another significant challenge. Grant funding does not last forever. Occupational therapy practitioners must plan for program sustainability from the beginning and explore avenues for garnering financial resources to provide ongoing support for the programming or practice. Throughout this text, sustainability is emphasized and explored in relation to program development and grant writing.

Other challenges may include the pressure to succeed in facilitating behavioral change. In community settings, occupational therapy practitioners find themselves acting as change agents for community health because they are experts in occupations and in transforming lives through health education and engagement. However, changing behavior is a complex process and programs do not always promote the intended or proposed change. The pressure to succeed in changing behavior can be a frustration and challenge that affects community practice, especially when related to grant funding that does not allow enough time or resources for change to occur. Many funders now recognize the challenge of behavioral change (Edberg, 2007). When developing a program or writing a grant proposal, practitioners must provide sufficient time and outcomes and acknowledge the challenges of health behavior change.

Another significant task of community program development is what Mitchell and Unsworth (2004) refer to as "time spent on non-OT work." In program development, occupational therapy practitioners may act in roles outside of their profession and may spend time on what is considered "non-OT work." For some practitioners, this may present difficulties, but for others, it may be a reward of this type of practice.

Finally, achieving success with a program is complicated. An occupational therapy practitioner may develop a great program, but attendance or participation is low. In this case, there may be a disconnect between the program and the community. As part of the evaluation plan, the occupational therapy practitioner must always build in methods for assessing and modifying the program to continue to meet community needs. Strategies for recruitment and promoting program buy-in are discussed later in this text.

Community practitioners must plan and think in ways different from practitioners in traditional practice settings. Despite the complications, occupational therapy practitioners can succeed in community practice and develop successful programs that make a difference. Two strategies for success include community immersion and developing viable partnerships in the community.

The Concept of Community Immersion

To succeed in community practice, practitioners must truly understand the needs and strengths of a community. One way that occupational therapy practitioners

can come to understand community needs is through community immersion. They must spend time in the community developing relationships and exploring the impact of occupation in the community (Cooper, Voltz, Cochran, & Goulet, 2007; Cross & Doll, 2008).

One way for practitioners to immerse themselves in the community is through working in a traditional clinical role in the community. Interacting with clients helps the practitioner understand trends of health and health behaviors. Many times, ideas for community practice develop out of patterns observed in clinical practice (Voltz-Doll, 2008).

Another way is to provide pro bono services, perhaps during evenings or on weekends. Through pro bono service practitioners can gain a perspective on the community. Services provided free of charge generally have positive outcomes, but the risk is that community members will assume that services will always be provided for free. Despite this, the advantages of pro bono work include building rapport with community members and the opportunity to build programmatic ideas to address community needs (Voltz-Doll, 2008).

BEST PRACTICE HINT

If you are providing pro bono services with the intention of developing a community program, be upfront with participants so that community members know the purpose and goals of the provided services.

Community immersion is crucial to success in community practice because the practitioner can come to know and understand the community. Knowledge of the community ensures that the practitioner identifies needs and strategies to address health issues that align with community values and culture. Immersion also allows the practitioner insight into system-based issues such as policies or infrastructure that can either promote or inhibit healthy living and occupational engagement.

The Concept of Partnership

In community practice, no one can work alone to solve the complex social problems and all the dynamics that affect health and well-being. A partnership model ensures that the needs of all parties involved are met. Partnerships are in no way perfect and take time to develop. In any partnership there will be misunderstandings, struggles, and frustrations. By following the principles outlined in **Table 1-5**, practitioners can provide a foundation for maintaining a successful **community partnership**. Partnerships are central to community practice in occupational therapy.

In a partnership, all parties come to the table with something to offer and all parties benefit. A partnership approach to community practice ensures success and examines "ways that scientific knowledge and community experiential knowledge can come together to address complex social problems" (Suarez-Balcazar et al., 2005, p. 48; Jensen & Royeen, 2001).

In a partnership model, the community and the healthcare practitioner work together to identify needs and develop the program in collaboration. According to

TABLE 1-5 MAINTAINING A PARTNERSHIP IN COMMUNITY PRACTICE

Principle	Description
Develop relationship based on trust and mutual respect	• Build relationships • Practice collaborative visioning • Develop common agenda
Identify community stakeholders	• Seek out community leaders • Develop relationships with community leaders • Take time to understand the leadership style of the community
Establish reciprocal learning style	• Value knowledge and experience of community members as much as own knowledge
Educate community members	• Educate community members on occupational therapy and the role it can play in the partnership
Develop communication structure	• Use communication styles of the community • Be available to communicate • Encourage partner to always be open and honest
Be present in the community	• Make an investment in the community by attending cultural or community events meaningful to the people
Maximize resources	• Acknowledge the resources of both entities in the partnership
Practice collaborative program development	• Develop programs in collaboration or enable program development to be driven by community members
Use a multimethod approach	• Use multiple approaches to assess and evaluate success
Build cultural competence	• Celebrate diversity • Acknowledge cultural differences • Be aware of how culture affects health beliefs and practices
Share accountability	• Share accomplishments equally
Implement collaborative dissemination	• Include community partner in dissemination

Source: Adapted from Suarez-Balcazar, Y., Hammel, J., Helfrich, C., Thomas, J., Wilson, T., & Head-Ball, D. (2005). A model of university–community partnerships for occupational therapy scholarship and practice. *Occupational Therapy in Health Care*, *19*(1/2), 47–70.

Suarez-Balcazar and colleagues (2005), maintaining a partnership requires seven principles: "(a) developing a relationship based on trust and mutual respect, (b) establishing a reciprocal learning style, (c) developing open lines of communication, (d) maximizing resources, (e) using a multi-methods approach, (f) respecting diversity and building cultural competence, and (g) sharing accountability" (p. 51). These principles are neither sequential nor hierarchical, but are all necessary in the partnership process. Other strategies for establishing and maintaining partnerships include identifying community stakeholders, educating the partner on the role of occupational therapy in the community, being present in the community, collaborating on program development, and collaborating on dissemination.

LET'S STOP AND THINK

What challenges to forming a community partnership do you think exist? How would you address these challenges as an occupational therapy practitioner?

Application to the Occupational Therapy Practice Framework

Community practice should be grounded in the concepts and values presented in the Occupational Therapy Practice Framework (OTPF). The OTPF provides guidelines for practitioners engaged in community practice. Community practice ties in to the OTPF by "supporting health and participation in life through engagement in occupation" in the community context (AOTA, 2008, p. 626).

Community is listed as an area of practice in the Framework. The OTPF discusses the importance of community life in the overall health and wellness of human beings, stating that "occupational therapy practitioners are concerned not only with occupations but also the complexity of factors that empower and make possible clients' engagement and participation in positive health-promoting occupations" (AOTA, 2008, p. 629).

Not only is community viewed as a context for practice in the OTPF, but also as an approach in regards to interventions for populations. According to the OTPF, the goal of population-based community interventions is to "enhance the health of all people within the population by addressing services and supports within the community that can be implemented to improve the population's performance" (AOTA, 2008, p. 655). Community programs that work with underserved communities match with the concept of occupational justice working to address health disparities.

Practitioners who follow the OTPF must have many of the skills that are discussed later in this text, including advocacy, consultancy, and education. The Framework promotes the health, participation, and engagement in occupation by members of a community.

Conclusion

Prior to engaging in program development and writing grant proposals to support such programs, occupational therapy practitioners must have a firm grasp of the concept of community practice. This chapter provides a foundation in community practice including basic introductions to the concepts of practice and models of practice. Community practice requires unique skills. The need for and benefit of building evidence in community practice are also important to ensuring that programs remain relevant and impactful.

Glossary

Community Individuals tied together by occupational engagement and a collective sense of meaning

Community-based participatory research (CBPR) A research model in which the community designs the research program and participates in the implementation of research focused on its own health issues

Community-based practice The location in which occupational therapy services are provided

Community-built practice Uses a capacity-based approach to explore the community needs and build programs to address these community-specified needs

Community capacity building Exploring and understanding a community's potential or ability to address health problems

Community-centered Applying a client-centered approach to a community

Community partnership When the community and the healthcare practitioner collaborate on identifying needs and the program is developed in collaboration

Community practice When occupational therapy practitioners use their skills to explore the determinants of health beyond the physical and take on a systems approach to understanding health and disease

Health "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1998)

Primary health promotion Activities for the well population to prevent disease or disability

Secondary health promotion Activities to encourage positive health behaviors to improve health status

Tertiary health promotion Activities to maximize the quality of life of individuals experiencing disease or disability

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PROCESS WORKSHEET 1-1 **WHERE DO I FIT IN COMMUNITY OCCUPATIONAL THERAPY PRACTICE?**

To consider your role in community-based practice, you can engage in a self-assessment process to facilitate your learning process. Rate yourself based on the following strengths and challenges of community practice.

Strongly Agree	**Agree**	**Undecided**	**Disagree**	**Strongly Disagree**
5	4	3	2	1

1. I value the concepts of practice in community practice.

   5 4 3 2 1

2. I believe that occupational therapists have a valuable role to play in community practice.

   5 4 3 2 1

3. I feel confident acting as a consultant in community practice settings.

   5 4 3 2 1

4. I enjoy being able to practice using a creative, independent approach.

   5 4 3 2 1

5. I have confidence in the principles of health promotion related to occupational therapy practice in the community.

   5 4 3 2 1

6. I have implemented health promotion programming successfully in a community.

   5 4 3 2 1

7. I enjoy building relationships with others.

   5 4 3 2 1

8. I like being part of a collaborative team addressing health concerns.

   5 4 3 2 1

9. I enjoy working with people from diverse backgrounds.

   5 4 3 2 1

10. I enjoy planning activities for a community.

    5 4 3 2 1

Continues

PROCESS WORKSHEET 1-1 **WHERE DO I FIT IN COMMUNITY OCCUPATIONAL THERAPY PRACTICE? (CONTINUED)**

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1

11. I prefer to play a consultant role related to occupational therapy over direct clinical practice.

5	4	3	2	1

12. I enjoy learning and applying social science theories to occupational therapy practice.

5	4	3	2	1

13. I do not mind an unpredictable practice environment or outcomes.

5	4	3	2	1

14. I am flexible when outcomes are not what are expected.

5	4	3	2	1

15. I do not mind spending time doing non-OT work.

5	4	3	2	1

Now add up your score to judge your confidence with community practice.

Total Score: _____

Please note: This activity is meant to be used as a tool to help you process your confidence in community practice and does not determine your ability to practice in community settings.

75–50: Confident Community OT

Based on your score, you are confident in the beliefs, skills, and challenges of an occupational therapy practitioner in community practice.

49–25: Developing Community OT

Based on your score, you are currently developing your beliefs and skills about community practice and are still unsure about the challenges of community practice.

24–15: Emerging Community OT

Based on your score, you are interested in community practice but need to participate in skill-building activities.

PROCESS WORKSHEET 1-2 **COMMUNITY PRACTICE FRAMEWORK**

Instructions: It is important to identify your practice approach for community practice. Conduct an analysis of the two types of frameworks for community practice discussed in the chapter: community-based occupational therapy practice and community-built occupational therapy practice. By identifying the pros and cons of each model for your practice setting, you can discover approaches and strategies from the frameworks that apply to your practice setting.

Community-Based Occupational Therapy Practice

Pros	Cons

Community-Built Occupational Therapy Practice

Pros	Cons

PROCESS WORKSHEET 1-3 **ADVOCACY IN COMMUNITY PRACTICE**

Instructions: Based on these case examples, describe how you would engage in advocacy related to community practice.

Case 1: You have received a grant from the state government to promote healthcare services in rural areas in your state. The grant is a 3-year grant with equal funding provided all three years. You receive notice that government priorities have changed and funding will not be provided for the third year of the grant. What do you do?

_____

_____

_____

_____

_____

Case 2: You are providing health education in a program on childhood obesity. You hear from the project director that if another grant is not secured, the program will dissolve. What do you do?

_____

_____

_____

_____

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PROCESS WORKSHEET 1-4 **PROFESSIONAL DEVELOPMENT PLAN**

Instructions: Identify strategies for enhancing the roles and responsibilities of a community occupational therapy practitioner.

Example:

Roles/Responsibilities	**Strategy for Skill Development**
Advocacy	• Become a member of the state association legislative committee • Participate in OT monthly activities • Identify a mentor with advocacy experience

Your turn:

Roles/Responsibilities	**Strategy for Skill Development**
Advocacy	
Assessment skills	
Applying occupational therapy in the community context	
Consultancy	
Education	
Health promotion planning	
Networking	
Team skills	