SECOND EDITION

Occupational Therapy in Community-Based Practice Settings

Marjorie E. Scaffa
S. Maggie Reitz

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For all those special people
who see what others ignore,
embrace what others fear,
and create new paths that others can follow.

Dedication

This text is dedicated to the memory of Dr. Gary Kielhofner (1949–2010), scholar, teacher, mentor, and friend. His extraordinary contributions to occupational therapy education, research, and practice are unparalleled.

Introduction to the Foreword

This is the foreword that appeared in the first edition of this text. It is particularly meaningful to me as it was written by Dr. Gary Kielhofner, who was my occupational therapy professor and mentor. Dr. Kielhofner died in September 2010 after a short battle with cancer, but his legacy lives on in the many students he taught and professionals he mentored. For these reasons, we have chosen to retain this foreword and dedicate the second edition of this text to Dr. Gary Kielhofner.

—Marjorie E. Scaffa, PhD, OTR, FAOTA

Foreword

Twenty-five years ago I collaborated on my first publication with one of my mentors, Florence Cromwell. The paper described preparation of occupational therapy students to work in community settings (Cromwell & Kielhofner, 1976). I had the good fortune of working with a mentor who appreciated that much of the future of occupational therapy would be in community practice. A quarter century ago, this was still a new idea.

In the intervening period a number of changes in health care, health demographics, and funding of health services have made community-based practice not only common but the most promising direction for the future of practice in occupational therapy.

It gives me great satisfaction to see that one of my former students has gone on to edit the first comprehensive volume in community practice. It is even more gratifying to note the scope and quality of chapters that make up this ambitious volume. Community practice means much more than physical placement in a community setting. Importantly, it represents a different paradigm of care than that seen in traditional hospital and rehabilitation settings. The therapist working in the community most likely works in an organization whose traditional medically defined settings. Moreover, the voices and viewpoints of those served will often carry much more weight than in a traditional setting. Therapists who wish to be effective in community practice must be prepared to take on new roles, to take unusual risks, and to envision service in creative ways. Thus, although community practice is not as anomalous as it was 25 years ago, it still represents new territory for most of occupational therapy.

Marjorie Scaffa and her colleagues have assembled a remarkable set of resources for the occupational therapist in community practice. The scope and depth of the chapters make this at once an authoritative work on community practice and an invaluable collection of resources.

—Gary Kielhofner, DrPH, OTR

Cromwell, F.S., & Kielhofner, G. (1976). An educational strategy for occupational therapy community service. American Journal of Occupational Therapy, 30, 629-633.

Preface

This book is the culmination of one aspect of the professional journey of Marjorie Scaffa that started when she was an undergraduate major in psychology with a minor in health education and continued on in an entry-level master's program to become an occupational therapist. During her years as an occupational therapy student at Virginia Commonwealth University, she was introduced to the Model of Human Occupation by Dr. Kielhofner and became increasingly excited about the potential for practice in nonmedical settings. When given the opportunity to choose a topic for a paper, Marjorie wrote about occupational therapy's role in community health, and the seeds of what would later become this book were sown.

As a practicing occupational therapist, she gained experience in a variety of settings but was most energized and excited by home health practice. Providing services in the home enabled her to become part of the person's daily life context in which the client participated in self-care, work, and leisure. Marjorie was impressed by how much more meaningful occupations were to individuals and their families in real-life environments.

Through our practice and further education, we both came to believe firmly that if occupation could restore function and enhance the quality of life for individuals with disabilities and their families, then it could also be used to prevent injuries and promote health in communities. Thus began our quests for doctorates in health education. We quickly realized that much of what we had learned in occupational therapy would be useful in community-based prevention and health promotion, but that we needed to become acculturated to the mind-set and conceptual frameworks of health educators, which were quite different from those of occupational therapy practitioners. We were exposed to planning, implementing, and evaluating preventive interventions directed at groups and populations rather than rehabilitative interventions directed at individuals.

Through time we were able to assimilate both of our professional identities as occupational therapists and health educators, which enabled us to envision this Second Edition. It is clearly and straightforwardly an occupational therapy text with an appreciation of the importance of community as a context for health.

We hope that you find the Second Edition of the book to be a useful and more developed discussion of the issues related to present-day community practice in occupational therapy and descriptions of a variety of settings in which this practice currently occurs. The book has grown from 18 chapters in the original edition to 29 chapters in this Second Edition, with sections devoted to each of the six areas of the American Occupational Therapy Association's Centennial Vision. Chapters have been added on community mental health services for children and youth as well as on forensic transition services. The number of chapters on productive aging has increased from one to five, with chapters being added on driving and community mobility, low-vision services, fall prevention, and aging in place. Chapters related to work have increased from one to three, with new chapters on ergonomics and welfare to work programs being the enhancements to this edition. The ability to add chapters on Lifestyle Redesign, technology in community-based practice, as well as chapters on health promotion in faith-based organizations, primary care settings, and academic communities together with the other additional chapters exemplifies how the profession's contributions to community health and well-being have significantly expanded since the first edition of this book.

The book remains designed as a textbook for entry-level occupational therapy students, but it also proves useful to practitioners wishing to facilitate a transition from medical model practice to community-based practice. We are grateful for the opportunity to participate in and contribute to the profession's expanding role in prevention, health promotion, and community health.

—Marjorie E. Scaffa
S. Maggie Reitz

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And last, but certainly not least, we would like to acknowledge the support of family and friends. We are fortunate to have understanding, caring, and thoughtful people in our lives, as we could not have completed this textbook without their assistance. However, our spouses, Blaise Chromiak and Fred Reitz, deserve the South Alabama Jaguar and Towson Tiger share of our gratitude and love for their patience as this project unfolded, evolved, and finally came to fruition.

Contents

Basic Principles and Relevant Issues

Chapter 1

Community-Based Practice: Occupation in Context

Marjorie E. Scaffa, PhD, OTR/L, FAOTA

We know what we are, but we know not what we may be.
—Shakespeare

Learning Objectives

This chapter is designed to enable the reader to:

- Describe the history of community-based practice in occupational therapy.
- Describe the variety of roles for occupational therapy practitioners in community-based practice.
- Describe the characteristics of effective community-based practitioners.
- Describe the history of paradigm shifts in occupational therapy.
- Identify key characteristics of a community practice paradigm for occupational therapy.

Key Terms

Client-centered approach
Community
Community-based practice
Community-centered initiative/intervention
Community health promotion
Community-level intervention
Dynamical systems approach
Ecological approach
Health
Paradigm
Paradigm shift
Strengths-based occupational therapy

Introduction

In 2017, the profession of occupational therapy and the American Occupational Therapy Association (AOTA) will turn 100 years of age. In order to set a course for the future and to celebrate the profession's history, the AOTA developed a Centennial Vision that reads: "We envision that occupational therapy is a powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society's occupational needs" (Baum, 2006, p. 610).

A community practice paradigm is entirely consistent with this vision. For example, expanding community-based occupational therapy services and population-based interventions could make occupational therapy more visible, thereby enhancing understanding and recognition of the profession. The improved awareness of occupational therapy also may increase consumer demand for services. If occupational therapy practitioners are working in more varied settings and providing needed services, then more opportunities to influence policies and take on leadership roles may result. Practicing in the community increases involvement with other professionals and assists in building alliances that also may expand the profession's power base. In addition, community practice enables the development of a variety of new roles for occupational therapy practitioners. Finally, because community practice occurs in environments where people work, play, go to school, and participate in activities of daily living, the profession is more likely to be aware of and meet society's occupational needs.

The AOTA Centennial Vision outlines six broad practice areas, including children and youth; productive aging; mental health; rehabilitation, work, and industry; disabilities and participation; and health and wellness (Baum, 2006, p. 611). Community-based services exist and can be developed within each of these practice areas, for example, ergonomic consultation, driver evaluation and training, hippotherapy, welfare-to-work programs, aging-in-place services, aquatic therapy, and violence prevention programs (Johansson, 2000; Scaffa, 2001). Occupational therapy as a profession has the opportunity to respond to and help resolve the social and health problems of the 21st century, including poverty, homelessness, addiction, depression, joblessness, chronic disease and disability, unintentional injury, violence and abuse, and social discrimination and stigma. Meeting the occupational needs of society will require not only the provision of occupational therapy services to individuals and families in community-based settings, but also the provision of occupational therapy services to organizations, communities, and populations.

An overview of community-based practice for occupational therapy is provided in this chapter. Also included are a review of the historical perspectives of community-based practice, an identification of the various roles associated with community-based practice, and a description of the characteristics necessary for effective community-based occupational therapy practice. The major paradigm shifts in occupational therapy, highlighting the impact of systems theory, are presented. Concluding the chapter is a discussion of the community practice paradigm as a client-centered approach to practice.

Historical Perspectives of Community-Based Practice

Community-based practice is not a new concept in occupational therapy (Table 1-1). Two founders of the profession, George Barton and Eleanor Clarke Slagle, developed community-based programs in the early 1900s. Barton, who was disabled by tuberculosis and a foot amputation, established Consolation House in New York in 1914. The program used occupations to enable convalescents to return to productive living (Punwar, 1994; Sabonis-Chafee, 1989). Eleanor Clarke Slagle was hired in 1915 to develop a program to provide persons with mental or physical disabilities an opportunity to work and become self-sufficient. The project was funded by philanthropic contributions and was located at Hull House, a settlement house in Chicago. In its first year of operation, the program served 77 persons who developed manual skills and received wages for their work. The goods produced in the workshop included baskets, needlework, rugs, simple cabinets, and toys (Reed & Sanderson, 1999).

Banyai (1938) wrote about the care individuals with tuberculosis were receiving while residing in sanitariums. While acknowledging the importance of occupational therapy intervention in the institution, she emphasized the need to follow the patient into the community. The ultimate goal was to restore the

Table 1-1 Historical Timeline of Community Practice in Occupational Therapy

Date	Event
1914	George Barton establishes Consolation House in New York.
1915	Eleanor Clarke Slagle establishes the work program at Hull House in Chicago.
1937	Humphreys advocates community treatment for persons with developmental disability.
1938	Banyai advocates following tuberculosis patients into the community after discharge from sanitariums.
1940	The AOTA reports on roundtable discussions held at national conference on the role of occupational therapy in community health.
1968	Bockhoven suggests that occupational therapy take responsibility for community occupational development.
1969—1973	In the United States, West, Reilly, and Mosey describe the need for occupational therapy services in the community.
1972	Llorens describes a community-based program in San Francisco for pregnant teenagers.
1972	Finn argues that the profession move beyond the role of therapist to "health agent."
1973	Hasselkus and Kiernat describe an independent living program for the elderly.
1974	The AOTA Task Force on Target Populations expands the role of the profession to include health promotion and disability prevention.
1977	Laukaran describes the major obstacles to community-based practice.
1982	Kirchman, Reichenback, and Giambalvo describe a prevention program for the well elderly.
1997	Well-elderly study published in the *Journal of the American Medical Association.*
2006	ACOTE accreditation standards revised with increased emphasis on health promotion and population-based services.
2006	AOTA adopts the 2017 Centennial Vision.

individual to a satisfactory level of social and economic functioning. Banyai (1938) believed that this required the occupational therapist to work with the person in the community after discharge from the institution.

The professional literature of the 1960s suggests that the field was on the verge of expanding its services outside of traditional medical settings (Laukaran, 1977). West (1969) asserted that "the traditional role of the occupational therapist, that of the reintegration of social function, is not a hospital service but rather a function that can be best filled in the community" (p. 231). Reilly (1971) advocated that the future growth of the profession was predicated on the transition of occupational therapy services from the hospital to the community. The focus of occupational therapy, in her view, should be to develop experiences and programs in the individual's community environment that enhance adaptive competencies. This broader perspective requires the professional to provide therapeutic programming in the individual's milieu, including home, workplace, and community.

In spite of these early admonitions to focus on broader health needs and services outside of institutional settings, the move to community-based practice was short-lived and very limited in scope. In the 1970s and 1980s, examples of outreach into the community included an independent living project for the elderly (Hasselkus & Kiernat, 1973), a project in San Francisco for pregnant teenage girls (Llorens, 1972), and prevention services for the well elderly (Kirchman, Reichenback, & Giambalvo, 1982). According to Laukaran (1977), three major obstacles to community-based practice existed at that time. These barriers were practical constraints, historical factors within the discipline, and gaps in knowledge and theory related to community-based practice. The

practical constraints were related to the limited number of opportunities for community-based practice at that time and the public perception of occupational therapy as a medical discipline. Historically, occupational therapy practitioners' professional identities had been associated with work in medical institutions. In addition, professional education programs emphasized preparation for practice in medical rather than community-based settings. Laukaran (1977) noted that some theoretical frameworks of that era (e.g., occupational behavior, biopsychosocial, and developmental models) were compatible with community-based practice. However, these early models were inadequate in providing guidelines and rationales for services in community settings.

Some of these same obstacles exist today, albeit in different forms. Opportunities for utilizing occupational therapy expertise in community settings are limitless but typically not designated as occupational therapy positions. For the profession to move into these settings, practitioners must seek out positions that although not labeled "occupational therapy" could benefit from the unique contributions of the discipline. The perception of occupational therapy as strictly a medical discipline continues to exist both outside and within the profession. The identity of "medical professional" is an alluring one, as in the past it denoted an aura of legitimacy. Many occupational therapy practitioners today are reluctant to "let go" of this restrictive image in favor of a more broadly defined role. In addition, professional preparation programs are slow to shift focus. However, many educators concur that the future of the profession will largely be determined by its ability to expand the scope of practice into community-based settings (Holmes & Scaffa, 2009a). Many more theoretical frameworks exist today than existed in the 1960s. These newly emerging models, based on the work of previous theorists, are readily applicable to community-based practice. Some of these theories and models are described in detail later in Chapter 3.

Interestingly, one of the boldest predictions and strongest support for the validity of occupational therapy services in the community came from a physician in 1968. Bockhoven (1968) suggested a new role for occupational therapists, described as "taking responsibility for community occupational development, alongside the businessman, city planner and the economist … to support growth of respect for human individuality in occupation" (p. 25). The AOTA (1974) Task Force on Target Populations redefined occupational therapy as "the science of using occupation as a health determinant" (p. 158). This definition advanced the notion that occupational therapy was not limited to the seriously or chronically ill but also could remediate mild to moderate impairments and contribute to health promotion and disability prevention.

Finn (1972), in the 1971 Eleanor Clarke Slagle Lecture, states: "In order for a profession to maintain its relevancy it must be responsive to the trends of the times … Occupational therapists are being asked to move beyond the role of therapist to that of health agent. This expansion in role identity will require a reinterpretation of current knowledge, the addition of new knowledge and skills, and the revision of the educational process" (p. 59).

These words are still true today. The expanded role of health agent requires practitioners to move into the community and provide a continuum of services; these include health promotion and disability prevention in addition to the intervention services typically provided by the profession. Health agent is more than "therapist." Other roles, such as consultant, advocate, community organizer, program developer, and case manager, are also included.

Definitions of Terms

To conceptualize and operationalize community-based practice in occupational therapy, definitions of some terms have been adopted for the purposes of this textbook. These terms include health, community, community-based rehabilitation, community-based practice, community health promotion, community-level intervention, and community-centered initiatives/interventions.

Health

Health is defined as the ability to: "realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life … a positive concept emphasizing social and personal resources, as well as physical capacities. . . . The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity" (World Health Organization, 1986, p. 1).

Community

"Community" means different things to different people. No single definition appears to capture the richness and diversity of the term, but combining the following definitions provides a broad and comprehensive perspective. Community refers to "non-institutional aggregations of people linked together for common goals or other purposes" (Green & Raeburn, 1990, p. 41). It is the "space where people think for themselves, dream their dreams, and come together to create and celebrate their common humanity" (O'Connell, 1988, p. 31). **Community** is "a social unit in which there is a transaction of common life among the people making up the unit" (Green & Anderson, 1982, p. 26). This social unit has its own norms and through the regulation of resources organizes both the environment and individual and group behavior.

The community or neighborhood setting is a vital part of growing up, raising families, and meeting the many challenges and stresses of modern life (Warren & Warren, 1979). According to Nisbit (1972), people do not come together in community relationships merely to be together; they come together to do something that cannot easily be done in isolation.

Community-Based Practice

Community-based practice is more comprehensive than community-based rehabilitation. Community-based practice includes a broad range of health-related services: prevention and health promotion, acute and chronic medical care, habilitation and rehabilitation, and direct and indirect service provision, all of which are provided in community settings. "Community" in this framework "means more than a geographic location for practice, but includes an orientation to collective health, social priorities, and different modes of service provision" (Kniepmann, 1997, p. 540). Community models are responsive to individual and family health needs in homes, workplaces, and community agencies. In this way, interventions are contextually embedded. The goal in community-based practice is for the client and the practitioner to become integral parts of the community. Some hospitals and rehabilitation centers provide field trips in the community for patients or clients and health fairs for community members, but these activities are not considered community-based services. They are more appropriately referred to as "community outreach" (Robnett, 1997).

Community Health Promotion

Community health promotion can be defined as "any combination of educational and social supports for people taking greater control of, and improving their own or the health of a geographically defined area" (Green & Ottoson, 1999, p. 729). Educational programs may be directed at individuals, families, groups, or communities through schools, work sites, organizations, and/or mass media. Social approaches focus on organizational, legal, political, and economic changes that support health and well-being. "Organized community effort is the key to community health. There are some things the individual can do entirely alone, but many health benefits can be obtained only through united community effort" (Green & Anderson, 1982, p. 4).

Community-Level Intervention

Community-level interventions "attempt to modify the socio-cultural, political, economic and environmental context of the community to achieve health goals" (Scaffa & Brownson, 2005, p. 485). These are population-based approaches to health and do not focus on individual health behavior change. Community-level interventions are directed at impacting systems that affect health in communities. Often initiated by health care and government agencies, they typically involve community organization strategies. Decisions are often based on the source of funding, and planning is done by a "lead" agency. The professional serves as an expert in a leadership capacity.

Community-Centered Initiatives/Interventions

Community-centered initiatives/interventions are often generated by leaders and members of the community and typically utilize existing community resources. Community coalitions form to identify common concerns and needs and to design approaches to solve community problems. Community-centered interventions follow the principles of client-centered practice, where the client is the entire

community. In this way, community-centered initiatives promote community participation, exchange of information, and community autonomy. The role of the professional is as a consultant, facilitator, and mentor in the community. Occupational therapists can participate in community-centered initiatives by "identifying occupational risk factors, engaging in problem-solving and proposing and implementing solutions" that meet the community's unique occupational needs (Scaffa & Brownson, 2005, p. 485).

Trends and Roles in Community-Based Practice

The AOTA 2010 Workforce Study (AOTA, 2010) indicated that 2.0% of occupational therapy practitioners work in community settings including adult day care, independent living centers, assisted living facilities, senior centers, and supervised housing among others. In addition, 2.3% work in settings characterized as "other" including driving programs, supported employment, sheltered workshops, and industrial rehabilitation/work programs, all of which are community-based. A total of 4.8% of occupational therapy practitioners work in early intervention programs. These data reveal that approximately 9.1% of occupational therapy practitioners work in community settings. This does not include the 2.9% of occupational therapy practitioners who work in community-based mental health programs and the 5.8% who work in home health.

Median annual compensation for occupational therapists working full-time in community settings ranged from $59,000 to $71,350, depending on the number of years of experience. The overall median annual compensation for occupational therapists working in community settings was $68,000, while for occupational therapists working full-time across all settings it was $64,722. This demonstrates that the common perception that occupational therapists in community settings earn less than their counterparts in more traditional settings is a myth (AOTA, 2010).

Occupational therapy practitioners have a significant role to play in supporting individuals in their homes and workplaces, facilitating their independence, and promoting their integration into the community (Stalker, Jones, & Ritchie, 1996). More than 30 years ago, West (1967) described her vision of the changing responsibility of occupational therapists to the community. This vision acknowledged the newly emerging focus on prevention and health promotion in medicine and the impact this new focus would have on practice settings, roles, and responsibilities. West (1967) predicted that, as a result of the change in focus, practice would move into new settings, "namely, the communities in which our potential patients live, work and play" (p. 312). She described four emerging roles that at the time were adding new dimensions to the traditional role of the clinically based occupational therapist. These new roles included evaluator, consultant, supervisor, and researcher.

Other roles that community-based practitioners may fulfill include program planners and evaluators, staff trainers, community health advisors, policy makers, and primary care providers. Practitioners in the community may function as community health advocates, consultants, case managers, entrepreneurs, supervisors, and program managers. Descriptions of these roles follow in the next section. It is important for community-based practitioners in these roles to develop networks for support and collaboration with other occupational therapy practitioners, health and social service professionals, and community leaders.

Role Descriptions

Community Health Advocate

As a community health advocate, practitioners identify the social, physical, emotional, medical, educational, and occupational needs of community members for optimal functioning and advocate for services to meet those needs. In addition, practitioners act as advocates and lobbyists by providing input and shaping legislation and government policies, thereby affecting local and national physical and mental health issues and changing environmental conditions to promote health.

Consultant

Occupational therapy practitioners in the role of consultant provide information and expert advice regarding program development and evaluation, supervisory models, organizational issues, and/or clinical concerns. Consultation is "an interactive process of helping others solve existing or potential problems by identifying and analyzing issues, developing strategies to address problems and preventing future problems from occurring" (Epstein & Jaffe, 2003, p. 260). Consultation services are most often

utilized when new programs are being developed or undergoing significant change and may be short-term or long-term, depending on the needs of the program. Within the community, occupational therapy practitioners can act as consultants to a variety of groups, such as Scouts or Boys & Girls Clubs, adult education programs, adult day care, transitional living programs, independent living centers, community development and housing agencies, health departments, military bases and organizations, and work site safety and health programs.

Case Manager

As a case manager, a practitioner coordinates the provision of services; advises the consumer, family, or caregiver; evaluates financial resources; and advocates for needed services. Case management requires a professional who has ample clinical experience, understands reimbursement mechanisms, and has good organizational skills. Frequently, the qualifications and duties of case managers are dictated by state regulations. Occupational therapy practitioners are most often designated as case managers in mental health and children and youth practice areas.

While the primary role of case managers is to ensure access to community services and resources, they may also assist in the development of independent living skills (e.g., money management, social interaction, and cognitive skills such as decision making and problem solving). Occupational therapists are qualified by their education and training to serve as case managers and/or to supervise others in case management positions.

Private Practice Owner/Entrepreneur

An occupational therapy entrepreneur is "an individual who organizes a business venture, manages its operation, and assumes the risks associated with the business" (Vaughn & Sladyk, 2011, p. 167). The entrepreneur may own a private practice, provide services on a contractual basis, and/or function as a consultant. In order for entrepreneurs to be successful, they must be able to assess and respond to the unique needs of their communities. Changing demographics, including the significant growth of the aging population, will provide a variety of opportunities for occupational therapy entrepreneurs. In order to be successful, entrepreneurs must have a wide range of skills including financial management, marketing, leadership, and organizational and team-building skills (Vaughn & Sladyk, 2011). A broad overview of entrepreneurship is provided in Chapter 8.

Supervisor

Supervisors typically manage and are responsible for all the activities of their team members. A supervisor sets up work schedules, delegates tasks, recruits and trains employees, and conducts performance appraisals. In occupational therapy practice, supervision is designed to "ensure the safe and effective delivery of occupational therapy services and foster professional competence and development" (AOTA, 2009, p. 797). The role of an occupational therapy supervisor varies from facility to facility but generally includes training and evaluating staff and fieldwork students, developing and reviewing intervention plans and progress updates, solving problems as needed, and contributing to budget and program development. Supervisors typically do not have final budgetary or personnel authority but assume responsibility for the day-to-day operations of the program.

Program Managers

Program managers are responsible for the overall design, development, function, and evaluation of a program; budgeting; and staff hiring and supervision. Many occupational therapists have served as program managers in community settings (Fazio, 2008). Program managers conduct needs assessments, SWOT (strengths, weaknesses, opportunities, threats) analyses, strategic planning, and program development functions. Occupational therapists not in positions officially designated as program manager may be asked to expand existing programs or develop new programs to meet client needs. Program managers in community-based settings tend to "use a more interactive approach that promotes open communication, feedback and collaboration than managers in more traditional, institutionally-driven medical settings" (Scaffa, Doll, Estes, & Holmes, 2011, p. 320).

Characteristics of Effective Community-Based Occupational Therapy Practitioners

According to Learnard, "occupational therapy in community health is both an art and a science"

(Robnett, 1997, p. 30). In addition to the typical occupational therapy focus on enhancing function through task analysis and modification of important life tasks and the environment, occupational therapists in community-based practice need a variety of other skills and attributes. According to Robnett (1997), Learnard believes effective community-based therapists exemplify the following characteristics:

- Sense of positive hopefulness
- Understanding of individuals in their specific personal circumstances
- Creativity to envision a variety of possibilities
- Ability to set aside one's cultural, personal, and professional biases and respect individual choices rather than passing judgment

Holmes and Scaffa (2009b) studied twenty-three occupational therapists working in emerging practice areas and attempted to identify the competencies needed to work in new or underdeveloped practice settings. The competencies were identified through the use of the Delphi technique of forecasting, whereby respondents have multiple opportunities to identify, rate, and rank the characteristics they deem essential for emerging practice. The competencies and characteristics were classified into five categories used in the AOTA Standards for Continuing Competence (AOTA, 1999), which included:

1. knowledge required for multiple roles,
2. critical reasoning necessary for decision making in those roles,
3. interpersonal abilities to establish effective relationships with others,
4. performance skills and proficiencies for practice, and
5. ethical reasoning for responsible decision making.

A sixth category—traits, qualities, and characteristics—was added based on the Delphi panel responses. The competencies and characteristics identified by the Delphi panel are listed in Box 1-1 (Holmes & Scaffa, 2009b).

In addition, the following attributes and skills are recommended for those contemplating practice in community settings:

- Comfort with indirect service provision
- Grant-writing skills
- Networking skills
- Organizational skills
- Professional autonomy
- Program planning and evaluation skills
- Public relations skills

Paradigm Shifts in Occupational Therapy

A **paradigm** is a conceptual framework that allows explanation and investigation of phenomena. Kuhn (1970) defined a paradigm as "universally recognized scientific achievements that for a time provide model problems and solutions to a community of practitioners" (p. viii). Paradigms have two essential characteristics. They are (a) sufficiently unprecedented scientific achievements that draw a large number of constituents from competing areas of inquiry, and (b) adequately open-ended enough to allow for the exploration of solutions to a variety of problems. A paradigm is a worldview that characterizes a particular group or discipline that has common interests. It is a "consensus-determined matrix of the most fundamental beliefs or assumptions of a field" (Kielhofner, 1983, p. 6). A profession or discipline-specific paradigm determines

- how professionals view their phenomenon of interest;
- what puzzles, problems, or questions practitioners will seek out in their work;
- what solutions will emerge; and
- what goals will be set for the direction of the profession.

A paradigm is the "cultural core of the discipline" and "provides professional identity" (Kielhofner, 1997, p. 17).

Kuhn (1970) asserted that change within a discipline or profession does not occur gradually. Rather, it occurs very dramatically. When a discipline abandons one view of the world for another, it has undergone a revolution, a drastic conceptual restructuring, called a **paradigm shift.** Often, there is much resistance to paradigm shifts and to those initiating them. Paradigm shifts dramatically change the existing rules, create new trends, and trigger innovations. Paradigm shifts occur in four stages: preparadigm, paradigm, crisis, and return to paradigm.

Box 1-1 Competencies and Characteristics Needed for Emerging Practice Areas

Listed in order of importance ratings

Knowledge Competencies*

Occupation-based practice for evaluation and intervention
Philosophy of occupational therapy
Occupational therapy models and frames of reference applied to intervention
Principles of client-centered practice
Occupational therapy practice framework: domain and process
Core values of occupational therapy
Program development
Potential occupational therapy role and contribution in the practice area
Community systems
Public health principles and practice models

Performance Skills Competencies

Envision occupational therapy roles and service possibilities
Implement client-centered practices
Assess, evaluate, and provide intervention for occupational issues
Work collaboratively with others
Identify and access available resources
Search, analyze, and synthesize evidence-based research for emerging practice
Seek opportunities to demonstrate and use skills to meet clients' needs
Select, administer, and interpret evaluation results for variety of practice areas
Conduct comprehensive task and activity analyses
Provide consultation to groups and individuals

Critical Reasoning Competencies*

Reason holistically
Translate theory to practice
Solve problems
Use clinical reasoning for client services
Think outside of the box
Use good judgment—know when to seek assistance
Think abstractly
Complete a SWOT analysis

Ethical Reasoning Competencies*

Self-assessment of strengths and needs for ongoing professional development
Principles of social justice
Principles of occupational justice

Interpersonal Abilities Competencies*

Listen actively
Communicate occupational therapy concepts to a variety of audiences
Establish relationships with stakeholders and community leaders
Network effectively with other professionals
Demonstrate cultural competence
Establish and maintain relationships with professionals
Seek mentors within and outside of the occupational therapy profession
Understand and use language and terms of other professions
Negotiate effectively
Ask for feedback, advice, and assistance from colleagues and friends

Traits, Qualities, and Characteristics

Self-starter, self-directed
Adaptable to new situations
Able to step outside of the medical model
Self-confident
Persevering, determined, and persistent
Flexible
Tolerant of ambiguity
An independent worker
Creative
Able to challenge the status quo

Category headings* from "Standards for Continuing Competence" by the American Occupational Therapy Association, 1999, *American Journal of Occupational Therapy, 53*, 559–560.
Data from: Holmes & Scaffa (2009). An exploratory study of competencies for emerging practice in occupational therapy. *Journal of Allied Health, 38* (2), 81–90.

Kielhofner conducted an historical examination of paradigm shifts in occupational therapy (Fig. 1.1). According to Kielhofner (1983), the pre-paradigm stage in occupational therapy traces its roots to the moral treatment movement with its humanistic focus. Moral treatment proponents advocated that the treatment of persons with mental illness should emphasize a daily routine of occupations in a family-like atmosphere (Neidstadt & Crepeau, 1998). Participation in occupations was believed to normalize disorganized habits and behaviors (Kielhofner, 1997). During the 18th and 19th centuries, the moral treatment philosophy was competing with a pathology-oriented approach in the treatment of the mentally ill.