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Professional Expertise of Community-Based Occupational Therapists

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PROFESSIONAL EXPERTISE OF COMMUNITY – BASED OCCUPATIONAL THERAPISTS

by

Lori Ann Madaus Lemorie

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Masters of Science
Department of Occupational Therapy

Western Michigan University
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ACKNOWLEDGMENTS

So many people were vital to the completion of this project. It truly stands as the work of many. I am pleased to have this opportunity to acknowledge the contributions they made.

The faculty and staff at this university were instrumental in this research project. My committee deserves mention for their patience, and endless encouragement. I appreciate the efforts of Julie Scott, and Hong Zheng at Computer Services for their assistance with analyzing the data.

My family played a vital role in bringing me to this point. My mother has done much to encourage my education. As a single mother of four, she promised, and delivered a college education to all of us. Words cannot express the gratitude I feel for her determination. Lastly, I must acknowledge the love and patience of my husband. It is his strength I draw from. It is his love that anchors me. He has made many sacrifices toward the completion of this project and this degree. Thank you for all your support, and patience. It is your turn now.

Lori Ann Madaus Lemorie
Occupational therapists are increasingly practicing in community-based settings. Due to changes in the health care system, the need for defining roles, and explaining what a profession can contribute to health care has been highlighted. The major goal of this study was to identify job roles, job skills, and professional expertise of community-based therapists. The Community Practice Project survey was mailed to 200 AOTA registered community-based therapists. A response rate of 42% was achieved. The results provided a profile of the typical community-based therapist. Principal roles, job skills, and areas of professional expertise were also identified. The adequacy of educational preparation was also assessed. Responding therapists reported they were not prepared to use the skills of networking, consulting, and communications skills. They were also not prepared in the expertise areas such as community resources, self-directed learning, and client centered approach to practice. Overall, therapists expressed satisfaction with work in community-based positions.
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INTRODUCTION

The number of occupational therapists practicing in community-based settings is increasing (Beech, Rudd, Tilling, & Wolfe, 1999; Devereaux, 1991; Townsend, 1988). This shift has been encouraged by trends in health promotion, disease prevention, cost-effectiveness, legislation, and political movements (Chui, 1998; Grady, 1995; Peat, 1991). Practicing in the community requires occupational therapists to acquire new skills, fill new roles, and focus treatment on individuals (Lysack, Stadnyk, Paterson, McLeod, & Krefting, 1995; Pimentel & Ryan, 1996). Practicing in the changing health care system requires the profession to show its effectiveness, define its scope, and communicate exactly what it can contribute to health care (Baum & Law, 1997, 1998; Bezold, 1989; Pew Health Professions Commission, 1993). These demands are made more difficult by the fact that traditional occupational therapy practice has focused on institutional settings (McColl, 1998; Peat, 1991).

Lysack et al. (1995) published the findings of a study that helps the occupational therapy profession fulfill these. The Community Practice Project (CPP) studied physical and occupational therapists in community-based practice in the province of Ontario. This study had three objectives.

1. To survey community therapists for opinions around community therapy and educational preparation.

2. To evaluate and develop a multidisciplinary course for undergraduate occupational and physical therapy programs.

3. To evaluate and develop materials for community fieldwork supervisors to
enhance their ability to prepare students for community practice (Lysack et al., 1995). The project provided a profile of the typical community-based occupational therapist. In addition, principal roles, specific job skills, areas of professional expertise and educational preparation were identified. Renwick, Cockburn, Colantonio, and Friedland (1996) used the information gathered by Lysack et al. to identify material occupational therapy curricula need to include. Renwick et al. utilized this data to develop a community-based course for occupational therapists. The data collected greatly expanded the understanding of what community-based occupational therapists are doing in this setting.

This project was a modification of the study originally done by Lysack and her colleagues (Lysack et al., 1995). Ross, Hall, and Heater (1998) stated that replication is an essential part of developing a body of research that should be seen as equal in value to original research. Bloomquist (1986) related several points that support the importance of replicative research. Occupational therapists are increasingly encouraged to participate in research as a means of validating the practice of the profession (McColl, 1998; Nelson, 1997; Teague, Cipriano, & McGhee, 1990; West, 1967).

This research endeavor was designed to satisfy specific goals. This study sought to identify job roles, job skills, and professional expertise of occupational therapists practicing in the community. This project meant to assess educational preparation for practice in this area. Finally, this study meant to identify international trends in community-based practice by comparing the results of this study with Lysack et al (1995). This project identified areas of continuing education recommended for practice in this setting.
LITERATURE REVIEW

Community-Based Practice

Occupational therapy literature offers various operational definitions of community-based practice (Townsend, 1988, Vanier & Hebert, 1995). For the purposes of this project, community-based practice will be used to mean practice where the site of intervention is in the community. The American Occupational Therapy Association (AOTA) determined whether a practice site is in the community. The setting of occupational therapy is defined as dependent upon four items: (1) the diagnosis, disabling condition, or injury the client has; (2) the potential risks to the client for developing disabling conditions; (3) the level and number of services needed by the client; and (4) the ability of the family or caregiver to provide support or supplemental care and supervision for the client. Home and community settings for practice are listed in this document: (a) home care, (b) halfway houses, (c) group homes, (d) assisted living, (e) sheltered workshops, (f) industry and business, (g) schools, (h) early intervention centers, (i) day care centers, (j) community mental health centers, (k) hospice, and (l) wellness and fitness centers (Moyers, 1999).

Shift Into Community-Based Practice

Health Promotion, Disease Prevention, and Health Care Reform

Occupational therapy literature reflects the profession’s historical interest in health promotion and the prevention of disability. Meyer supported the belief that the skills of an occupational therapist are equally as valuable to healthy persons as to ill
persons (Finlayson & Edwards, 1995). West (1967) addressed health promotion when she discussed the occupational therapists' changing responsibility to the community. West suggested a new focus in the health-related professions on prevention and the provision of comprehensive health services. She said what was needed was a new accent on health versus disease that emphasized maintenance of optimum health. In an Eleanor Clark Slagle lecture, West suggested that occupational therapists should think more about serving people in the community. In a 1968 paper on the importance of prevention West identified nine roles as secondary prevention, and projected numerous roles in primary prevention that could be filled by occupational therapists (White, 1986). Weimer, at a 1970 AOTA conference, said "the thrust needed for medical-social preventive health efforts was the prevention of deficient health and promotion of optimum wellness" (White, 1986, p. 746). Weimer outlined a view of health as a continuum from promotion to protection, identification, correction, and accommodation (White, 1986). Finn, in her 1971 Eleanor Clarke Slagle lecture, devoted much time to discussing the occupational therapist in prevention programs. Finn urged therapists to consider the development of alternate models of practice and to investigate role expansion from therapist to health agent (Finlayson & Edwards, 1995). Jacobs (1985) pointed out that focusing on immediate treatment needs may lead to neglect of long range planning necessary for the success of their patients after treatment is over. White (1986) stated "the challenge of the eighties is for occupational therapists to become health promoters" (p. 746). Polatajko (1994) pictured a practice whose focus would "shift from reducing impairment through purposeful activity to preventing handicap through occupational enablement" (p. 591). Baum & Law (1997) suggested that the health care system should be designed to encourage occupational therapists to focus on the long term
health needs of their clients. Occupational therapists have consistently advanced the importance of health promotion and disease prevention (White, 1986).

A health promotion and disease prevention health care system is believed to be emerging (Baum & Law, 1998; Renwick et al., 1996; Stout, Atkins, & Hamann, 1989; Townsend, 1988). The traditional model of managing is seen as innately inadequate (Adamson et al., 1994, Carswell-Opsoomer, 1990). The World Health Organization urged member nations to work on public health and recognize the limitations inherent in traditional biomedical approaches to health care delivery (Adamson et al., 1994). The Pew Health Professions Commission (1993) listed numerous trends in the allied health professions as including a refocusing on health promotion, declining access to health care, and increasing costs of health care. The number of elderly and disabled accessing the health care system is increasing and expected to continue to increase in the future (Carswell-Opsoomer, 1990; Devereaux, 1991; Yerxa, 1994). This rising demand for health care services is exceeding the capacity of the traditional health care system, and the moneys designated to support the system (Carswell-Opsoomer, 1990; Hurff, Lowe, Ho, & Hoffman, 1990; Renwick et al, 1996). Devereaux (1991) cited the National Institute of Health as reporting “mortality is decreasing, while morbidity and disability are increasing. In all age groups, the prevalence of disability is increasing faster than population growth ... In terms of prevalence and cost, disability ranks as this Nation’s largest health problem (National Institutes of Health, 1990, p. 24)” (p. 944). Limitations of the traditional biomedical approach, increasing demands upon the health care system, and the increasing costs of providing traditional biomedical health care provided an incentive for change.
The United States government is took steps to reduce the impact of disability (Baum & Law, 1998; Bezold, 1989; United States Department of Health and Human Services, 1990). The United States Department of Health and Human Services created a report titled Healthy people 2000 as a road map for improving the health of all citizens. This report outlined a national agenda with the perspective of “the potential to prevent unnecessary disease and disability and to achieve a better quality of life for all Americans” (p.1). This built upon the health strategy initiated in Healthy people: the surgeon general’s report on health promotion and disease prevention. The ideas outlined were meant to reduce preventable death and disability, enhance quality of life, and reduce the health care disparities prevalent within American society. Health promotion and disability prevention programs are viewed by occupational therapists as the attainment of a level of health for every person which permits them to lead a life that is socially and economically productive (Cusick, 1990) “Ultimately, health promotion is helping people help themselves. Within health promotion, people identify their health needs, and utilize available tools/information to elicit change in their own lives.” (Finlayson, & Edwards, 1995, p 72)

Health promotion and disease prevention programs are considered an exceptional fit for occupational therapy (Pew Health Professions Commission, 1990; Rimmer, 1999; Strickland, 1991). Ideas from health promotion form an integral part of occupational therapy’s theory. The purpose of occupational therapy is to prevent disability and to promote, maintain or restore occupational performance, health and spiritual well being (Madill, et al., 1989; Yerxa, 1994). Occupational therapists must prevent the secondary effects of trauma, disease, or illness that might ultimately interfere with reaching independence (Baum, 1980). Baum and Law (1998) stated
"occupational therapy practitioners believe in the importance of balance between the areas of occupation ... to the achievement of physical, mental, spiritual, emotional, and social health. Community health initiatives are challenging us to operationalize these beliefs in practice” (p. 9). A philosophy that increases the focus on prevention and health promotion highlights occupational therapy’s orientation to productive living and the effects of the environment (Madill et al., 1989; Townsend, 1993; Yerxa, 1994). The emphasis on disability prevention and health promotion created several opportunities for occupational therapists to contribute to the health care system (White, 1986). Occupational therapists are well equipped to function within a health care system that de-emphasizes the biomedical model delivery of health services (Adamson et al., 1994; Shannon, 1985). Nelson (1997) made the bold statement “wellness pays. Nothing could be more positive for the profession of occupational therapy” (p 20).

Health promotion has created an impetus for occupational therapy to expand into community-based practice. White (1986) outlined the effect of this focus of wellness as leading the occupational therapy profession into five main areas including nontraditional community settings. Pew Health Professions Commission (1993) wrote

The best locations for wellness activities are those that are most accessible to the community needing the services: worksites, schools, and aging centers. Allied health professionals predominate in community-based settings and are key players in wellness and prevention. Their participation will only increase in the future by virtue of both the locations of their practices and the content of their skills. (p. 38)

Practicing in the community allows for providing health care to greater numbers of people through the use of community members and community resources (Berman, Gwatkin, & Burger, 1987). The new health paradigm will foster the development of
community partnership in which consumers, communities, and professionals collaborate to create strategies to manage health problems and prevent secondary disabling conditions. This approach requires the participation of communities in identifying problem areas, and creating solutions that will be successful (Baum & Law, 1997; Cusick, 1990; Finlayson & Edwards, 1995). For health promotion to succeed it must be supported by the community. The community must be involved in the decision making process and the implementation of programs (Finlayson & Edwards, 1995; Lysack, 1995).

Allied health professions in nontraditional settings are presented as viable substitutions for more expensive forms of medical and institutional care as a response to pressure for cost containment (Pew Health Professions Commission, 1993; Rimmer, 1999). Focusing on the long term health needs of individuals to improve their health and prevent disability will minimize the costs to the system of long term health care (Baum & Law, 1997; Finlayson & Edwards, 1995). Community-based practice also benefits the economy by returning individuals to work, providing investment opportunities, and creating new employment opportunities (Devereaux, 1991; Jacobs, 1985; Peat, 1991). A community-based approach to providing health care services is cost effective (Berman et al., 1987; Bowen, 1996; Chui, 1998). Providing health care services in the community can substantially decrease the costs to the public (Atchison, 1997; Stout et al., 1989). Congressional testimony reported in the document Medicare hearings on controlling costs and improving care: Hearings before the Subcommittee on Health of the Committee on Ways and Means revealed a 40% to 87.8% savings when home care was provided instead of hospital care (Atchison, 1997). Beech et al. (1999) performed a study comparing the economic consequences of early release to community-based rehabilitation as
compared to traditional hospital based rehabilitation. Beech et al. found that community-based rehabilitation achieved similar outcomes at lower costs. Chui (1998) argued a comprehensive rehabilitation program requires a hospital based program complemented by a community-based program for maximum cost-benefit.

Political Movements, Legislation, and Managed Care

Several political movements have created new roles for occupational therapists in community-based settings. Therapists are encouraged to provide treatment in the least restrictive environment. Therapists are seeing the disabled return to their communities in greater numbers (Tiara, 1985). The independent living movement is identified as encouraging occupational therapy practice in the community (Bowen, 1996; DeJong, 1993; Grady, 1995; Nelson, 1997). The disability rights movement is active in the incorporation of occupational therapy into community-based practice (DeJong, 1993; Grady, 1995; Townsend, 1993). Community-based rehabilitation programs drew occupational therapists into the community (Chui, 1998; Peat, 1990). These movements stressed the idea that disability arises from the failure of the social environment to adjust to the needs of people with disabilities rather than from the inability of persons with disability to adjust to the requirements of the society (Jongbloed & Crichton, 1990; Townsend, 1993). Working with this concept of disability, occupational therapists are encouraged to practice in the community (Devereaux, 1991; Grady, 1995; Townsend, 1993).

Federal legislation has created many occupational therapy positions in community-based settings (Grady, 1995; Tiara, 1985; Werner, 1998). Public Law (PL) 94-142, enacted in 1975, required that all children receive free and appropriate
educational services. PL 99-457, enacted in 1986, provided for early intervention
services. Both of these items of legislation name occupational therapy as a related
service to special education. The Individuals with Disabilities Education Act, enacted
in 1990, expanded and reinforced PL 94-142 and PL 99-457 (Grady, 1995; Werner
进一步 reinforced occupational therapy practice in the community. The ADA is
designed to assist with the removal of architectural, economic, and societal barriers
that currently restrict the involvement of disabled individuals in the community
(Devereaux, 1991; Grady, 1995; Yerxa, 1994). Compliance with federal legislation
has created a demand for occupational therapy practice in the community (Grady,
1995; Tiara, 1985).

Managed care has also served to direct occupational therapy practice into the
community (Adams, 1998; Grady, 1995; Rimmer, 1999). Managed care seeks to
control expenditures. Medicare payment systems shift the bulk of practice from
inpatient services to outpatient services in community-based settings. This has
resulted in the shortening of hospital stays and a general reduction of access to
rehabilitation (Chilton, 1996; Rimmer, 1999; Shannon, 1985; Tiara, 1985). Medicare
changes have already effected an increase in community-based practice (Atchison,
1997; Peat, 1991; Tiara, 1985). Revised Medicare guidelines encouraged the
expansion of occupational therapy in the home health care arena. Home health
agencies are expected to continue to grow (Atchison, 1997; Peat, 1991). Managed
care is expected to increasingly call upon the occupational therapy profession to
satisfy health care demands (Rimmer, 1999).
Trends in Occupational Therapy Workplace Settings

There is an international trend in occupational therapy showing a shift toward community-based practice (Beech et al., 1999; Strickland1991; Townsend, 1988). Within the profession of occupational therapy, community-based practice has existed since the 1920’s. West (1967) noted a shift of occupational therapists into community-based practice. Community-based practice expanded in the 60’s and 70’s with home health agencies and private practice (Vanier & Hebert, 1995). Devereaux (1991) found that in the 70’s and 80’s community settings showed the largest increase in employment of occupational therapists. Strickland (1991), while reviewing forty years of occupational therapy practice, noted that occupational therapy practice areas have significantly shifted from being primarily institutionally based, to being primarily community-based. McColl (1998) stated that 37% of occupational therapists are practicing in the community. This shift in setting is hypothesized to be the result of an increasing emphasis on health promotion and disease prevention, a changing health care system, and increasing economic constraints (Adams, 1998; Renwick et al., 1996; Vanier & Hebert, 1995).

The Importance of Community-Based Occupational Therapy

“Occupational therapists who provide service in real life environments are not only practical but are employing the most sophisticated form of intervention supported by neurobiology, evolutionary biology and anthropology” (Yerxa, 1994, p. 587-588). Occupational therapists possess knowledge of function that makes the profession a perfect fit for community-based practice (Finlayson & Edwards, 1995; Pew Health Professions Commission, 1993; Stancliff, 1996). Occupational therapy’s potential for facilitating healthy lifestyles and healthy communities should encourage
therapists to be active in communities at a personal and professional level (Cusick, 1990; Yerxa, 1994). Practicing in the community has numerous advantages in several different arenas. The transition to community living after illness or trauma is such a critical time in recovery that ensuring the presence of further therapy in the community is crucial (Baum, 1980; Chilton, 1996; Gage, Cook, & Fryday-Field, 1997). Community-based occupational therapy practice is an effective means of smoothing the transition back to community living from hospital settings (Chui, 1998). In addition, working in the community is more conducive for a holistic approach (Devereaux, 1991). Community-based practice also provides a means of tailoring each approach directly to the individual client (Stancliff, 1996). Community-based practice is more relevant for specific clients and more capable of providing motivation than institutional programs. Perhaps the most valid argument is that working in the community serves occupational therapy clients well (Adams, 1998; Stout et al., 1989; Yerxa, 1994).

Occupational therapy treatment must consider the community and culture of an individual (Morse, 1987; Townsend, 1993; Yerxa, 1994). Grady (1995) quoted Yankelovitch as saying community evokes the feeling that...

Here is where I belong – these are my people. I care for them, they care for me, I am part of them, I know what they expect from me, and I from them, they share my concerns. I know this place, I am on familiar ground. I am at home. (p.302)

A great challenge for practicing occupational therapists is to understand the unique culture and community of each individual (Grady, 1995; Pimintel & Ryan, 1996; Townsend, 1987). Working in the community is demanding. A standardized approach to treatment is eliminated since each community is unique in structure, priorities, and resources (Peat, 1991; Stancliff, 1996). This challenge is highlighted by the perception that occupation is determined by society and culture (Polatajko,
Ignoring the ethnic, religious or cultural values of a community risks leaving an individual unable to integrate into their own cultural group (Morse, 1987; Townsend, 1993). Occupation as treatment should be culturally based to best ensure its applicability to life outside of the treatment context. Morse (1987) observed that culture should be viewed as an organizing framework used to guide behavior and give meaning to daily activities. Culturally based activities can by used to reach treatment goals, to explore an individual’s cultural identity, and to involve the individual in the development of a program (DeMars, 1992; Morse, 1987). This ability to integrate culture into intervention is a unique and valuable aspect of occupational therapy (DeMars, 1992). DeJong (1993) viewed the relationship between individual and community as interdependent and reciprocal. Failure to uncover all of the skills an individual needs to participate in their community can leave them unable to survive economically or socially (Adams, 1998; Locher, 1957; Shannon, 1985). Community support must be made available for individuals to function in their communities (DeJong, 1993; Jongbloed & Crichton, 1990; Locher, 1957). Ultimately, failing to provide services within the community can defeat the purpose of therapy -- learning to live in the community (Peat, 1991).

Occupational therapy treatment must consider an individual’s environment (Finlayson & Edwards, 1995). The environment can have an effect upon health (Brownson, 1998; Cusick, 1990; Law, 1991; Townsend, 1987, 1993). To completely understand the effect of a disability, an individual cannot be considered outside the context of their environment (Baum & Law, 1997, 1998; Dressler & MacRae, 1998; Yerxa, 1994). An individual’s level of functioning is a dynamic interaction between the person, their environment, and their occupations (Finlayson & Edwards, 1995; Jongbloed & Crichton, 1990; Polatajko, 1994). Therefore, all components of the
environment must be considered to fully understand the individual’s abilities and potential (Carswell-Opzoomer, 1990; Finlayson & Edwards, 1995; Law, 1991). The environment is key to the functioning of an individual. It influences every aspect of daily living such as personal values, and reactions to stress (Finlayson & Edwards, 1995). Polatajko (1994) related a case study that highlighted the effect of the environment.

29-year-old Larry McAfee had a motorcycle accident that left him unable to walk, eat, or even breathe independently. After a year of intensive rehabilitation, out of finances, Larry was ... doomed to a life in a hospital bed where, he said, ‘I used to just lie there on my back, being just so bored’ (Schindehette & Wescott, 1993, p. 85). Two years later, ‘Broken in spirit after being warehoused in a series of institutions, McAfee fought for the legal right to shut off his life-sustaining respirator’ (Schindehette & Wescott, 1993, p.85). Larry McAfee won his case. However, he is alive and well and living in the first independent-care home in the state of Georgia. While engaged in his fight to die, he discovered that he had options other than boredom, that in an environment that enabled occupation he could have an active, meaningful life. But Larry McAfee warned, ‘If ever I have to return to an institution, then I prefer death’ (Schindehette & Wescott, p. 86). (p. 591)

Success of disabled individuals is dependent upon numerous qualities of the environment (Carswell-Opzoomer, 1990; Jongbloed & Crichton, 1990; Law, 1991). The importance of considering the environmental context should encourage occupational therapists to treat in an individual’s environment (Carswell-Opzoomer, 1990; Pollack & Stewart, 1998). Therapy needs to occur in a natural setting to be most effective for the individual (Chui, 1998; Pollack & Stewart, 1998). Abberley (1995) and Jongbloed and Crichton (1990) pointed out that occupational therapists’ failure to consider the effects of the environment upon the individual is a weakness of the profession. Abberley continued to say that occupational therapy practice
frequently removes individuals from their environment for treatment despite the recognition of the importance of the environment upon health.

The Effect of Community-Based Practice Upon the Occupational Therapy Profession

Expanding Health Care Teams

New concepts of disability, environmental effects, and the importance of community contribute to expanding health care teams. The health care team is expected to expand to include a variety of community members: (a) the disabled individual, (b) their caregivers, (c) architects, (d) engineers, (e) independent living counselors, (f) public health officials, (g) case managers, (h) recreation and exercise personnel, (i) city planners, (j) law enforcers, (k) school boards, and (l) transportation specialists (Baum & Law, 1997, 1998; Jongbloed & Crichton, 1990; Pollack & Stewart, 1998). This enhanced team includes those capable of accessing in-depth knowledge of community organizations (Baum & Law, 1997). Inclusion of these individuals in the health care team provides a more comprehensive view of the client, their environment, and their community. These individuals also offer a more effective and efficient means of enacting changes in the environment and community (Baum & Law, 1997). Participating in these teams is critical to practice in the community (Baum & Law, 1998; West, 1967).

Client Focused Treatment

The individual is recognized as the expert regarding their disability and the primary decision-maker regarding their treatment (Bowen, 1996; Dressler & MacRae, 1998). Individuals, their families, and caregivers are expected to participate in the decision-making processes of treatment, and the evaluation of care (Adams, 1998;
Therapists are encouraged to continually offer their client choices and foster collaboration with their clients (Bowen, 1996; Peat, 1991). Research has shown that allowing clients to make choices decreases costs, decreases treatment time, and increases client motivation in treatment (Bowen, 1996).

Involving clients in treatment reveals two other principles of client focused practice: (1) the therapist and the client are regarded as equals (Hurff et al., 1990; Jongbloed & Crichton, 1990; Townsend, 1993); and (2) therapists are now expected to incorporate goals and objectives specific to clients into treatment (Baum & Law, 1998; Dressler & MacRae, 1998). Clients are no longer viewed as passive recipients of service (Adamson et al., 1994; Hurff et al., 1990). An egalitarian partnership is easier to attain in a community setting than in a hospital setting (Jongbloed & Crichton, 1990). Additionally, therapists need to examine the needs and wants of clients, and find a means of providing them what they want the way they want it (Baum & Law, 1998; Chilton, 1996; Dressler & MacRae, 1998). Stancliff (1996) provided an excellent example of incorporating client goals and objectives specific to clients when she quoted a community-based occupational therapist describing her practice. “What’s really different about this is that it is a method of looking at each individual person and ... then developing the service or program as opposed to having a program that people get pigeon-holed into” (p. 15).

Changing the Environment

The definition of disability as an extension of environmental, societal, and community restraints places demands on the direction of occupational therapy treatment. Occupational therapists are expected to help communities to become more accepting of diversity and the disabled (Carswell-Opzoomer, 1990; Grady, 1995;
Jongbloed & Crichton, 1990). The occupational therapy profession is being called upon to remove social barriers preventing the disabled from participating in their communities (Dressler & MacRae, 1998; Jongbloed & Crichton, 1990; Yerxa, 1994). Addressing these societal barriers is hypothesized to facilitate the development of barrier free environments (Baum, 1980; Rimmer, 1999). Therapists also need to assist interaction between clients and their environment (Grady, 1995; Yerxa, 1994). This may be accomplished by altering the environment (Finlayson & Edwards, 1995; Jongbloed & Crichton, 1990; Rimmer, 1999). It has been noted that the most effective treatments are those that can be incorporated into daily routines. This is best accomplished by occupational therapists working in the environment to change the environment (Polatajko, 1994; Pollack & Stewart, 1998).

"Although occupational therapists are expertly skilled at evaluating the environment, either to find the best match or to alter it to allow the person to optimally function, we tend to focus instead on changing the person" (Bowen, 1996, p23). Despite understanding the importance of the environment, occupational therapists are not incorporating this concept into practice (Abberley, 1995; Bowen, 1996; Jongbloed & Crichton, 1990). Bowen (1996) notes that therapists are 12 times more likely to write goals that focus on changing the client rather than goals that address altering the environment. Occupational therapists are currently failing to focus on modifying the environment of the individual, and this failure is highlighted as a weakness in the profession (Abberley, 1995; Bowen, 1996; Jongbloed & Crichton, 1990).
Community-Based Roles

The shift to community-based practice has opened up new roles for occupational therapists. Occupational therapists are predicted to fill the role of administrator; relegating tasks to the least trained qualified individual (Berman et al., 1987; Chui, 1998; Strickland, 1991; West, 1967). Occupational therapists are viewed as resources for local government, community organizations, and individuals (Chui, 1998; Dressler & MacRae, 1998; Madill et al., 1989). Therapists also serve as mentors in group settings (Cusick, 1990; Dressler & MacRae, 1998). Another role for occupational therapists in the community is consultant (Hurff et al., 1990; King, Monical, Schlorff, Wallace, & Ebner, 1970; Pollack & Stewart, 1998). Therapists are expected to advocate for the rights of their clients (Cusick, 1990; Gage et al., 1997; Tiara, 1985). The role of advocate also urges therapists to advocate for healthy public policy (Carswell-Opzoomer, 1990; Jongbloed & Crichton, 1990). Therapists are filling the role of enabler of function (Finlayson & Edwards, 1995; Townsend, 1993). The need to be involved in networks creates the role of collaborator for occupational therapists in the community (Finlayson & Edwards, 1995; Teague et al., 1990; Townsend, 1988, 1993). The role of educator is becoming more prominent in community-based occupational therapy (Chui, 1998; Madill et al., 1989; Teague et al., 1990). The role of case manager has developed for occupational therapists in the community (Devereaux, 1991; Tiara, 1985; Strickland, 1991). In addition, occupational therapists are creating community-based programs specific to the needs of individual communities (Teague et al., 1990; Townsend, 1987; Vanier & Hebert, 1995). This particular role closely resembles that of an entrepreneur. Therapists are further encouraged to adopt the role of business administrator (Devereaux, 1991; King et al., 1970; Shannon, 1985). Lastly, community-based occupational therapy
practice places an emphasis upon the need of therapists to adopt the role of researcher to enhance the knowledge base behind their practice (McColl, 1998; Nelson, 1997; West, 1967).

Community-Based Skills and Expertise

The changes in the health care system as well as the novel roles and the contemporary approaches to treatment developing in this setting require that community-based occupational therapists acquire new skills. The skills identified by literature may be roughly partitioned into two categories: (1) skills that facilitate practice in the emerging health care system, and (2) skills that facilitate practice in the community.

A review of literature shows several skills seen as essential to occupational therapy practice within the confines of the evolving health care system. Participating in the developing health care system demands that therapists accommodate increasing accountability. Ensuring cost-effective care is also a skill required for participation in the emerging health care system (Chui, 1998; Hurff et al., 1990; Pew Health Professions Commission, 1993). Therapists need to develop the skills of practicing prevention and promoting healthy lifestyles. Another skill for therapists in this environment is to effectively involve the patients and their families in the decision-making process (Finlayson & Edwards, 1995; Pew Health Professions Commission, 1993; Werner, 1998). Therapists must also be proficient at enabling function to practice within the prevailing attitude regarding health (Madill et al., 1985; Vanier & Hebert, 1995). These skills support the conclusion that working within the emerging health care system places many demands upon the occupational therapy profession.
Practicing occupational therapy in the community is revealed by literature as requiring novel skills. Community settings are supported, maintained, and developed by therapists who are skilled at supporting, maintaining, and developing strong networks (Hurff et al., 1990; Madill et al., 1989; Townsend, 1987). Therapists must be able to understand how community organizations organize themselves, and how they are governed. Therapists also need to develop the skill of locating resources to support their programs (McColl, 1998; Townsend, 1987; Werner, 1998). The community-based setting for practice is more accessible to therapists capable of writing grants (Dressler & MacRae, 1998). The development of community-based programs requires that occupational therapists become adept at business skills (King et al., 1970; Shannon, 1985). In addition, the skill of advocating is necessary to integrate health promotion into community settings. Therapists must demonstrate competence at mediating to succeed in community-based practice (Madill et al., 1985; Vanier & Hebert, 1995). Consultative skills are particularly important to practice in the community (Baum & Law, 1998; Finlayson & Edwards, 1995; Hurff et al., 1990). Communication and interpersonal skills are emphasized as vital to practice in the community for effective interaction on health care teams and maintaining client involvement (Adamson et al., 1994; Shannon, 1985). The breadth of these findings support the uniqueness of community-based practice.

The Education of Community-Based Practitioners

Community-based practice uses specialized knowledge that must be included in educational curricula (McColl, 1998; Shannon, 1985). Pimentel and Ryan (1996) listed areas that community-based occupational therapists would like to learn more about; (a) the environment, (b) appropriate functional activities, and (c) dealing with
challenging behavior. Business knowledge such as administration and economics are suggested to be important in a professional curriculum. A general background of political science would benefit therapists in this setting. Occupational therapists working in the community need to be prepared to function in different organizational settings. In this setting, therapists also need to be able to work effectively as part of health care teams (Shannon, 1985). There is also evidence that the clinical reasoning of community-based occupational therapists is unique, and deserves emphasis in an educational curriculum (Munroe, 1996). Society is becoming increasingly technological, and highlights a need for a computer science background for therapists (Devereaux, 1991; Shannon, 1985).

Practicing in the changing health care system demands acknowledgment by educational programs (Bezold, 1989; Pew Health Professions Commission, 1993). Viewing disability as a function of the environment requires that therapists be prepared to analyze and facilitate function within the environment (Bowen, 1996). Education of occupational therapists needs to accentuate the importance of an individual’s culture (Morse, 1987). Education is a possible strategy for communicating to the government, communities, and individuals the many contributions occupational therapists can make in this setting (Townsend, 1988). The changing health care system, and the ramifications of these changes on the profession demands that educational programs focus on research training (Shannon, 1985). Health profession educators need to address relevant competencies to keep up to date with the needs of American health care and the changing health care system (Bezold, 1989; Pew Health Professions Commission, 1993).
METHOD

Instrumentation

This study built upon the research of Lysack et al. (1995). The findings of the Community Practice Project (CPP) were presented by Lysack et al. The CPP survey instrument was originally developed by fourth year occupational therapy and physical therapy students at Queen’s University in Kingston, Canada. Lysack et al. made revisions to the CPP survey. An instrument expert critiqued the final result. A revised form of the CPP survey was used in this study. Changes were made to reflect the population to be studied, the United States health care system, and the use of the English language in the United States. These changes were subject to review by an author of the original study, and a face validity study. The author of the original study felt that the changes made would not alter the intent of the study. Community-based occupational therapists that participated in the face validity made recommendations to increase the clarity of questions, and provided an estimate of the time needed to complete the survey. Recommended alterations received from the face validity were incorporated into the survey. The revised survey consists of 27 items including forced choice and open-ended descriptive questions to provide both qualitative and quantitative information.

Subjects

Two hundred therapists practicing in community-based settings were randomly selected to receive the survey. The AOTA registries provided lists of registered therapists practicing in Michigan, Illinois, and Indiana in various settings.
Community-based practice was defined as practice where the site of intervention is in the community. Appropriate sites were identified per Moyers (1999). Home and community settings for practice include the following: home care, halfway houses, group homes, assisted living, sheltered workshops, industry and business, schools, early intervention centers, day care centers, community mental health centers, hospice, and wellness and fitness centers. Two hundred therapists who met the inclusion criteria were randomly selected as subjects for this study.

Analysis

The data gathered was analyzed dependent upon the question type. Responses to forced choice questions were entered into a computer spreadsheet program. These results were analyzed with frequency tables. These percentages were used to indicate general trends, general areas of professional expertise, and other similar quantitative aspects of the study. Statistical tests were completed to determine if there were significant differences between groups. Qualitative data was analyzed for trends, and used to support quantitative data.
RESULTS

Of the 200 surveys mailed to community-based therapists, 84 were returned. This is a response rate of 42%. While this response rate is not considered excellent it is considered adequate (Babbie, 1999). Not all of the respondents provided answers to every question. Thus, the total number of responses varies from question to question. Of the respondents, 77.6% responded to all forced choice, quantitative questions. At least one open-ended question was answered by 85.5% of respondents.

Profile of Respondents

The data gathered supplied a profile of the typical respondent. Table 1 provides an overview of the respondents to this survey, and those that responded to the Lysack et al. (1995) study with respect to gender, age and education. Degrees in subjects other than occupational therapy were reported by 34% of respondents. Of the respondents, 98.8% were currently employed. Of the respondents, 67% reported working in one community-based position. Of the respondents, 27% reported working in two community-based positions. Of the respondents, 43% have held their primary job for less than five years. Of the respondents, 70% have held their second job for less than five years.

Table 2 compares the Lysack et al respondents to the respondents of this study regarding their primary job setting, caseload, job roles and their employers’ occupation. Self-employment was reported by 21.3% of respondents. A significant amount of respondents receive referrals from family physicians, 53.7%, and other physicians, 43.9%. There were several other referral sources of interest: (a) other
Table 1
A Percentage Comparison of Respondent Profiles

<table>
<thead>
<tr>
<th>Category</th>
<th>Lysack at al</th>
<th>Present Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>99</td>
<td>97.5</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>2.5</td>
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<table>
<thead>
<tr>
<th>Age</th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>20-29</td>
<td>21</td>
<td>13.3</td>
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<tr>
<td>30-39</td>
<td>44</td>
<td>14.5</td>
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<tr>
<td>40-49</td>
<td>23</td>
<td>49.4</td>
</tr>
<tr>
<td>50+</td>
<td>12</td>
<td>22.9</td>
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</table>

<table>
<thead>
<tr>
<th>Education</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Certificate in OT</td>
<td>-</td>
<td>2.4</td>
</tr>
<tr>
<td>Bachelors Degree</td>
<td>66</td>
<td>47.6</td>
</tr>
<tr>
<td>Masters Degree</td>
<td>10</td>
<td>47.6</td>
</tr>
<tr>
<td>Doctorate</td>
<td>2</td>
<td>2.4</td>
</tr>
</tbody>
</table>
health professionals, 61%; (b) physical therapists, 51.2%; (c) occupational therapists, 35.4%; and (d) school staff including administrators, and teachers, 38%. The greatest primary source of income indicated was salary, 80.5%. Direct billing, 6%, and Medicare, 4.9%, were the next greatest reported sources of income.

Table 2

<table>
<thead>
<tr>
<th>Category</th>
<th>Lysack et al</th>
<th>Present Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>School/School Board</td>
<td>16</td>
<td>59</td>
</tr>
<tr>
<td>Community/Home</td>
<td>48</td>
<td>21.7</td>
</tr>
<tr>
<td>Psychiatric Hospital</td>
<td>9</td>
<td>1.2</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Caseload</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric</td>
<td>20</td>
<td>68</td>
</tr>
<tr>
<td>Adolescent</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Adult</td>
<td>31</td>
<td>14.6</td>
</tr>
<tr>
<td>Geriatric</td>
<td>12</td>
<td>6.6</td>
</tr>
<tr>
<td>Mixed</td>
<td>33</td>
<td>9.3</td>
</tr>
</tbody>
</table>
Table 2 -Continued

<table>
<thead>
<tr>
<th>Category</th>
<th>Lysack et al</th>
<th>Present Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician</td>
<td>75</td>
<td>90.4</td>
</tr>
<tr>
<td>Consultant, Educator</td>
<td>85</td>
<td>74.7</td>
</tr>
<tr>
<td>Administrator, Manager</td>
<td>30</td>
<td>13</td>
</tr>
<tr>
<td>School Board/Teacher</td>
<td>-</td>
<td>39.6</td>
</tr>
<tr>
<td>Health Care Administrator</td>
<td>45</td>
<td>15.7</td>
</tr>
<tr>
<td>Government Administrator</td>
<td>-</td>
<td>12.9</td>
</tr>
<tr>
<td>OT</td>
<td>17</td>
<td>10</td>
</tr>
</tbody>
</table>

Job Skills Necessary for Community-Based Practice

There were several job skills identified as necessary for practice in the community. Job skills are defined as those behavioral activities that new graduates are expected to be able to perform (Lysack et al, 1995). Respondents indicated whether their education had prepared them for specific job skills. Job skills identified as necessary include: (a) patient assessment, (b) written communication, (c) verbal communication, (d) charting, consulting, (e) staff education and in-services, and (f)
networking. Table 3 considers the percentages of respondents who were prepared to use a skill, use a skill, and those who used a skill and did not feel prepared for its implementation. Table 4 lists areas of continued education and specialized techniques recommended for community-based practice.

Table 3
Percentage Use and Preparation for Job Skills

<table>
<thead>
<tr>
<th>Job Skill</th>
<th>Prepared For Use</th>
<th>Skill Used</th>
<th>Used, Not Prepared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Assessment</td>
<td>66.3</td>
<td>100</td>
<td>33.7</td>
</tr>
<tr>
<td>Written Communication</td>
<td>55.4</td>
<td>100</td>
<td>45.6</td>
</tr>
<tr>
<td>Verbal Communication</td>
<td>49.4</td>
<td>97.6</td>
<td>49.4</td>
</tr>
<tr>
<td>Charting</td>
<td>62.7</td>
<td>86.7</td>
<td>33.3</td>
</tr>
<tr>
<td>Consulting</td>
<td>16.9</td>
<td>86.7</td>
<td>83.5</td>
</tr>
<tr>
<td>Staff Education/In-services</td>
<td>31.3</td>
<td>85.5</td>
<td>-</td>
</tr>
<tr>
<td>Networking</td>
<td>20.5</td>
<td>72.3</td>
<td>76.7</td>
</tr>
</tbody>
</table>
Table 4
Recommended Continued Education for Community-Based Practice

<table>
<thead>
<tr>
<th>Educational Area</th>
<th>Percent Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory Integration</td>
<td>39</td>
</tr>
<tr>
<td>Oral-Motor Issues</td>
<td>20</td>
</tr>
<tr>
<td>Neurodevelopmental Treatment</td>
<td>19</td>
</tr>
</tbody>
</table>

Areas of Professional Expertise

Respondents identified several areas of professional expertise utilized in community-based practice. Professional expertise was defined as high level professional functioning acquired after knowledge and attitudes have developed with occupational therapy experience in the field (Lysack et al, 1995). It was also indicated whether they felt prepared to implement this expertise. Areas of expertise used in this setting include: (a) self-directed learning, (b) clinical reasoning, (c) client-centered approach to practice, (d) community resources, (e) advocacy, and (f)
multicultural practice. Table 5 addresses the percentage of respondents who felt prepared in an area, those that used an area, and those that used the area and did not feel prepared.

Table 5

Percentage of Use and Preparation for Areas of Expertise

<table>
<thead>
<tr>
<th>Area of Expertise</th>
<th>Prepared For Use</th>
<th>Skill Used</th>
<th>Used, Not Prepared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Directed Learning</td>
<td>40</td>
<td>92.5</td>
<td>60.8</td>
</tr>
<tr>
<td>Clinical Reasoning</td>
<td>66.3</td>
<td>86.3</td>
<td>34.8</td>
</tr>
<tr>
<td>Client-Centered Approach to Practice</td>
<td>45</td>
<td>85</td>
<td>48.5</td>
</tr>
<tr>
<td>Community Resources</td>
<td>26.3</td>
<td>71.3</td>
<td>71.9</td>
</tr>
</tbody>
</table>
DISCUSSION

Job Roles of Community-Based Occupational Therapists

This study uncovered several significant aspects of job roles. The most common job roles were identified. Concerns about the clarity of job roles also surfaced. The implications of these concerns on the profession must be considered.

The results of this survey indicated that community-based occupational therapists frequently fill the role of clinician, and consultant/educator. Lysack et al (1995) found the most common roles to be consultant/educator, and clinician in that order. The role of consultant has been extensively discussed in literature (Hurff et al., 1990; Pollack & Stewart, 1998). The role of educator is emerging in literature as important for community-based practice (Chui, 1998; Madill et al., 1989; Teague et al., 1990). Therapists in the community are increasingly working closely with people outside the occupational therapy profession. Only 10% of respondents reported that they were employed by occupational therapists. Therapists are required to educate not only their clients, but also the health care team they are working with about occupational therapy. This necessity makes it more important that therapists have a clear understanding of what occupational therapy is and its role in treatment.

The changing health care system is demanding that allied health professionals clearly define what they will offer to clients (Bezold, 1989; Pew Health Professions Commission, 1993). Many respondents voiced concern that the role of occupational therapists in the community is determined by the therapists’ interests, strengths, and understanding of occupational therapy. A respondent emphasized that a therapist considering this practice area needs “a clear idea how their OT skills are being used
so that they are not doing someone else's job in the name of OT.” Another respondent felt this was important because “there is a lot of blurring of roles that can be difficult for your inexperienced therapists.” The potential for the blurring of job roles is considered quite high. This lack of clarity could be a significant weakness in the occupational therapy profession. If occupational therapists are unsure of their roles, they cannot clearly define their contribution to health care. Occupational therapy needs to define its role as unique and necessary (Baum & Laum, 1997; 1998; Devereaux, 1881; Pew Health Professions Commission, 1993). Impressing upon occupational therapy students the role of occupational therapy in treatment settings could be a valuable first step toward meeting this need.

Skills and Expertise of Community-Based Occupational Therapists

The skills and expertise identified by respondents can be grouped into three categories: (1) interpersonal skills, (2) clinical skills, and (3) community specific skills.

Respondents stressed the importance of interpersonal skills. A majority of respondents identified four skills and areas as necessary for community-based practice: (1) written and verbal communication, (2) consulting, (3) staff education/inservices, and (4) advocacy were used by a majority of respondents. This category corresponds well with the job roles identified. Working as a consultant requires that a therapist be able to communicate their expertise to communities for execution. Working as an educator similarly emphasizes the importance of coherent communication. Many therapists in the community teach methods of carrying out intervention to whoever may be present to implement a program. For skills so
commonly used, it is disastrous that only around half of therapists using this skill felt prepared for its implementation.

Respondents also indicated a strong need for clinical skills. More than half of respondents identified seven skills and areas of expertise as necessary for practice: (1) patient assessment; (2) charting; (3) self directed learning; (4) clinical reasoning; (5) client-centered approach to practice; (6) professional issues; (7) and use of treatment modalities. A clear understanding of these basic skills would serve to cement an idea of occupational therapy in the minds of new therapists. This is particularly important considering that community-based therapists frequently work independently. While the educational system is addressing these needs, there is always room for improvement. One respondent related her experience with a self-directed learning curriculum.

I was well prepared in my education. But what was really taught was the ‘seek and ye shall find’ curriculum. So instead of ‘holding our hands’ and listening to students whine and complain, the ‘seek and ye shall find’ was done. We were expected to find out [information] not just have it spooned into our brains. Now true we (all of us) were angry cause the instructors would [not] hold our hands, but we were better prepared for the complexities of OT, then and now, because we knew how to move along without handholding.

Clinical reasoning can be taught (Neistadt, 1992). There is also evidence that the clinical reasoning used by therapists in the community may be unique (Munroe, 1996). This uniqueness suggests it might merit attention within an educational curriculum. A client-centered approach to treatment implies that the person and their environment and community are being addressed (Brownson, 1998; Grady, 1995; Stancliff, 1996). Centering treatment on the client defines success as the client achieving goals they are interested in (Stancliff, 1996). Centering treatment on the client also implies that any lack of compliance can be interpreted as failure of the
therapist to address the individual’s desires and interests (Bowen, 1996; Dressler & MacRae, 1998). Abberley (1995) noted that therapists allowing the individual to be the primary decision-maker incorrectly attribute failure in treatment to the individual’s lack of motivation, the lack of support within the health care system, and various other areas. This error suggests a professional failure where occupational therapists are not successfully implementing the principles that center treatment on the client (Abberley, 1995).

A final area of expertise includes community specific skills. A majority of respondents indicated that these six skills and expertise were important for community-based practice: (1) networking, (2) community resources, (3) management of volunteers, (4) program evaluation, (5) health promotion/disease prevention and (6) multicultural practice issues. Knowledge in these areas can serve to tailor a program to the needs of a community. Understanding the community resources available, and having the networking abilities to recruit assistance should facilitate agreement between a community’s needs and resources and the implementation of community-based programs. Beyond requiring the presence of occupational therapists in the community, health promotion and disease prevention programs require the participation of the community. Program creation and evaluation should be structured to keep the community involved.

Lysack et al (1995) identified four areas of skills and expertise as important to community practice. The first area was client-centered practice with an internal area of multiculturalism. The second area was clinical reasoning and self-directed learning. The third area was knowledge of community resources and advocacy. The final area of expertise was specialized knowledge such as health promotion. While
the grouping of components was done differently between studies, the skills and areas of expertise identified were similar.

Group Effects on Skills and Areas of Expertise Identification

The profile of respondents shows two potential groupings: (1) bachelors and masters degrees as highest level of education; (2) school occupational therapists, and those working outside of the school. The number of respondents whose highest educational level was a bachelors degree was equal to the number of respondents whose highest educational level was a masters degree. There were no significant differences between these two groups ($p=.05$). A little more than half of respondents primarily worked in a school or for a school board. The responses of school based therapists were significantly different from the responses of therapists working in other locations. School therapists reported using different skills ($p=.004$). Therapists in the school differed on the skills they felt prepared to use ($p=.05$). These therapists differed on the areas of expertise they used in practice ($p=.10$). It is possible that these therapists altered the results of the study.

Education Issues

Townsend (1988) stated that education on community-based practice is the core factor in preparing occupational therapists for community contributions. Pimentel and Ryan (1996) found that none of their subjects felt that community-based practice had been covered adequately in college. Lysack et al. (1995) identified a need for better preparation for community-based practice. Lysack et al. indicated that 85% of community-based therapists felt that continued education was necessary to
meet the needs of their position. Of respondents to this study 91% felt that continuing education was necessary for practice in this area.

There were several skills and areas of professional expertise identified as necessary for practice that therapists were not prepared for through their formal education. Respondents to this survey were concerned about a lack of preparation for the following skills: (a) consulting, (b) networking, (c) staff education/in-services, (d) verbal communication and (e) written communication. A respondent identified the skills of peer collaboration, and networking as necessary to counteract “the professional isolation that tends to occur in home health/community settings.” Respondents to Lysack et al (1995) identified several skills as not sufficiently covered in their formal education: (a) networking, (b) consulting, (c) staff education/in-services, (d) administration, (e) patient education teaching and (e) individual counseling. Respondents to this survey identified these areas of professional expertise as not adequately covered in their formal education: (a) community resources, (b) self-directed learning, (c) client-centered approach to practice and (d) advocacy. Lysack et al. respondents also identified areas of expertise as not satisfactorily covered in their formal education: (a) community resources, (b) advocacy, (c) multicultural practice issues, (d) health care legislation, (e) program evaluation, (f) self-directed learning, (f) disease prevention and (g) community development.

Respondents also had many ideas for improvements in educational programs. Therapists were interested in having more focus on treatment issues. One respondent wanted therapists to remember that “[w]orking in the community and especially in homes is ‘the real world’ sometimes hospital/clinic therapists are very unrealistic in their recommendations and treatment approaches.” Another respondent further urged
therapists to have “[r]ealistic expectations of treatment, considering time and material limitations.” A respondent reported that community-based practice runs into problems “related to lack of community resources ie. housing, personal assistant services, transportation to areas outside of city limits, etc. as well as lack of health care coverage for services, meds, equipment.” Therapists feel that third party payers are restricting practice in this area. “I feel that the current model for service delivery compromises the quality of service. I would love to reduce our dependence on third party payers and deliver OT services in affordable groups or at cost.” An aspect many therapists wanted addressed in educational programs was dealing with large volumes of paperwork. “One actually must choose if they will excel as a clinician or as an administrator who gets all documentation completed on a timely basis” stated one respondent. Another issue addressed was the need for more hands on training. Other respondents felt that they were not prepared to work with assistants, and did not know how to supervise them. The difference between medical and non-medical settings was also an area mentioned needing more attention. A final concern was the need to understand the roles of other professionals.

Education of occupational therapists must reflect these needs within community-based practice. The traditional education of heath care professionals is appropriate for the roles and responsibilities that will be encountered in traditional health care (Bowen, 1996; Peat, 1991). McColl (1998) stated that occupational therapists need to be prepared to work within the confines and expectations of community-based practice. Peat (1991) stated that “[h]ealth professionals must receive special training on professional roles appropriate for community programmes [sic]” (p 232). Realizing what beginning therapists are not adequately prepared for could be the first step to providing complete educational programs.
Fieldwork Suggestions

Several issues were raised concerning fieldwork. With the increased interest in community-based practice, more therapists are being contacted to provide fieldwork experiences. These opportunities are frequently economically and logistically unfeasible. However, therapists in this area did not encourage the development of fieldwork in community-based settings. One respondent stated that “a student must have core treatment experiences in traditional settings, eg acute or rehab hospitals before venturing out into often unstructured treatment settings.” Another respondent felt that “students would really benefit from more exposure to real-world OT practices. Perhaps with brief observations, or even on videotape” instead of fieldwork placements. Therapists also suggest that the area is so specialized that training can only be received “on the job.”

Research Issues

The need for community-based therapist to adopt the role of researcher has been greatly emphasized in literature (McColl, 1998; Nelson, 1997; West, 1967). However, this research indicated that only 2.3% of respondents fill the role of researcher. Further, 13.3% of respondents reported they used the skills of a researcher while 50.6% reported that these skills were not relevant. For occupational therapy to succeed in community-based practice, therapists must produce evidence that treatment is effective (Baum & Law, 1997; Bezold, 1989; Devereaux, 1991; Pew Health Professions Commission, 1993). Research showing the effectiveness of treatment is important to the profession. It provides strength to our knowledge base. It is the support for treatment. Research on effectiveness also sends a message to all allied health professions about the value of occupational therapy intervention (Bezold,
1989; Grady, 1987). Respondents were cognizant of the need for more awareness of the occupational therapy profession to “increase physician referral for appropriate clients.” Several respondents noted that occupational therapy needed to be promoted as a viable profession in this setting, but did not suggest methods for accomplishing this.

Limitations

This study has several limitations which include (a) the lack of a second mailing, (b) a purposive sampling area, (c) a focus on educational preparation for community-based practice and (d) the survey instrument used.

This research project did not include a mechanism for a second mailing. Had this step been included, it is possible a higher response rate could have been achieved. A higher response rate would give the data collected more credibility as representing the thoughts of community-based therapists.

The therapists selected for this survey were from specific states. The intent was to gather in depth information on how occupational therapy was used in this region. Due to this narrow geographic area, the responses cannot be generalized to all community-based therapists practicing in the United States.

The focus of the CPP survey was on the link between job skills, professional expertise, and educational preparation (Lysack et al., 1995). This focus has inherent assumptions that must be considered. The ability of professional occupational therapy curricula to address the needs of respondents must be considered. Respondents recognized this limitation as one respondent stated “there was little training in home care, but I don’t think it would have helped because it is an area that
is dependent upon experience.” The market demand for community-based occupational therapists must also be considered.

A final limitation concerns the formation and structure of the survey. The CPP survey was developed in 1991 and 1992 with a perspective that was current for that time (Lysack et al., 1995). As Lysack et al. state, the area of practice has become much more dynamic since then. Another limitation is that this survey was developed for use in Canada for comparison with Canadian educational criteria and curricula. Health care in Canada follows a socialist medicine model where as in the United States health care is considered as an industry with profit margins and cost saving measures. Despite efforts to compensate for these differences, the survey was not clear. Several respondents avoided answering questions noting that they did not understand what the question was asking. A final limitation with the survey is that several questions were not included. The survey did not separate therapist with an entry level masters’ degree from therapists with an advanced masters’ degree. The survey failed to identify the occupational therapy programs respondents graduated from. The survey also failed to identify the year that therapists graduated from their occupational therapy program.

Conclusions

The aim of this research was to identify job roles, job skills, and professional expertise in community-based practice. It was also interested in assessing the educational preparation of therapists for practice in this area. A final aim was the identification of international similarities comparing the Canadian respondents to Lysack et al (1995) and the American respondents to this study. The findings of this
study have satisfied these expectations. This study also uncovered areas where therapists seeking to practice in this area should seek out experiences.

This study provided much information. The study developed a profile of the typical respondent, their job roles, skills, and areas of professional expertise. There were two significant findings of this study regarding job roles. The first is the large potential for blurring professional roles. The second is the tendency for job roles to conform to the interests and expertise of a particular therapist. Significant findings of this study regarding job skills were that networking, consulting, and communication skills were areas that are not adequately addressed in curricula. Significant findings of this study regarding professional expertise were that community resources, self directed learning, and client centered approach to practice were areas that need more attention in curricula. The results of this survey are quite similar to the results of the Lysack et al (1995) study. Therapists interested in working in this area should seek out specific experiences. One such experience would be fieldwork in a strong traditional setting. Another would be to pursue courses in Sensory Integration.

In general, respondents were very positive about working in community-based settings. An underlying aspect was the effect of changes in the health care system on community-based practice. One respondent noted “I loved my job with community mental health before privatization. Since then the volume of work has increased to impossible (over 100 clients) and the emphasis has switched from quality of life and care of the client to money and ‘billable services’.”
Appendix A

Protocol Clearance From the Human Subjects Institutional Review Board
Date: 15 December 1999

To: Stanley Paul, Principal Investigator
    Lori Lemorie, Student Investigator for thesis

From: Sylvia Culp, Chair

Re: HSIRB Project Number 99-11-19

This letter will serve as confirmation that your research project entitled "Professional Expertise of Community-Based Occupational Therapists" has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: 15 December 2000
Appendix B

Community Therapist Survey
COMMUNITY THERAPIST SURVEY

SECTION A

The following five questions are about your background and education.

1. Sex: 
   - Female ___
   - Male ___

2. Age: 
   - 20-24 ___
   - 25-29 ___
   - 30-39 ___
   - 40-49 ___
   - 50-59 ___
   - 60+ ___

3. Please indicate your highest educational qualification completed or in progress:
   - Certificate in OT or non OT Diploma
   - Diploma in OT
   - Bachelors in OT
   - Bachelors in OT, (degree completion)
   - Masters
   - Doctorate
   - Other ____________________________

4. Please state the year of graduation from your highest educational qualification: ____

5. Please list any other degrees or post-graduate education you have and include any degrees in progress.

   ________________________________
   ________________________________
   ________________________________

6. A. Are you presently employed? ___ Yes ___ No

   B. If you are not presently employed, would you like to be working in the community at this time?
      ___ Yes ___ No
C. If yes, please indicate why you are not presently working:

   ___ no job available
   ___ requires driving a vehicle
   ___ do not feel you possess the necessary skill/training
   ___ personal circumstances
   ___ other

7. What is the approximate population of the city in which you work?

   ___ less than 5,000
   ___ 5,000 - 10,000
   ___ 10,000 - 50,000
   ___ 50,000 - 100,000
   ___ 100,000 - 500,000
   ___ 500,000 - 1,000,000 (Indianapolis)
   ___ 1,000,000 - 2,000,000 (Detroit)
   ___ more than 2,000,000 (Chicago)

** FOR QUESTIONS #8 THROUGH #15, PLEASE CONSIDER ALL OF YOUR PRESENT FULL-TIME AND PART-TIME OCCUPATIONS RELATED TO COMMUNITY-BASED PRACTICE. **

8. Please state your present job title(s), the number of hours you spend each week at each job, and how many years you have held each position:

<table>
<thead>
<tr>
<th>Job Title:</th>
<th>Hours/Week:</th>
<th>Years in Position:</th>
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<tbody>
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</table>


9. Please identify your principle role(s) at your job(s). (Check all items applicable to you.)
   _Clinician
   _Administrator
   _Educator
   _Researcher
   _Consultant
   _Trainer
   _Manager
   _Other __________________________

10. Please check off the job locations in which you spend the most time. (If you have only one job, please check only one job location. If you have more than one job, please rank the three job locations in which you spent the most time.)

   NB: I = most time spent 2 = second most time spent 3 = third most time spent

   __general hospital
   __rehabilitation center
   __pediatric-hospital
   __school/school board
   __community/home
   __daycare center,
   __insurance company
   __retail/business
   __military base
   __specialized institution
   (e.g. visually impaired)
   __private hospital
   __psychiatric hospital
   __private clinic
   __industry
   __research laboratory
   __post-secondary institution
   __government agency
   __professional association
   __athletic facility
   __other __________________________

11. How did you acquire your job? (Check all that apply to you.)

   __advertisement
   __personal contact
   __other __________________________
   __word of mouth
   __agency

12. Are you self-employed? __ Yes __ No
13. If you are not self-employed, what is your employer’s occupation?

___ physical therapist
___ occupational therapist
___ physician
___ teacher/principal
___ coach
___ government administrator
___ health care administrator
___ other

14. From whom do you receive referrals? (Check all that apply to you.)

___ physical therapists
___ occupational therapists
___ other health professionals
___ self-referral
___ family physicians
___ other physicians
___ insurance companies
___ other

15. What is the source of your income? (Please rank the top three sources of income that apply to you.)

NB: I = greatest source of income 2 = second greatest source 3 = third greatest source

___ salary
___ Medicare
___ worker's compensation
___ Medicaid
___ direct billing
___ insurance company
___ other

SECTION B:

** IF YOU HAVE MORE THAN ONE JOB, PLEASE ANSWER ALL REMAINING QUESTIONS ACCORDING TO YOUR CURRENT JOB THAT IS MOST COMMUNITY-BASED.

For questions #16 to #20, please use the following scale:

Strongly agree  Agree  No Opinion  Disagree  Strongly Disagree
1 2 3 4 5

16. During your training, you were aware that the job which you presently hold was a career option.

1 2 3 4 5

17. There are opportunities for growth and promotion in your job.

1 2 3 4 5
18. You are satisfied with your current job.

_1  _2  _3  _4  _5

19. You feel that your formal OT training prepared you for your present job.

_1  _2  _3  _4  _5

20. It has been necessary to take continuing-education courses or other training to meet the needs of your present job.

_1  _2  _3  _4  _5

21. Please list any additional areas of education or training courses after your basic degree which you believe are necessary for your present job.

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

22. Please list any further education or training courses which you have taken to assist you in working in the community.

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
23. Please indicate the one category which best describes your client age group.

- [ ] pediatric
- [ ] adult
- [ ] adolescent
- [ ] geriatric

24. In the following areas of professional expertise:

   a) areas of expertise you **currently use**
   b) areas of expertise your formal OT/PT training **prepared you for**
   c) areas of expertise **not relevant** for your job

<table>
<thead>
<tr>
<th>Area of Expertise</th>
<th>Expertise Used</th>
<th>Prepared For</th>
<th>Expertise Not Relevant</th>
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</thead>
<tbody>
<tr>
<td>Health promotion/disease prevention</td>
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<tr>
<td>Community development</td>
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<td>Clinical reasoning</td>
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<tr>
<td>Self-directed learning</td>
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<td>Private practice</td>
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<td>Client-centered approach to practice</td>
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<tr>
<td>Health care legislation</td>
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<tr>
<td>Community resources</td>
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<tr>
<td>Health care systems organization</td>
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<tr>
<td>Illness experience</td>
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<td>Advocacy</td>
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<td>Program evaluation</td>
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<td>Professional issues</td>
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<tr>
<td>Multicultural practice issues</td>
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</table>
25. In the following list of job skills, please check:

a) job skills you currently use
b) job skills your formal OT training prepared you for
c) job skills not relevant for your job

<table>
<thead>
<tr>
<th>Skills</th>
<th>Skills Used</th>
<th>Prepared For</th>
<th>Skills Not Relevant</th>
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<tbody>
<tr>
<td>Patient assessment</td>
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<tr>
<td>Charting</td>
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<td>Use of treatment modalities</td>
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<td>Exercise prescription</td>
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<tr>
<td>Patient education/teaching</td>
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<td>Staff education/inservices</td>
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<td>Consulting</td>
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<td>Administration</td>
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<td>Personnel management</td>
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<td>Financial management</td>
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<td>Management of volunteers</td>
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<td>Verbal communication</td>
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<td>Written communication</td>
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<td>Networking</td>
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<td>Sales/promotion</td>
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<td>Individual counseling</td>
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<td>Group counseling</td>
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<tr>
<td>Medical/Legal assessment</td>
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<td>Research</td>
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<td>Specialized techniques (e.g., sensory integration, relaxation therapy, etc.)</td>
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<td>Please list:</td>
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<td>Other Skills:</td>
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26. Related to your community based or non-traditional job, please suggest any additions or amendments that you feel would have improved the OT program when/where you did your training.

________________________________________________________________________

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27. Please provide any further comments you have about practice in the community or nontraditional areas or any of the issues mentioned earlier in the survey.

________________________________________________________________________

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28. Would you like a summary of the study findings sent to you?

___Yes  __No

** ** THANK YOU VERY MUCH FOR YOUR COOPERATION AND ASSISTANCE! ** **
BIBLIOGRAPHY


