Community-tailored occupational therapy in primary health care to promote individual and community health

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The term *community* describes belonging to a group by being in a geographical area or holding a "common identity" (Trentham, Cockburn, & Shin, 2007, p. 56). According to the World Health Organization (WHO), a healthy community enables people to "mutually support each other in performing all the functions of life and in developing their maximum potential" (1998, p. 13). Occupational therapists could be natural stewards of community health, yet despite our shared professional values, individual efforts and designation as "community" practitioners, I believe we fall short in supporting individuals to be healthy in their communities, let alone in supporting whole communities in achieving health. What follows is a critical reflection on limiting factors and one alternate possibility for community occupational therapy, community-tailored primary health care, based on clinical experience in one urban, Canadian context.

Limiting features of community practice

Ideally, a community-dwelling individual accesses an occupational therapist, achieves a goal (e.g., independence in community mobility) and enjoys some related benefit (e.g., increased autonomy). This person generalizes the newly acquired benefit (e.g., to access a public library), improving individual health through meaningful participation in occupations and roles. Better still, this individual's improved function generates benefit for others (e.g., development of a reading program that others can attend), contributing to the health of the community as a whole. In my experience, such a chain of events is often the only employer- or program-approved mechanism for community occupational therapists to impact the health of a community. This mechanism is tenuous given its focus on individuals and reliance on their membership in a healthy community (e.g., one that has a library), and so, to promote healthy communities, occupational therapists need to directly contribute to community health.

Yet, there are a number of environmental influences that limit community occupational therapists' contribution to community health. One is the **historical positioning of occupational therapy** within the health sector (Townsend & Sandiford, 2012) and the dominant medical model that has organized occupational therapy practice by pathology and prioritized treatment over prevention. This is further complicated by the limitations inherent in the **siloing of resources** into health, justice and other sectors when it comes to working holistically with people and communities to address multifactorial issues. Another factor is a **Western cultural focus on individuality** that separates persons from their environment, an idea contrary to the established importance of social determinants on individual and community health (WHO, 1998) and to occupational therapy's holistic theoretical perspective. Finally, **hegemonic assumptions** reflected in policies that favour those who already belong to "healthy" communities limit occupational therapy's impact in other communities, due to factors such as socioeconomic status, education and more. For instance, a policy to discharge clients after missing a mailed-out appointment notice disadvantages those without a stable address or with literacy challenges and prevents access to occupational therapy for those who missed the appointment due to lack of transportation, caregiver support or even a telephone to reschedule the appointment.

Given these systemic limiting factors, the achievement of the WHO's vision of healthy communities will likely require major systemic change, which occupational therapists can help actualize through the coming years. Yet even now, there are opportunities to move community occupational therapy into better alignment with this vision. One way forward is through community-tailored primary health care practices (Health Canada, 2012) that are built to address the broad, social-determinants-of-health needs of specific communities, taking into consideration their members' common concerns and preferences, such as in the following example of current practice.

Mobile Outreach Street Health (MOSH): An example of community-tailored occupational therapy in primary health care

MOSH is a primary health care team created to improve health among persons who are street-involved, at risk of homelessness or experiencing homelessness. Working as the occupational therapist with MOSH has provided me with opportunities to put the WHO's vision for healthy communities into practice. In 2009, I was empowered and supported by the community and my employer to customize my practice with as few unnecessary limitations on service delivery as possible, to facilitate individual and community health. The following table highlights features of my practice that have been tailored to the needs, concerns and preferences of persons experiencing homelessness, as per service provider and first-person accounts, as well as per the health literature (Frankish, Hwang, & Quantz, 2005).

In my community practice, making an impact on individual and community health as an occupational therapist remains challenging, but it is tangible. A few successful examples of initiatives that have had individual and community reach include the MOSH Bike Project, which has matched over 90 street-involved persons with bicycles as affordable, active transportation, and Adsum for Women & Children's PeerWorks, a mentored

Table 1
Practice features to promote individual and community health

Community considerations	Community-tailored practice features
Reducing barriers to access to service is essential.	Accept referrals from any source, including verbal self-referrals. Offer quick access to capitalize on windows of opportunity like release from jail, opportunity for tenancy or interest in substance use change (quick access can result in a large caseload, but individual engagement fluctuates frequently, permitting adequate caseload management for a proportion of engaged individuals at any given time.) Recruit potential clients through outreach at community gatherings. Avoid restrictive policies related to "no shows," duration of time on caseload, prerequisite health or functional problems permitting eligibility for service, etc.
Relationship-based care (i.e., a relationship with a trusted provider) facilitates positive outcomes.	Be present and patient, to build trusting relationships rather than only to accomplish a goal. Work to full scope of practice—partake in transdisciplinary activities to efficiently meet individuals' needs rather than only making referrals for activities that are within occupational therapy's scope of practice. Be open minded to possible applications of occupational therapy—entertain a broad range of occupation-based goals important to individual and community health, such as maintaining tenancy through addressing hoarding behaviours or learning to prepare for bed bug treatment; apply holistic problem solving, such as to help landlords house individuals who struggle with tenancy.
Systemic issues play a very significant role in individual and community health, as lack of resources constrains individuals' power to impact outcomes.	Work with the community to identify common challenges and champion change through activism (Townsend & Sandiford, 2012), inclusion, community development (Lauckner, Krupa & Paterson, 2011) and institutional and neighborhood change, sharing resources, research and other means. Share occupational therapy knowledge and values with community members, service providers and decision makers, to contribute to the community's capacity to sustainably meet their own health and occupational needs.

work program that has engaged women with lived experience of homelessness in paid apartment management activities for a non-profit housing provider to the economic, social and occupational benefit of all involved parties. Community-tailored primary health care occupational therapy lends itself well to using occupation to meet individual and community needs while contributing to both individual and community health.

If community practice rests on the concept of healthy community, let occupational therapists recognize the conditions necessary for community health and partner with decision makers to make the systemic changes necessary to embed ourselves accessibly in communities. As practitioners, let us be intentional in applying visions of possibility to factors limiting individual and community health.

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About the author

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