

1971 Eleanor Clarke Slagle Lecture

The Occupational Therapist in Prevention Programs

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Social Change

In order for a profession to maintain its relevancy it must be aware of the times, interpreting its contribution to mankind in accordance with the needs of the times. When social change was slower it was possible for a profession to make this transition gradually; to proceed in a process of evolution, with new ideas and methods slowly replacing formerly held concepts and practices. However, in our era in history, this process of adjustment has had to be accelerated in order to keep pace with the rapidity with which our society is changing. In today's world, the demand to act is often presented to us before we have had sufficient time to understand and assimilate the meaning and significance behind the demanded actions. This is a tenuous position in which to be placed. One is presented with the need and the pressure to respond to that need but without the time to reflect on the knowledge and skills required to respond effectively. Reality, today, is continually outdistancing our preparation to respond to it.

Until the twentieth century, the pace of change allowed the average person the opportunity to incorporate change while feeling a sense of stability. But during this century the scope, the scale, and above all, the pace of change have been accelerated: Change in our society has developed a visibility it did not possess in former times. C. P. Snow comments, "Until this century social change was so slow that it could pass unnoticed in one person's lifetime." Such is no longer the case. Alvin Toffler in his book, *Future Shock*, addresses himself to the current phenomenon of accelerated change and its impact on man's ability to adapt. Toffler reflects on the exhaustion which can engulf the individual as he reaches an overload in his capacity to adjust to the new.²

Occupational Therapy and Social Change

This concern about modern change is particularly applicable to the profession of occupational therapy in 1971. For at this moment in our professional history we are being asked to

Originally published 1972 in *American Journal of Occupational Therapy, 26,* 59–66. Please note that there was no Eleanor Clarke Slagle Lecture in 1970.

expand our role identity from that of therapist to health agent. Because of the change in emphasis on the delivery of health services we are being asked to move beyond the treatment of patients into the arena of health planning and the development of prevention programs: "to broaden our traditional, more limited identification with medicine . . . to enlarge our concept from that of being a therapist to one of functioning as a health agent with responsibility to help insure normal growth and development"³ within the lives of all the people in a community.

This is a demand that needs to be acted on immediately if we are to take our place with others involved in the health problems of our day. Yet it is a demand that will require extensive reorganization of our current practices; changes we have not had the time to explore fully. To expand our services beyond the clinic into health planning for the community requires changes in the interpretation of our current knowledge, the addition of new knowledge and skills, the abdication of learned behavior patterns, and the revision of our educational process.

This expansion of role identity will require us to give up something we know for something new and unknown. Our education has trained us to work with the disabled person, usually within an institutional setting. Our knowledge, our training, our experience have all formed us to function within a clinical model—evaluating, treating, and rehabilitating the disabled person. We know the problems of today's society as they are reflected in the life of a particular patient but that is quite different from dealing with the problem at a community level. Yet we are faced with the request to change. Not to change gradually over a period of years but to change now; to be relevant to the needs of the times in which we live we must change our model of practice.

We find ourselves in the position of having to act while simultaneously trying to gain the knowledge necessary to act within our new role identity. The printed words in the books written about change in today's society have come alive for us. In our professional life we are actually *experiencing* the words. In today's world the demand to act is often presented to us before we have had sufficient time to understand and assimilate the meaning and significance behind the demanded action. We are living in a professional reality that is outdistancing our preparation to respond to it.

Faced with the drama of this situation we have a choice as individual occupational therapists. We can deny the urgency of the need to become involved in health planning and prevention programs and go on with our everyday activities; we can accept the importance of the mandate but feel that we can contribute more to the service of mankind by remaining in our present role as clinician; we can admit the concept of role identity change and ponder its significance in isolation away from the daily realities of practice; or we can accept the challenge and begin to change the emphasis of our practice, implementing new programs as increased knowledge and understanding are achieved.

As a clinician and administrator I chose the route of expanding my own identity to incorporate the role of health agent, and assumed the responsibility of reorganizing an occupational therapy department according to the new emphasis in health services. This reorganization has now been in progress for two years. In preparation for this lecture I

attempted to study this process of change; not to report to you an autobiographical journey but rather to share with you some of the issues that became evident during this experience—issues we need to understand if we are to develop comprehensive prevention programs and revise our curricula to prepare the future occupational therapist in the role of health agent.

Practice of Occupational Therapy—1960 to 1970

In order to understand these issues as they relate to the process of expanding services into the community, it is necessary to relate these issues to the practice of occupational therapy and the changes within the health services.

To understand the position of occupational therapy practice at this particular moment when changes are being demanded of it, we need to consider the developments within our practice during the past decade. The mandate for expansion of our services into health planning comes at a time when we are just beginning to develop our full identity as a profession within a therapy role. We have progressed from technician receiving a prescription from the physician to our present position as principal agent in the treatment of patients who require an intervention process employing the therapeutic use of activities.

After years of intuitive service to the sick and disabled we have now begun to define our practice and validate our clinical impressions through research studies. During the decade of the 1960's we began, in earnest, to study the process of normal growth and development and to interpret this knowledge as it applied to the patient with developmental deviations or fixations. We studied the theorists in cognition and began to refine our understanding of the role which specific activities and experiences play in the development of perceptual-motorcognitive skills.4 We probed deeper into the psychological aspects of activities. We increased our knowledge of group process and the use of task-oriented groups in developing one's interpersonal skills.⁵ We began to communicate to others the debilitating effects of disability on the satisfaction of these basic needs. We no longer had to apologize for our association with the practical activities of daily life because we had reached the level of awareness that it was through these activities that the disabled person was able to maintain his sense of human identity: to keep that sense of self-dignity and independence that can be so quickly lost in an institutional setting. We took our new understanding of human functioning and started to develop evaluation and treatment methods to correct specific deficits impeding the ability of the patient to fulfill these basic human needs. We responded to the permanently disabled person's need to maintain a normal way of life within the limitations of his disability, and helped him develop his social, vocational, and avocational interests.

The 1960's were productive years in the maturation of occupational therapy and the advent of the 1970's could be looked upon as the time for greater refinement in our clinical practice. At last we were beginning to define clearly the contribution of activities to the treatment of the sick and disabled. We had grown beyond the need to seek our identity by simulating the services or appearances of another profession. Therefore, as we entered the 1970's, there stretched out before us an array of avenues to follow in analyzing activities, in refining our evaluation procedures, and in developing more effective treatment techniques.

Change in Delivery of Health Services

But the needs of a particular period in history do not wait upon a timetable of priorities. Emphasis was being placed on developing prevention programs in the fields of mental health and pediatrics. Starting in the 1960's concern was centered on the importance of preventing disorders in children through the implementation of special programs. Well-baby clinics were established in local communities, Head Start for the preschool child was introduced, and more attention was given to the child with learning disabilities. In the field of mental health the trend away from large state institutions and the establishment of community mental health centers was developing. Although these centers provided clinical services to people in a particular geographical area, specific attention was directed toward the establishment of collaborative relationships with other institutions in the community as a means of developing primary prevention and early intervention programs. In the field of public health there was growing concern for the increased numbers of people suffering from long-term chronic conditions such as arthritis, diabetes, mental retardation, and alcoholism.

Fully recognizing the continuing need of many people for direct clinical and treatment services, there was the growing realization that many of the problems dealt with daily in the clinic could be prevented or modified if only earlier intervention had been available. Those within our society who had studied the health demands of today were saying that, for both human and economic reasons, we must expand our efforts to create an environment that would prevent serious illness and disability. The time had come to recognize that unless we began to refocus our attention on keeping people well, we would never be able to stem the tide of human suffering in our country.

The era of maintaining the health of a community through the control of communicable and infectious diseases was behind us. We had the knowledge to conquer these destroyers of human life and we must now move on to those chronic and disabling conditions that do not cause immediate death but, rather, years of human suffering and waste of human potential. In public health we had passed the time when all our energies had to be focused on the most basic physical health needs of the people. We were now able to devote our attention to the social disorders which not only affect the physical life of the individual but also have social, psychological, and economic ramifications for the individual, his family, and the society at large. Sudden illness and death have been replaced by disorders spanning an extended period of disability. Many chronic conditions limit the individual's ability to function for years. It is the length of time involved in these chronic disorders, the variety of services required, and the large numbers of people affected by them which have made chronic disorders such a major health problem today.⁸

Realizing, therefore, the need to counteract the amount of disability in our society, and recognizing that the most viable way to stop this amount of disability was through preventing it from occurring, emphasis was placed on prevention. In addition to this desire to prevent disability was the desire to provide an environment in which each person would be free to reach his fullest potential of human development. The achievement of this supportive environment was seen as an extremely complex task but it was felt that the effort made to reach this goal would be worthwhile. The need to improve the quality of all aspects of life was

seen as part of the responsibility of health planning because health problems are interrelated with all the other aspects of life. It is not possible to consider the solution of health problems without being aware of the influence of other social factors, such as, economics, housing, and family life, on one's state of health.

The interrelationship of health issues and the other social forces in the community is illustrated graphically by the current problem of the elderly in our society. The control of communicable disease and the advance of medical science have combined to allow the individual of today a longer life span. This extension of life has presented complications when considered in relationship to other forces in our society. The technological advances have created a trend toward urban living, with smaller houses, constant mobility, and the separation of the nuclear family from its extended members. As a result of this life pattern there is usually no room for the aging parent in the home of the child. Housing, therefore, becomes a major concern for the elderly. Even if the elderly remain in their own homes, neighbors change so often that the sense of security among friends is often missing. Further, the cost of living continues to rise in our society. Financial retirement plans made twenty or thirty years ago are no longer sufficient to sustain the older person. Although many elderly people are still capable of working, the retirement policies of business and industry force inactivity on the older individual. Unable to work, concerned about finances, and often alone, the older person begins to withdraw from life experiences. Depression, poor eating habits, and inactivity often result. Then again protection from disease has not completely eliminated the degenerative conditions that often result from the aging process—conditions that require the older person to receive assistance with his daily life. Too often, however, the needed services which would allow the person to remain in his own home are not available. As a result, the older person must be placed in an institution. Here care is available but the expense is great. Institutions, no matter how comfortable, can never replace one's own home, and the elderly person begins to develop a sense of hopelessness. Often the children are concerned but are so caught up in coping with our rapidly changing environment that feelings of resentment begin to develop against the parent. Financial assistance beyond the family is usually needed and the care and expense of the older person becomes society's responsibility. The problem of aging becomes, therefore, not simply a health problem but a complex social problem.9

Issues to Consider in Prevention Programs

Supported by a growing body of knowledge in occupational therapy clinical practice and aware of the need and priority of health prevention service, it is now necessary to begin the examination of the kinds of issues to be considered by occupational therapists, as we accept the mandate to move beyond the role of therapist and become health agents and progress along the continuum from hospital and clinical services to the community and health programs.

Issue One

The first issue relates to the environment in which one carries out his practice. Prevention programs are carried out in the community, with the primary institutions—such units as the

family, the school, the law, places of business, the health center, and the church. Each of these institutions makes a contribution to a person's life to one degree or another. They provide each person with the opportunities to gain the "increments of ego strength and personality robustness" which enable him to cope with the demands and pressures of daily life. To maintain the sense of well-being of the people in the community and to allow them the opportunity to develop their human potential, these primary institutions must respond adequately to the needs of the people. If they do respond in effective ways then the environment provides the nurturing elements needed for human growth and happiness. Unfortunately, the perfection of these institutions has not been attained and one of the responsibilities of those engaged in prevention work is the development of programs and services that will contribute to the perfection of these institutions.

Included in the list of primary institutions are ones which have usually been outside the professional interests of the occupational therapist. Little concern has been given, for example, to the functioning of local industries, or the overall administration and policies of the school system. Until the present time the occupational therapist has limited himself primarily to the health center. Even here, though, the occupational therapist has related more to the internal functioning of the health center rather than concerning himself with the health center's role and responsibility in the community. The occupational therapist is familiar with what goes on within the walls of the health center, but the remaining primary institutions in the community are often perceived only at the level of vague general awareness.

When moving, therefore, into community programs it is necessary for the occupational therapist to become knowledgeable about these other institutions, to understand more fully their functions, their goals, their policies, and their methods of operation. It is only in this way that the occupational therapist can begin to develop appropriate communications with the primary institutions. In collaborative efforts with these primary institutions the occupational therapist must discern those areas in which he can make his contribution.

Issue Two

Consideration of this factor of collaboration introduces us to a second issue. Before the occupational therapist reaches out to the primary institutions he must have a clear understanding of the services he has to offer. Although the occupational therapist has been responsible for delineating the kinds of services he has to offer to the patients within a clinical setting, treatment programs have had the advantage of years of experience in relating specific treatment services to a particular disability. Prevention programs are new for occupational therapists and there are no traditions upon which to base one's actions. It is possible to try to reinterpret clinical programs so that they fit the particular needs of a community but it must be remembered that the clinical programs were developed for the person with a specific pathology. The programs in the community have to relate to the maintaining of a person's health. Therefore, in considering community programs the occupational therapist must have an understanding of health in order to develop appropriate prevention programs.

Dubos notes that, "solving problems of disease is not the same thing as creating health . . . the task of health demands a kind of wisdom and vision which transcends specialized

knowledge of remedies and treatments and which apprehends in all their complexities and subtleties the relation between living things and their total environment."11 Health is far more than just the absence of disease. The word *health* is an abstract term that has been given to a highly complex, multivariable condition of man. Those who have attempted to define health have come up with a series of characteristics. Gordon Allport suggests six principal characteristics of the healthy personality. First, he considers the capacity of the individual to extend himself to interests outside his own body and material possessions. The second characteristic Allport attributes to the healthy personality is self-objectification. This is the capacity of the individual to achieve a spatial and temporal quality in his orientation to life. The third attribute is a unifying philosophy of life. All port states that this philosophy of life may, or may not, be religious, but in any event it has to be a frame of meaning and responsibility into which life's major activities fit. Fourth, Allport sees a healthy person as one who is capable of relating to other human beings in a warm and profound manner. Fifth, Allport attributes an importance to the possession of realistic skills, abilities, and perceptions with which to cope with the practical problems of life. And sixth, Allport considers the capacity to possess a compassionate regard and respect for all men and the willingness to participate in common activities that will improve the human lot.¹²

Using Allport's six characteristics as a foundation, let us attempt to develop a definition of a healthy person. A healthy person is one who is accepting of himself, responsive and concerned about other people, sees meaning in his existence, and is capable of productively fulfilling the daily demands of his life. Now, no definition of health, however, completely expresses the full understanding of this concept, but such a definition as the above does provide a basis upon which to develop a more comprehensive understanding of the subject.

It is significant to note in Allport's description of the healthy personality the role played by one's involvement in active participation in his environment. The healthy person does not remain preoccupied with self-interests but extends himself to others and relates to them in a productive manner within the daily events of life, accomplishing this through the use of his skills and abilities.

The healthy person is an active person. This fact has been recognized by philosophers and psychologists searching for a greater understanding of man. Aristotle stated that virtue is activity, by which he meant the exercise of the functions and capacities that are peculiar to man. Happiness to Aristotle was the result of activity and use, it was not a quiescent state of mind.¹³ According to Erich Fromm, "man is not only a rational and social animal . . . he can also be defined as a producing animal, capable of transforming the materials which he finds at hand, using his reason and imagination; not only can man produce, he must produce."¹⁴

Issue Three

Armed with a realization of the concept of health, and particularly the aspect of human activity and man's relationship to the activities in his environment maintaining his sense of health, the occupational therapist must begin to reinterpret his body of knowledge. He must begin to relate his understanding of the ways in which man, throughout the stages of his life and in his active interactions with his environment, develops the characteristics that define health.

He must begin to consider ways in which he can apply this knowledge within the primary institutions within the community. One example would be the association of play experiences in the cognitive and emotional development of the preschool child, and the application of this knowledge to the education of child-care workers in a community day care center.

Issue Four

This reinterpretation of the occupational therapist's body of knowledge and skills brings us to the next issue—the importance of thinking creatively. In order to meet the challenge of developing effective prevention programs we must begin to exercise our imaginations. The imagination is a mental process which, all too often in our technological society, has been dulled. We have been trained to take facts and put them together logically without the benefit of our own mental images. In our educational process the imagination has too often been relegated to a creative writing course, or a literature course, and omitted from our more scientifically-oriented courses. Yet how do people begin to see associations that have not been perceived before if they do not use their imaginations?

We are often amazed at the way a poet seems to see inside a situation and extract from it the richness of its essence. One reason for this skill rests on the development of his imagination; on his capacity to think in mental images. One poet I know refers to the specialization process in education as training people to put their knowledge into boxes. If one gets a thought that does not fit the criteria of the box, then it is discarded. A poet instead has transcended the box mentality and is open to all aspects of reality, manipulating them mentally into new images and associations.

It is this process of creative thinking which is required of us, as occupational therapists, in order to interpret our knowledge about human performance, growth and development, work, play, and human relations so that it becomes functional material for developing prevention programs in the service of maintaining the health of a community. It is necessary for us to begin to think creatively about our particular understanding of man's needs and to start to build new images around this knowledge.

Issue Five

Once we have begun the process of recombining our knowledge it is necessary to consider ways in which this knowledge can be translated into actual programs. This brings us to another issue—the development of a method to translate one's plan into action. Over a period of years we have broken down our units of knowledge and applied them in the treatment situation. For most of us in our professional careers, we entered practice with associations already established between a plan and the act. In our educational process we have studied man physically and psychologically, learned the various ways in which his functioning may be pathological because of a disease or disability, and have practiced the methods employed to treat the problem. Therefore, in our clinical practice the process of proceeding from a plan to an act has centered on the particular patient coming to us for service. We have adapted our general knowledge to translating a plan into an act for a particular patient. The situation in the community, however, is quite different. Instead of working with a single patient, we are

working with a primary institution or several primary institutions possessing a litany of complexities far beyond the problems of a single person. The primary institution does not have a single, well-defined problem which is seeking solution. The primary institutions are coping with a wide variety of factors impinging on the health of people in the community. The task that is presented to us is the establishment of a method of processing the needs of the primary institutions and the services the occupational therapist has to offer.

A method which has proved satisfactory consists of conceptualizing ideas and plans into progressively more specific conceptual units until one is able to express his thoughts in action-oriented terms. This process requires the mental discipline to continue to breakdown a thought until it can be translated into a specific action relating directly to the initial idea. When dealing with such broad concepts as human performance, health, and social systems there is a tendency to forget that these words represent a complex association of facts that must be analyzed carefully if the particular components of these concepts are to be combined so that a definite plan can be carried out. Without breaking down these concepts, a chasm which cannot be crossed exists between the thought and the act. Everyone sometime in his life has had the experience, I am sure, of being able to speak knowledgeably and at length about a particular concept, but finds that he is totally lost when asked to express this concept in a concrete act. In this situation the person has not conceptualized his knowledge in action terms. But once he has broken down the concept into units of action he is able to act.

Issue Six

Once we have broken down our concepts it is possible to act—to begin to take our knowledge of activities and their significance to man and develop new programs. The implementation of new programs brings with it a recognition of risk-taking, which is the next issue to be discussed. We are most comfortable when we know the route and the expected outcome of our actions. In the process of developing new programs within a new environment it is not possible to know fully the route which the program will take or the specific details of the final outcome of the plan. Over the years we have become familiar with the expected behaviors of those working within a medical institution and have been able to transfer this information to new staff and students. Health planning, however, requires us to relate to people from non-medical settings and from different organizational structures. Often one is involved with people from various settings simultaneously. Without the comfort of knowing the behavioral responses to expect, anxiety and apprehension can become overwhelming feelings. To cope with the need to become comfortable in unfamiliar situations we must begin to develop new skills in interpersonal relationships; to become more acutely sensitive to the behavioral cues of others as well as more conscious of our own patterns of relating.

Issue Seven

Of particular importance in dealing with new situations is a deeper understanding of the communication process. Through our professional education we have embraced a style of relating technical information comprehensible only to others trained in medically-oriented fields. We have developed a way of thinking about certain information and often assume

that everyone else thinks in the same frame of orientation. When we speak, for example, about the stages of development we are thinking about the process of development—the particular process by which a person progresses along the developmental continuum. Many teachers, however, see stages of development from a static frame of orientation. They think about the child at age five, or age six, or age seven but not about the process by which the child grows from age to age.

In order to communicate with parents, teachers, Golden Age directors, clergymen, and the like we must be able to communicate our ideas in language that is understandable to the other person. This requirement forces us to admit those areas of our knowledge which remain vague and ill-defined under the mantle of the professional term. For example, unless one fully understands the psychosexual stage of orality it is very difficult to help a neighborhood recreation leader realize the particular needs of a boy in his sports group fixated at this stage of emotional development.

Issue Eight

Clear communication provides an important step in the introduction of new ideas or programs. The introduction of new ideas, new programs, or new ways of thinking and acting in a primary institution represents the core issue in prevention work. As clinicians we are used to having patients come to us for help. The person is in need and seeks our assistance. In prevention work the occupational therapist goes to the people in the primary institutions. The significance of this reversal of roles must be fully understood. It is necessary to demonstrate to the other person or group of people the feasibility of accepting the plan, the idea, the program, or the service offered by the occupational therapist. Unless the occupational therapist fully understands the service he has to offer, believes in the value of the service, and can explain how that service will benefit the other person, the desired collaboration will not occur. In order to present appropriate programs and communicate clearly about them, therefore, a great deal of thought and planning must go into the preparatory work for prevention programming.

Because the other people sometimes do not see the worth of the proposed plan, or are hesitant to accept the plan because of internal organizational factors, the element of frustration accompanies the implementation of prevention programming. Most clinicians have had the experience of a patient refusing to attend occupational therapy and know the feelings of frustration and futility that such an experience can arouse. In developing prevention programs these feelings are magnified because of the amount of preliminary work that has had to go into each plan and the endless variations in the problems and obstacles encountered. As Leonard Duhl says, "The input of information constantly redefines the situation, the problem, and the possible range of solutions." Therefore, a well-defined, well-planned program may have to be revised a dozen different ways before there is agreement on the details of the plan.

Issue Nine

Because of the complexity of factors involved in developing prevention programs the morale of the staff becomes our final issue. Effective prevention work is carried out at the grass-roots

level of the community. If change is to take place within the primary institutions in a community it is not sufficient that the person at the head of the institution, such as the school superintendent for example, be in agreement with the ideas. The people who actually carry out the daily action plans are the ones who must be enthusiastic. In order to maintain this kind of willingness to change on the part of others the occupational therapist must be able to maintain his sense of objectivity and interest in the project. To do this the occupational therapist must have the opportunity to look at his own feelings and also see the personal growth opportunities in the experience. To accomplish these things the occupational therapist must be receiving assistance in sorting out his own feelings and obtaining guidance in continuing his own personality development. It is for these reasons that staff supervision becomes a crucial part of any prevention-oriented program. The supervision must relate to the individual needs of each staff member for specific knowledge and skills, for the ability to deal with one's feelings, and for the development of a professional identity as an occupational therapist in the role of health agent. Because of the need for the development of a supportive system for staff involved in the pioneering work in health planning and prevention programming, a hierarchy of supervision can be developed where each staff member receives supervision from a more experienced therapist while in turn supervising a less experienced therapist. This method provides for the development of a network of support, and through this process the individual occupational therapist begins to learn ways in which he can find support for his efforts within himself, and is able in time to relinquish the great need for external support.

Summary of Issues

We have now concluded the discussion of the specific issues which began to crystallize as we proceeded through the process of expanding an occupational therapy department from an inpatient service to include prevention programs. Nine separate issues were extracted from the process data gathered over the past two years of developing prevention programs. To restate them again, they include (1) the function of primary institutions in maintaining the health of the people of a community and the need for occupational therapists to understand the functions, goals, and policies of these primary institutions; (2) the planning of appropriate programs and services based on man's need to engage in interaction with the objects in his environment in order to maintain his health throughout his life; (3) the need to reinterpret the body of knowledge available within the profession of occupational therapy in order to apply it in the service of keeping people healthy rather than in helping people minimize their disabilities; (4) the creation of new associations of our available knowledge in order to respond more accurately to the pressing reality needs of today; (5) the establishment of an organizational model which will allow translation of abstract plans about activities, human action, and the delivery of health services into concrete actions; (6) the presence of risktaking and its ramifications on one's ability to function and persevere when faced with an unfamiliar environment; (7) the necessity of reexamining communication patterns to insure real communications among people; (8) the need to create a climate of acceptance for a planned program and the development of the skills needed to assist others in seeing the value of these programs; and (9) the role of supervision in maintaining the performance and professional growth of the staff members.

Community Programs

Before proceeding to the concluding section of my presentation I would like to share with you the kinds of programs that provided the process material from which these issues were extracted. These programs include early intervention programs for children, ages 4 to 12 years, who are beginning to present the first indications of behavioral and learning problems; a consultation service to teachers; an inservice education program in developmental screening and program planning for teachers in day care centers; an outreach program to community agencies assisting the elderly; a workshop for mothers and preschool children in early childhood development and parent-child relationships; an inservice education program on perceptual-motor development for mental health workers; development of new models of parent education and counseling; and the introduction of knowledge about developmental levels in human performance in a community drug program.

Curriculum Changes

Having localized some of the issues arising out of prevention programming we are now faced with their significance in the mandate to occupational therapists to move beyond the role of therapist to health agent. In discussion of each of these issues I have alluded to the change that must occur in the education of occupational therapists both at the level of academic professional education and at the level of continuing education for practicing occupational therapists.

In order to expand into the areas of health planning and prevention programs, occupational therapists must possess a comprehensive knowledge and understanding of the meaning and significance of activities in the development of man's fullest potential. It is natural for man to be active; to interact with the objects in his environment, to develop his physical, cognitive, and psychosocial abilities.

Man must exist in an environment which provides him with the opportunities to grow and develop as a total human being through his interaction with people and with the activities and objects in the environment if he is to remain healthy. The study of activities and the application of this knowledge to provide man with a better way of life are the essences of the profession of occupational therapy. Therefore, as the profession with this charge, we must move beyond the confines of focusing our attention on the value of a specific activity to achieve a specific result and include a more comprehensive understanding of activities and human action. It is only with such an understanding that we will be able to respond to the needs of the primary institutions in our communities and develop the kinds of particular services these institutions require in order to maintain the health of the people in the community. We must not give up the knowledge we now possess in activity analysis as it applies to the physically and psychologically disabled person, but rather we must expand this knowledge.

Secondly, we must develop our ability to become leaders; to move with confidence into the community and collaborate in the creation of a healthier environment, contributing our knowledge of activities and human action. We need, therefore, to be able to problem-solve, to understand the factors involved in complex social systems and define the problems where we can make a contribution.

And thirdly, we must increase our knowledge about the society in which we live. We must understand the effect of technology on man's way of life today, to realize the reasons behind the young people's push to return to a more human-oriented life style, to understand the economic, political, and social forces that predominate in today's society.

Summary

The trend, today, in health services is toward the prevention of disability. We are a profession possessing knowledge that is particularly necessary to maintain the health of people. To move from therapist to health agent demands us to change but to change in a forward, positive way. We do not have to give up what we know, rather, we must instead be willing to know more.

For years we have been concerned with the disabled person's right to maintain his dignity and self-worth by reaching his maximum level in human functioning. The needs of our times are now asking us to contribute to the preservation of each person's right to achieve his highest level of human functioning.

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