Occupational Therapy’s Perspective on the Use of Environments and Contexts to Facilitate Health, Well-Being, and Participation in Occupations

Introduction

Occupational therapy practitioners\(^1\) view human performance as a transactive relationship among the client (people, groups, or populations), the client’s occupations (daily life activities), and environments and contexts. Environments are the external physical and social aspects that surround clients while they engage in an occupation. Contexts are the cultural, personal, temporal, and virtual aspects of this engagement; some contexts are external to the client (e.g., virtual), some are internal to the client (e.g., personal), and some may have both external features and internalized beliefs and values (e.g., cultural; American Occupational Therapy Association [AOTA], 2014b).

Using their expertise in analyzing these complex and reciprocal relationships, occupational therapy practitioners make recommendations to structure, modify, or adapt the environment and context to enhance and support performance. Both environment and context influence clients’ success in desired occupations and are therefore critical aspects of any occupational therapy assessment, intervention, and outcome. This assumption is consistent with current education and health care laws and policies, which stipulate that assessment and intervention by providers take place in the natural and least restrictive environments (LREs) that support the client’s successful participation. Table 1 reviews key legislation and court cases related to occupational therapy intervention and how they apply to practice.

Purpose

The purpose of this document is to articulate AOTA’s position regarding how, across all areas of practice, occupational therapy practitioners select, create, and use environments and contexts to support clients as they achieve health, well-being, and participation in desired occupations.

Occupational Therapy Process

Occupational therapy practitioners collaborate with clients to identify both strengths and barriers to health, well-being, and participation. As part of this process, practitioners consider a variety of environmental and contextual factors to inform the clinical reasoning process that guides client evaluation, intervention, and targeting of outcomes.

Occupational therapy practitioners analyze the environment and context to understand how these elements can best support learning and performance. Solutions are then generated to reduce identified barriers or build on supports through modifications and adaptations.

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\(^1\)When the term *occupational therapy practitioner* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2006). *Occupational therapists* are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. *Occupational therapy assistants* deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2014a).
Table 1. Legislation and Court Cases Related to Occupational Therapy Practice

<table>
<thead>
<tr>
<th>Federal Law, Court Case, or Movement</th>
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| Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93–112) | • The Rehabilitation Act of 1973 is a civil rights law that states that no person may, on the basis of his or her disability, be “excluded from the participation in, or denied the benefits of . . . any program or activity receiving Federal financial assistance” (29 U.S.C. § 794(a).  
• In educational settings, this law requires that schools ensure equal educational opportunities for students with a qualifying disability through the provision of special education services, related services, modifications, or accommodations.  
• Occupational therapy services can be used in any program funded with federal funds to ensure equal access for people with disabilities.  
• In educational settings, occupational therapy practitioners can participate in developing a student plan under Section 504, help suggest and implement needed modifications and accommodations, and provide related services. | |
| No Child Left Behind Act of 2001 (NCLB; Pub. L. 107–110) | • NCLB is the most recent reauthorization of the Elementary and Secondary Education Act of 1965 (Pub. L. 89–313).  
• It expands accountability standards for schools receiving federal funding.  
• It includes children with disabilities in the accountability models developed to gauge student and school success.  
• NCLB created increased motivation for schools to use all existing resources to improve the achievement of all students.  
• It created broader opportunities for occupational therapy to be used by schools to benefit students with and without disabilities. | |
| Individuals With Disabilities Education Improvement Act of 2004 (IDEA; Pub. L. 108–446) | • IDEA is the law governing how early intervention services for children ages birth–3 years are provided; it addresses the provision of special education and related services to students ages 3–21.  
• The purpose of IDEA Part B for students ages 3–21 is “to ensure that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living” (34 C.F.R. 300.1[a]).  
• The purpose of IDEA Part C for children ages birth–3 years and their families is to enhance and expand states’ capacity to provide early intervention services and to help maintain, implement, and coordinate interagency services for early intervention with children ages 0–3 years.  
• Of note, IDEA requires that “removal of children with disabilities from the regular educational environment occurs only if the nature or severity of the disability is such that education in regular classes cannot be achieved satisfactorily” (34 C.F.R. 300.114[a][ii]).  
• IDEA identified occupational therapy as a related service for eligible children under Part B for school-age children.  
• It established occupational therapy as a primary service provider for children age birth–3 years under Part C.  
• Under both programs, occupational therapy practitioners participate in evaluation and implementation, including analyzing and adjusting the context of and environment for learning and participation in school. | |
### Table 1. Legislation and Court Cases Related to Occupational Therapy Practice (cont.)

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| Social Security Amendments of 1965 (Medicare and Medicaid; Pub. L. 89–97) | • These amendments established a national public health care program, Medicare, to meet the needs of older Americans and people with disabilities (Social Security Disability Insurance) who qualify for services on the basis of disability status and a sufficient work history.  
• They established an optional state–federal program to provide health and rehabilitation services for low-income people and certain people with disabilities. | • The amendments created a system of health care financing and insurance for older Americans and for people who would otherwise not have health and other services.  
• It created a steady funding stream for health care, including occupational therapy.  
• Social, community, and individual supports can in some circumstances be paid for by Medicare.  
• Medicaid has many options for coverage of occupational therapy, including programs that provide community and home-based supports for long-term care. |
| Older Americans Act of 1965 (OAA; Pub. L. 89–73) | • The OAA created a network of local and state entities, many called Area Agencies on Aging (AAAs), that are funded through OAA resources.  
• Programs and services are focused on older people to plan and care for their lifelong needs.  
• The goal of these programs is to keep older adults living independently in their own homes.  
• A broad range of services are covered, based on local needs, and may address nutrition, caregiver support, community safety, and fall prevention. | • The OAA provides flexible funding options that support community health and social services programs for older adults, which may include occupational therapy.  
• It increased focus and emphasis on community-based living resources and the promotion of aging in place. |
| Omnibus Budget Reconciliation Act of 1987 (Federal Nursing Home Reform Act; Pub. L. 100–203) | • This act created a set of national minimum standards of care and a bill of rights for people living in certified nursing facilities.  
• It requires nursing homes to develop individualized care plans for residents that focus on maintaining or improving the ability to walk, bathe, and complete other ADLs to the maximum extent possible.  
• The act requires nursing homes to develop individualized care plans for residents and training of paraprofessional staff.  
• It protects residents’ right to be free of unnecessary and inappropriate physical and chemical restraints. | • This act created requirements as well as opportunities for occupational therapy practitioners to facilitate optimum function, attention to mental health, and maximum participation. Occupational therapy practitioners’ care plans and interventions in nursing facilities, whether funded through Medicare or Medicaid, should be targeted to these goals.  
• Occupational therapy practitioners may address environmental modifications and adaptations needed for maximum performance and safety, both in personal environments (e.g., wheelchairs, beds) as well as bedrooms, bathrooms, and common areas. |
| Americans With Disabilities Act of 1990 (ADA; Pub. L. 101–336) | • The ADA built on previous civil rights legislation targeted at protecting the rights and enhancing participation of other minorities.  
• It provides a clear mandate to end discrimination against people with disabilities in all areas of life.  
• The ADA includes 5 titles that address employment, state and local government services, transportation, public accommodations (i.e., public places and services), and telecommunications. | • The ADA supports initiatives and interventions, including occupational therapy expertise, that promote function and participation for people with disabilities across the lifespan.  
• Occupational therapy practitioners can support the end of discrimination through their knowledge of independent living, accessibility, environmental modifications, supported employment, competence-based evaluation for employment, and implementation of reasonable accommodations in all settings. |

(Continued)
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| **Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978 (Pub. L. 95–602)** | • These amendments provide federal funding in cooperation with states to establish a national network of consumer-run community facilities and services.  
• Independent living centers now exist across the country.  
• The amendments advocate for the removal of architectural and transportation barriers that prevent people with disabilities from sharing fully in all aspects of society. | • The amendments support provision of occupational therapy evaluation and intervention in the natural environments in which people live, work, and play to help people adapt to the realities of their physical, social, attitudinal, and political contexts.  
• Intervention includes consultation, program development, and advocacy with teachers in schools, supervisors in jobs, citizens' organizations, local governments, businesses, local media, and advocacy organizations. |
| **Olmstead v. L.C. (1999)** | • In a 6–3 ruling by the U.S. Supreme Court against the state of Georgia, this case affirmed the right of people with disabilities whose living situation is supported by state or federal funds to live in their community.  
• The ruling requires states to place people with mental disabilities in community settings rather than in institutions if at all possible.  
• It dictates that community placement must be appropriate; that the transfer from institutional care to a less restrictive setting is not opposed by the affected person; and that the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities. | • *Olmstead v. L.C.* established the precedent for the enforcement of a federal mandate for services to be provided in the LRE and in settings of choice for people with disabilities.  
• The case created opportunities for occupational therapy practitioners to design accommodations, interventions, and related services to support community living for people with disabilities. |

Note. ADLs = activities of daily living; LRE = least restrictive environment.

Practitioners can recommend environmental and contextual modifications and adaptations such as those in the following examples:

- **Physical environment:** Improving accessibility of kitchens (lowering counter height and creating open floor plan) for clients using wheelchairs who want to engage in the occupation of cooking. Adding visual cues in the home environment to structure homemaking tasks to increase safety and organization for people with cognitive limitations.

- **Social environment:** Encouraging a student on the autism spectrum to connect with a peer mentor to attend various activities on campus, including sporting events.

- **Personal context:** Educating older adults on community mobility options.

- **Temporal context:** Consulting with a newly retired business executive about volunteer options involving financial planning and entrepreneurship.

- **Virtual context:** Collaborating with classroom teachers to provide appropriate technology.

Occupational therapy practitioners also recognize that specific interventions may need to begin outside the natural setting in which performance takes place and be completed in a setting in which components of occupations or underlying factors and skills can be targeted. For example, during inpatient rehabilitation, an adult with a spinal cord injury would practice community mobility in a simulated community environment in the rehabilitation facility to enable independent shopping on discharge to home.
Ultimately, interventions occurring in natural or modified environments support clients where they live, work, or play and wherever occupations take place (e.g., homes, classrooms, playgrounds, work, recreation or community centers). Providing appropriate intervention in the most appropriate environment is consistent with the values and purpose of occupational therapy. Practitioners also realize that many additional factors, such as limited financial, organizational, and personnel resources and the complexity of the client’s condition, may inform various service delivery options. For example, although the most natural environment in which to address cooking difficulties for a client who is experiencing poststroke weakness in one arm may be the home, the client’s medical status may dictate that training occur in a subacute rehabilitation facility.

Providing opportunities for all members of society to engage in health-promoting occupations through flexibility in the analysis of the environment and context in which clients thrive is essential. Table 2 provides additional examples of how occupational therapy practitioners use and modify the context and the environment to support health and participation in occupations.

Table 2. Case Studies

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<th>Case Description</th>
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| **A 15-month-old boy** was born at 29 weeks’ gestation. He has had difficulty sitting up, particularly during feeding, and achieving other developmental milestones. He is living at home with his family. | The focus of intervention is to support the entire family in sustaining their family life while addressing the child’s developmental needs. Intervention is provided in the home with an emphasis on how to adapt the natural environment to support the child’s occupational performance and development. | • After discharge from the NICU, provide direct intervention in the child’s home to promote safety and establish the child’s developmental skills.  
• Collaborate with the family to structure and modify the physical and social environments in the home to support occupational performance.  
• Educate the caregiver in developmental principles, positioning, and activities to facilitate feeding and development.  
• Consult with family and other members of the transdisciplinary team to support family goals. | • Performing everyday activities in the natural setting provides reinforcement and support to achieve and enhance performance and competence (Dunst et al., 2001; Dunst, Trivette, Hamby, & Bruder, 2006).  
• Helping families accommodate to the demands of daily life with a child with developmental delays helps them develop appropriate and sustainable routines congruent with the family’s values and the child’s developmental needs (Keogh, Benheimer, Gallimore, & Weisner, 1998).  
Additional Resources  
Frolek Clark & Kingsley (2013)  
Kingsley & Mailloux (2013) |
| **A 3-year-old girl** with social and emotional regulation challenges attends a center-based preschool program. | The focus of intervention is to provide early childhood services in an inclusive classroom to enhance the child’s opportunities for play with peers in naturally occurring situations that arise in the classroom. Occupational therapy intervention is integrated into the classroom activities. | • Structure playgroups to promote peer social interaction skills.  
• Direct intervention with the child and parents to promote self-regulation and establish routines to facilitate the child’s transitions throughout the day.  
• Consult with the early childhood team to analyze the demands of the preschool class and make recommendations for adaptations to support performance.  
• Center-based early intervention services have a positive effect on children’s social functioning (Blok, Fukkink, Gebhardt, & Leseman, 2005).  
• Preschoolers with disabilities perform as well, if not better, when placed in quality inclusive classroom settings and play groups (Bailey, Aytch, Odom, Symons, & Wolery, 1999; Odom, 2000).  
• Parents of children with disabilities commonly report that they perceive inclusive classroom practices as contributing to their child’s | |
A 7-year-old student with cognitive, motor, and speech delays participates in a special day class in a public school. He has difficulty processing sensory information, interacting with peers, focusing on academic tasks, using his hands for tasks, and maneuvering on equipment.

The goal of the tailored environment is to provide the structure necessary for the child to learn specific skills for participation in a less restrictive environment in the future.

The intervention focuses on developing medication routines to help the client return to his home. If he is unable to manage his medications, he might need to move to a group home with more structured supervision.

By analyzing the social and physical environment in the client’s home and community, the occupational therapy practitioner can identify external cues and resources to optimize the client’s occupational performance. Guided by the child’s needs, the IEP team, which includes the occupational therapist and the parents, determines that the child is having difficulty participating with typically developing peers and would benefit from a special day class for students with behavioral challenges. Although such placements are viewed as more restrictive, the regular classroom environment is currently overwhelming for the child.

Examples of Occupational Therapy Interventions Addressing Specific Environments and Contexts

- Educate the IEP team about the effect of the environment on sensory processing and the relationship to behavior in a school setting.
- Consult with the IEP team and teachers to structure, adapt, and modify the classroom and playground environments so that the child has opportunities to meet sensory needs by participating in vestibular, tactile, and proprioceptive activities throughout the school day.
- Collaborate with the student to help him establish strategies and routines for sensory regulation, emotional and behavioral deescalation, and appropriate coping skills.
- Develop a peer buddy system to promote appropriate social interactions with modeling and role-play during social group.
- Provide direct intervention to facilitate integration of sensory systems in an environment rich in sensory experiences and equipment.

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<td>A 7-year-old student with cognitive, motor, and speech delays participates in a special day class in a public school. He has difficulty processing sensory information, interacting with peers, focusing on academic tasks, using his hands for tasks, and maneuvering on equipment.</td>
<td>Guided by the child’s needs, the IEP team, which includes the occupational therapist and the parents, determines that the child is having difficulty participating with typically developing peers and would benefit from a special day class for students with behavioral challenges. Although such placements are viewed as more restrictive, the regular classroom environment is currently overwhelming for the child.</td>
<td>- Educate the IEP team about the effect of the environment on sensory processing and the relationship to behavior in a school setting. - Consult with the IEP team and teachers to structure, adapt, and modify the classroom and playground environments so that the child has opportunities to meet sensory needs by participating in vestibular, tactile, and proprioceptive activities throughout the school day. - Collaborate with the student to help him establish strategies and routines for sensory regulation, emotional and behavioral deescalation, and appropriate coping skills. - Develop a peer buddy system to promote appropriate social interactions with modeling and role-play during social group. - Provide direct intervention to facilitate integration of sensory systems in an environment rich in sensory experiences and equipment.</td>
<td>- The student may attend to classroom instruction for longer periods of time when sensory needs are addressed (Schilling, Washington, Billing-sley, &amp; Deitz, 2003). - Teaching children self-regulation strategies (a cognitive approach to manage sensory needs) helps them manage their behavior (Barnes, Vogel, Beck, Schoenfeld, &amp; Owen, 2008; Vaughn et al., 2003). - Supporting a school-age child’s occupational performance and behavior improves participation in school (Schaaf &amp; Nightlinger, 2007). - Suspended equipment and opportunities to carefully monitor various and safe sensory experiences is a hallmark of sensory integration intervention. These opportunities may only be available in a carefully designed environment (Parham et al., 2007).</td>
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<td>A 28-year-old man with schizoaffective disorder lives alone. He has difficulty organizing his daily routines to manage his medications. He was recently admitted to the hospital because of an acute exacerbation of his illness. He wants to be discharged home.</td>
<td>The intervention focuses on developing medication routines to help the client return to his apartment. If he is unable to manage his medications, he might need to move to a group home with more structured supervision. By analyzing the social and physical environment in the client’s home and community, the occupational therapy practitioner can identify external cues and resources to optimize the client’s occupational performance.</td>
<td>- Educate the medical team and case manager about performance deficits that affect medication routines. - Request that a pharmacist or nurse teach the client how to read labels and practice filling his medication box correctly. - Advocate for reminder calls for refills from the pharmacy or another entity. - Teach the client skills to establish habits and routines that support medication management, such as regular</td>
<td>Environmental supports are more likely to improve functional behavior for people with schizoaffective disorder when the supports are customized for the person and situated in the person’s home (Velligan et al., 2000, 2006).</td>
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Additional Resources

- Case-Smith (2013)
- Frolek Clark & Kingsley (2013)
- Kingsley & Mailloux (2013)
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<td><strong>Clients living in a shelter</strong> for homeless people want to meet basic needs, remain safe, and reduce the potential for harm.</td>
<td>sleep–wake times, use of an alarm clock and calendar to track when to take and refill medication, and storage of medication in a consistent location (e.g., on a nightstand).</td>
<td>• Establish defined areas and organize schedules within the shelter to enable clients to engage in self-care, education, work preparation, and play and leisure activities.</td>
<td>Life skills interventions have the potential to support the complex needs of people situated in the homeless context (Helfrich, Aviles, Badiani, Walens, &amp; Sabol, 2006).</td>
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<td><strong>A 52-year-old successful businessman</strong> had a right middle cerebral artery stroke 1 year ago, resulting in left-sided weakness and decreased balance. He lives at home and has tried to return to his job as a financial consultant but has struggled to maintain his productivity at work.</td>
<td>Using a consultative model, the intervention focuses on modifying the physical and social environments to promote safety and meet the clients’ basic needs.</td>
<td>• Establish defined areas and organize schedules within the shelter to enable clients to engage in self-care, education, work preparation, and play and leisure activities. • Design physically accessible spaces and equipment to enable clients to complete basic ADLs. • Educate clients in life skills interventions to address the environmental demands of homelessness. • Establish a self-governance and grievance committee to address safety in the shelter. • Post emergency procedures and community resources.</td>
<td>• Adapt activity demands for participation in necessary and desired occupations. • Modify the home environment to optimize safety and reduce the impact of weakness and fatigue (Fänge &amp; Iwarsson, 2005; Stark, 2004; Stearns et al., 2000). • Consult with the employer to modify the work environment by using assistive technology to change the task demands. • Set up an ergonomically advantageous setting by adjusting work routines and schedule to support work performance (Whiteneck, Gerhardt, &amp; Cusick, 2004). • Consult with community agencies regarding access (e.g., transportation, public bathrooms, timing of crosswalk lights, safe railings). • Specific strategies are effective in improving performance skills and participation in roles and routines after stroke (Ma &amp; Trombly, 2002; Trombly &amp; Ma, 2002). • Occupational therapists evaluate contextual factors of the work environment (e.g., work tasks, routines, tools, equipment) and use this information to plan interventions that facilitate work performance (AOTA, 2011). • Occupational therapy practitioners consult with community agencies, business owners, and building contractors, among others, to create environments that promote occupational performance for all (AOTA, 2000). Additional Resources: Wolf, Chuh, Floyd, McInnes, &amp; Williams (2015) Wolf, Chuh, McInnes, &amp; Williams (2013)</td>
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| Older adults residing in an assisted-living facility are at high risk for loss of balance and falls. | The focus of intervention is to maintain the clients' occupational engagement through a multifactorial approach that includes elements such as strength and balance training; education; modifying activity demands; and creating a safe and supportive environment, including falls prevention. | • Consult with facility administrators, architects, and facility staff to design an environment that  
  o Reflects a noninstitutional character,  
  o Eliminates barriers to physical mobility,  
  o Provides lighting without glare, and  
  oClusters small activity areas together. | • The design of the social and physical environment influences the function and well-being of older adults (Day, Carreon, & Stump, 2000).  
• Occupational therapy practitioners advocate for and contribute to the creation of an environment in which the demands do not exceed the client's capabilities (Cooper & Day, 2003).  
• Occupational therapy practitioners identify and modify environmental barriers (Davison, Bond, Dawson, Steen, & Kenny, 2005). |
| A 74-year-old woman with Alzheimer's disease lives in an apartment in the inner city with her husband of 45 years. She has become lethargic and no longer initiates activities. Her husband now does all the shopping, cooking, and cleaning. He is overwhelmed with the demands of caregiving. | The intervention focuses on supporting the caregiver's and the care recipient's health and participation in desired occupations and activities and enabling them to remain in their home as they age. | • Educate the caregiver about the disease process and the impact of the environment on the care recipient's occupational performance.  
• Recommend modifications to the home environment to manage daily care activities.  
• Provide emotional support and information on coping strategies and stress management to caregivers.  
• Facilitate use of community and family support.  
• Provide support and education on the uses of adaptive equipment in the home. | • People with dementia or Alzheimer's disease can live at home, remaining in their roles and contexts for a longer period of time, if given enough support from caregivers (Haley & Bailey, 1999).  
• An in-home skills training and environmental adaptation program (Gitlin et al., 2003) improves the quality of life for both the caregiver and the care recipient with fewer declines in the care recipient's occupational performance and less need for caregiving (Gitlin, Hauck, Dennis, & Winter, 2005).  
• Home-based occupational therapy is effective and cost-efficient for community-dwelling older adults and their caregivers (Graff et al., 2008).  
• People with Alzheimer's disease perform better at home than in unfamiliar environments; it is harder for them to adapt to new environments (Hoppes, Davis, & Thompson, 2003). |

Additional Resource
Siebert et al. (2014)

Additional Resources
Padilla (2011)
Schaber (2010)

Note. ADLs = activities of daily living; AOTA = American Occupational Therapy Association; IEP = individualized education program; NICU = neonatal intensive care unit.
Summary

Occupational therapy practitioners work with a wide variety of clients across the lifespan. The goal of occupational therapy is to facilitate achievement of health, well-being, and participation in life through engagement in occupation (AOTA, 2014b). Practitioners consider current educational and health care laws and policies as they make recommendations to modify, adapt, or change environments and contexts to support or improve occupational performance. On the basis of theory, evidence, knowledge, client preferences and values, and occupational performance, they assess the intervention settings and the environmental and contextual factors influencing clients’ occupational performance. In their interventions and recommendations, practitioners focus on selecting and using environments and contexts that are congruent with clients’ needs and maximize participation in daily life occupations. Practitioners’ expertise is essential to support clients’ health and participation in meaningful occupations.

References


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