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TOPIC: Report of Ad Hoc Committee on Mental Health Practice in Occupational
Therapy

December 18, 2006

Executive Summary

Introduction

In July, 2006, AOTA President Carolyn Baum and President-elect Penelope Moyers invited a group of AOTA members to meet and develop a report for the AOTA Board of Directors regarding issues in the area of Mental Health that are facing the profession of occupational therapy and that are integral to fulfilling the Centennial vision. The World Health Organization (WHO) reports that one in four people in the world will be affected by mental or neurological disorders at some point in their lives. Around 450 million people currently suffer from such conditions, placing mental disorders among the leading causes of ill-health and disability worldwide. (WHO, 2001) Occupational therapy has its roots in the treatment of mental illness, but concerns have existed for many years about practice and education in this area. AOTA has engaged in various activities related to these issues in the past fifteen years. Information about some of the past and current activities addressing mental health issues serve as background and are included in the full report.

Discussion and Recommendations of 2006 Ad Hoc Group on Mental Health

In responding to the questions posed to the 2006 Ad Hoc Group on Mental Health, four primary issues were identified. These issues are consistent with the thinking and or recommendations of previous and current AOTA groups including the Occupational Therapy in Mental Health Systems Workgroup of 2005 (appointed by the President), the workgroup appointed by the President in response to the 2006 RA Charge

to examine strategies and barriers to achieving Qualified Mental Health Provider status for occupational therapists in mental health, the AOTA/AOTF workgroup to identify recommendations for Disaster Preparedness and Response, and the COE survey of educational preparation related to Severe and Persistent Mental Illness. These issues include: 1) core competencies for entry-level occupational therapy practitioners in mental health practice, 2) the role of occupational therapy practitioners in mental health systems, 3) payment/reimbursement sources for occupational therapy in mental health, and 4) evidence to support occupational therapy practice in mental health. Although there are significant challenges towards success in each of these areas, there are also opportunities available that can support our progress towards reestablishing occupational therapy as a primary provider in mental health systems. Transformation of the current mental health system has been identified as a federal and state priority in response to the President's New Freedom Commission on Mental Health Report (2003) and significant funding and time is being spent on this by many federal agencies (USDHHS, SAMHSA, 2005).

Recommendations

Many of the priorities listed below can be undertaken simultaneously and the profession can build upon the victories achieved, but these priorities represent not only areas where we can make initial progress but where the need is greatest. To achieve our ultimate goal of making occupational therapy a typical and necessary part of mental health treatment requires a coordinated effort involving changes in advocacy, educational preparation, licensing/certification, creating a body of research evidence, establishing a system of post-degree supervision and educating the public, policy makers, payers and other providers about what occupational therapy can bring to mental health practice and

how rehabilitation in mental health is equally as important as it is for physical illnesses and developmental disabilities.

1. Establish core competencies for mental health occupational therapy practice and the educational methods to obtain them.

1.1 Bring together experts in a face to face meeting to further delineate and specify the scope of practice in mental health occupational therapy. This group would also identify the knowledge and skills necessary to carry out these practices.

1.2. Create a model curriculum for entry level mental health occupational therapy. It is suggested that representatives from COE, MHSIS, EDSIS and other mental health educators make up the group that develops this curriculum. The model curriculum should be based on the scope of practice identified in recommendation 1.1. Furthermore, the model curriculum should provide general guidelines regarding the amount of time/emphasis on a particular topic (e.g. suggesting credit hours).

2. Expand the role of occupational therapy in mental health systems

2.1. Explore the Association's position on the use of Advanced or Specialty Certification related to advocacy in the area of mental health. AOTA's Certification programs could be used to address challenges and concerns when competing with other non-entry level professional designations of QMHP status. Explore establishing a system of post graduate supervision that is consistent with other QMHP professionals.

2.2. Explore methods for developing leaders in mental health occupational therapy (e.g. combined OT-MBA programs or mentorship programs, hosting leadership institutes at conferences, supporting the development of OTD leadership tracts, mentorship programs, on-line education programs, recruiting students with business skills and interests).

2.3 Explore collaborations with other mental health professional and consumer organizations to determine how we could become partners (e.g. presentations at conferences, booths at exhibit halls) and how those partnerships can advance our goals.

3. Expand the reimbursement resources for mental health practice.

3.1. Advocate broadening reimbursement for occupational therapy in mental health under Medicare local coverage determinations.

3.2 Advocate broadening reimbursement for occupational therapy in mental health under Medicaid at the state level in collaboration with AOTA State Affiliates (e.g. develop resources for states to use, track potential changes to the Medicaid rehabilitation option at the Federal level to oppose narrowing of the definition and to support the use of the distinct occupational therapy benefit to offset any restrictions on the rehab option).

3.3. Advocate with managed care companies to broaden reimbursement for occupational therapy in mental health.

4. Create and disseminate evidence that supports occupational therapy in mental health.

4.1 Identify outcomes that are meaningful to consumers and payors that can be addressed by mental health occupational therapy practitioners.

4.2. Invite program directors from NIMH, NIDRR and/or NARSAD) to present an institute at AOTA on relevant research initiatives at their institutions, and tips for successful grant writing.

4.3. AOTA to facilitate the attendance of mental health OT researchers at advisory councils or other appropriate meetings of granting agencies.

4.3. Expand the evidence based reviews to explore focused questions related to recovery oriented outcomes in schizophrenia and mood disorder. These reviews should be consistent with the core competencies identified in 1.1.

4.4. Conduct evidence based reviews related to core competencies of mental health occupational therapy for elders with depression.

4.5. Publish a compendium of already published research articles and systematic reviews that are either critical to the knowledge base of mental health occupational therapy practitioners and/or support mental health occupational therapy practices.

Full Report

Introduction

In July, 2006, AOTA President Carolyn Baum and President-elect Penelope Moyers invited a group of AOTA members to meet and develop a report for the AOTA Board of Directors regarding issues in the area of Mental Health that are facing the profession of occupational therapy and that are integral to fulfilling the Centennial vision. The World Health Organization (WHO) reports that one in four people in the world will be affected by mental or neurological disorders at some point in their lives. Around 450 million people currently suffer from such conditions, placing mental disorders among the leading causes of ill-health and disability worldwide. (WHO, 2001) Occupational therapy has its roots in the treatment of mental illness, but concerns have existed for many years about practice and education in this area. AOTA has engaged in various activities related to these issues in the past fifteen years. Information about some of the past and current activities addressing mental health issues will serve as background for this report.

Background

In 1995, the AOTA Mental Health Education Task Force (MHETF) reported on a series of focus groups of practitioners, educators and students which examined mental health education and practice in occupational therapy. They identified numerous issues effecting practice and education and made recommendations to address them (AOTA Mental Health Education Task Force, 1995). Subsequently, a motion was passed by the AOTA Representative Assembly recommending a task group be formed to examine the recommendations of the MHETF and identify a course of action for AOTA. This task group recommended the formation of a leadership training project in mental health that

would be modeled upon AOTA's Promoting Partnerships, a project that had been successfully mounted to address issues in occupational therapy practice in school systems.

The AOTA Mental Health Partnership Project (Hanft & Scheinholtz, 1999) was funded by the AOTA in 1999 to identify leading practices in mental health occupational therapy and to provide training to state representatives to promote leadership and advocacy in mental health services. In the first year of the project, training modules were developed through work with leaders in the practice of mental health occupational therapy and through collaboration with the National Mental Health Association and the National Alliance for the Mentally Ill. Twenty eight state Occupational Therapy Associations chose to participate in the project and paid travel expenses for their representatives to attend the training program. Outcomes of the project included promotion of state level networks of occupational therapy practitioners and educators and training at state and local conferences, and many collaborative activities with state and local consumer and advocacy groups. In addition, since the completion of the project, numerous participants have assumed national leadership positions, e.g. Speaker of Representative Assembly, Chairperson of Special Interest Sections, or advanced in academic and research activities pertinent to mental health.

In 1999, the U.S. Surgeon General (USDHHS, 1999) identified that 21 percent of children had a diagnosable mental or addictive disorder associated with at least minimal functional impairment and 11 percent experience significant to extreme functional impairment. AOTA recognized that a focus on this area of mental health was needed to promote the identification and utilization of occupational therapy services for these

children. Under the auspices of the ASPIIRE project funded by the U.S. Department of Education, Office of Special Education Programs, AOTA formed a special workgroup to review occupational therapy services for children and youth with behavior/psychosocial problems. A group of occupational therapy practitioners, educators and a consumer representative met in September, 2000 to develop recommendations for preparing and supporting occupational therapy practitioners for this area of practice. The workgroup described occupational therapy's role and the resources and challenges to providing interdisciplinary services, including occupational therapy, to children/youth with behavioral and psychosocial issues and their families (Hanft, 2000).

In response to these recommendations, AOTA sponsored several educational programs over the next several years at its annual conference and featured several articles in OT Practice magazine on the topic of occupational therapy services for children and youth. In addition, AOTA conducted an evidence-based review of literature to identify activities within the domain of occupational therapy which addressed issues that interfered with occupational performance of children and youth, for example in the areas of academic performance, self-care, family and home responsibilities and social participation. The results of the evidence-based review and implications for occupational therapy practice were incorporated into the Occupational Therapy Practice Guidelines for Children with Behavioral and Psychosocial Needs (AOTA, 2005). Wishing to further disseminate the findings of this evidence-based review and to provide training in areas identified by the 2000 workgroup, AOTA collaborated with the University of Minnesota to submit a research proposal to the Maternal and Child Health Division of the U.S. Health Resources Services Administration (HRSA). The proposal was well received by

HRSA, but not funded due to limited resources. Evidence-based reviews on autism and sensory integration were initiated by AOTA in 2006 and a proposal was recently submitted to the Agency on Healthcare Research and Quality to hold a dissemination conference for occupational therapy practitioners to translate the relevant findings of the three reviews for pediatric mental health

In addition, in the late 1990s, AOTA had been focusing on the area of violence prevention in children and youth in response to a series of shootings that occurred in schools in the United States. In September, 2000, AOTA was awarded an \$85,000 contract to study occupational therapy's role in violence prevention relative to pediatric mental health. Families and Schools Together (FAST) is an evidence-based and manualized violence prevention program that involves families and children with school and mental health professionals in an activity based time limited intervention.

AOTA/FAST was funded by the Center for Mental Health Services (CMHS), a division of the Substance Abuse and Mental Health Services Administration (SAMHSA) under the U.S. Department of Health and Human Services (HHS) as part of its violence prevention initiative. The AOTA/FAST Project involved occupational therapists and occupational therapy students and was completed in May 2001. Overall, the research found that occupational therapists are appropriate for the role of FAST team leaders and have a unique perspective and skill set to contribute to FAST program implementation and development (AOTA, 2001).

Also in 2001, AOTA completed an evidence-based review on substance use disorders to determine effective treatment interventions fitting within the scope of occupational therapy practice. A narrative summary of the findings and

recommendations for occupational therapy practice was published in AJOT (Stoffel & Moyers, 2004) and evidence briefs on selected articles from the study were published on AOTA's webpage.

Recent AOTA activities that address occupational therapy practice in mental health include: liaisons and collaborations with federal agencies and non-governmental organizations that focus on mental and addictive disorders; advocacy on federal legislation to promote mental health parity; investigation of state regulations that identify occupational therapists as qualified mental health providers; involvement in the Annapolis Coalition project on education and training of the mental health workforce; establishing an AOTA board certification in mental health and identifying specific competencies to attain it; conduct of a survey by the AOTA Commission on Education of the curricula of educational programs that address mental health services for adults with severe and persistent mental illness; formation of a workgroup to recommend a plan to AOTA and the American Occupational Therapy Foundation regarding disaster preparedness and response, which has a significant mental health/psychosocial focus; and providing educational programs at annual conference that focus on evidence-based mental health practice in community settings that focuses on consumer centered practice and recovery from mental illness.

In 2005, a presidential ad hoc group met and submitted a report to the AOTA board of directors on promoting occupational therapy in mental health systems. The workgroup submitted seven recommended actions and several were either approved by the AOTA Board of Directors or submitted as motions to the AOTA Representative

Assembly by the President for further discussion and action in 2006 (Pitts, Lamb, Ramsay, Learnard, Clark, Scheinholtz, Metzler & Nanoff, 2005).

In 2006, the RA approved an AOTA policy statement on occupational therapy practice in mental health. The RA also approved several motions related to mental health in 2006 which resulted in ongoing activities. A workgroup has been formed to examine specific barriers and strategies to attain qualified/core mental health practitioner status at state and federal levels for occupational therapists; it will report to the 2007 RA. An evidence-based review on mental health has been initiated with a literature review on one focused question which is to be completed by July, 2007. The mental health survey being conducted by the Commission on Education has been completed with a report and recommendations going to the 2007 RA (A draft of the report was shared with this ad hoc group). The workgroup on disaster preparedness and response is finalizing its work and expects to report to AOTA and AOTF in early 2007 and AOTA is conducting discussions with the U.S. Department of Health and Human Services, specifically the Office on Disability and the Substance Abuse and Mental Health Services Administration, and the Red Cross regarding the role and certification of occupational therapy practitioners as disaster mental health providers.

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barriers to achieving Qualified Mental Health Provider status for OT practitioners in mental health, the AOTA/AOTF workgroup to identify recommendations for Disaster Preparedness and Response, and the COE survey of educational preparation related to Severe and Persistent Mental Illness. These issues include: 1) core competencies for entry-level occupational therapy practitioners in mental health practice, 2) the role of occupational therapy practitioners in mental health systems, 3) payment/reimbursement sources for occupational therapy in mental health, and 4) evidence to support occupational therapy practice in mental health. Although there are significant challenges towards success in each of these areas, there are also opportunities available that can support our progress towards reestablishing occupational therapy as a primary provider in mental health systems. Transformation of the current mental health system has been identified as a federal and state priority in response to the President's New Freedom Commission on Mental Health Report (2003) and significant funding and time is being spent on this by many federal agencies (USDHHS, SAMHSA, 2005).

Core competencies for entry level occupational therapy practitioners in mental health practice.

Before the core competencies can be identified there must be some consensus as to what constitutes the occupational therapy scope of practice in mental health. In addition, the scope of practice must be backed by evidence that is drawn not just from occupational therapy literature and research but other psychology/psychiatry related sources as well. The occupational therapy scope of practice should take into account all areas of mental health practice, including acute care, partial hospitalization program,

private practice, long term care, schools, and all areas of community practice. Once the scope of practice is identified, there must be a set of established competencies that all occupational therapy practitioners have when graduating to ensure there is a product that can be marketed to all of the practice areas mentioned above. Included in these competencies are such things as establishing a clinical reasoning framework, skills for developing understanding of the state and local mental health system, and systematic program development, to name a few. These competencies would allow occupational therapy practitioners to practice their full scope of practice and include participating in mental health system activities such as treatment planning, discharge planning, case management, program development and management, etc. Furthermore, these core competencies would emphasize teaching occupational therapy practitioners to provide population based services.

The survey of mental health content in occupational therapist and occupational therapy assistant education programs provides a resource as to the competencies that are currently being taught (these will be specified in the COE report to the RA in 2007). This can be compared against the list of competencies that are truly necessary for entry level occupational therapy practice in mental health. In addition, the 2006 ACOTE standards include many competencies directly related to mental health practice (See Appendix A). Competencies that fall outside the realm of direct service are some of the most vital for establishing occupational therapy in current mental health systems but are also the most likely to be missing from occupational therapy education programs. They include competencies that are important for all practice areas such as:

- Advocate for services to meet the needs of individuals, groups and populations;

- Work collaboratively with community organizations, social service agencies, and other partners in design of supportive environments and services;
- Develop and implement public education programs and other mechanisms for providing information about client needs;
- Evaluate the research literature (including the literature outside of occupational therapy) and apply evidence to practice;
- Develop and evaluate the effectiveness of programs and use evaluation data to revise programs;
- Develop business plans to establish new forms of service provision;
- Market occupational therapy services to administrators, payors, and other mental health professionals;
- Identify sources of funding and secure grants to provide needed services;

There are additional competencies that are specific to mental health practice including:

- Apply current evidence based interventions from psychiatric rehabilitation/other psychosocial literature;
- Apply recovery model principles to occupational therapy and provide evaluation, planning and treatment that are truly consumer driven;
- Negotiate and work within state and local systems important to recovery -, i.e., employment support, income support (social services) and housing support.

It is important that the core competencies in mental health occupational therapy are consistent with the needs of consumers. The recovery model, which originated with consumers, provides information about what consumers want from service providers.

The adoption of the recovery model for mental health services provides enormous opportunity for occupational therapy practitioners. The recovery model as described in the *Phase One Research Report: A National Study of Consumer Perspectives on What Helps and Hinders Recovery* (2002) identifies 8 areas or domains of concern for consumers during the process of mental health recovery.

1. **Basic material resources** – livable income, safe and decent housing, healthcare, transportation, a means of communication
2. **Social dimension** – interdependent social relationships including families, friends, peers, neighbors, colleagues that are mutually supportive and beneficial
3. **Meaningful activities** (connect to community) – job and career, education, volunteering, group advocacy efforts, part of program design/policy level decision-making
4. **Personhood** (an internal sense of self, inner strivings, and whole being) - hope, faith, purpose, expectancy, goals, options, role models, friends, optimism, positive personal experiences
5. **Self-agency** (intentionally living one's life on one's own accord) – understand their experience, be educated and have good information, actively participate in making important choices
6. **Empowerment** – control and power over their lives with access to meaningful choices and resources (basic material resources, social dimension, self-agency)
7. **Independence** – self-determination, basic civil and human rights and freedoms, livable income, transportation, housing; interdependence

8. **Peer services**– expanded support of peer education, outreach, role models, mentors, advocates; experienced experts/peer specialists employed across all levels of mental health service provision

These areas of concern are consistent with the types of occupational therapy outcomes identified in the *Occupational Therapy Practice Framework* (AOTA, 2002) (engagement in occupations to support participation in context - occupational performance in ADLs, IADLs, work, education, play, leisure; client satisfaction; adaptation – resilience; health and wellness; quality of life) but the occupational therapy outcomes do not seem to be very well-developed nor operationalized in current occupational therapy practice in mental health. For example, after receiving occupational therapy services has the person been more successful in daily living in their supported apartment or been able to keep their job because of more punctual attendance? Are occupational therapy practitioners providing services that are relevant and meaningful to the client? Have the number of adverse events that precede termination of a job or housing situation been reduced after receiving occupational therapy services? Do clients feel empowered to make decisions about their daily activities and social contacts and consequently are more satisfied? Do consumers receive education and accurate information to monitor their own physical health status? Does participation in occupational therapy foster hope? Is the client able to deal more effectively with daily problems after occupational therapy services (resilience)? Does the consumer get along better with friends, peers and family members because of occupational therapy? Does the child/young adult attend school more frequently because of occupational therapy

services? This list of questions could be used to help in the identification of outcomes for occupational therapy research.

By matching our core competencies with the outcomes that are of greatest interest to consumers and families we can maximize our impact in the field of mental health. In addition, many service systems (e.g. state hospitals, community mental health systems, the VA system) are adopting recovery principles. Therefore occupational therapy practitioners can more readily enter those systems with expertise that complements the goals of recovery.

The role of occupational therapy practitioners in mental health systems

There are two separate but related policy issues facing the profession as it expands its role in the area of mental health practice. Qualified Mental Health Provider (QMHP) status is very important for gaining access to employment and reimbursement under the mental health system administered by most states as a separate entity from their Medicaid program even though Medicaid funds provide substantial funding to that entity. On the other hand, there are opportunities for occupational therapy practitioners to provide occupational therapy to people with mental illness by advocating with the various payers to cover occupational therapy and specifically coverage of billing for occupational therapy evaluation and treatment for people with mental health diagnoses. These differences in these two areas require separate strategies to ensure that occupational therapy practitioners can have an expanded role in all aspects of mental health practice.

The field of mental health has been noted by the Institute of Medicine, among others, as being ineffective due to the segmentation of the system and siloed nature of practice. This presents an additional barrier as other disciplines that currently have

QMHP status will likely be opposed to including occupational therapists as QMHP.

Occupational therapy must clearly define its role and contribution in order to eliminate or at least reduce opposition from current core or qualified mental health professions and in order to make our case to payers. Another strategy is to promote occupational therapy as a primary discipline within the scope of psychiatric rehabilitation. Since occupational therapy is generally regarded as a primary player in physical rehabilitation and because of our history in mental health rehabilitation, we have a strong foundation upon which to build this argument. Highlighting the role of occupational therapy as a rehabilitation profession that treats impairments of function regardless of the cause, both physical and mental, is a vital step for moving the profession forward. To achieve that goal, we must improve our outcomes data and practice evidence in order to bolster our arguments and convince payers that occupational therapy is an efficient and effective service for people with mental illness.

Mental health practice is looked at largely as talk therapy and pharmaceutical intervention for people with mental illness and the groups most broadly accepted as mental health professions by both consumers and payers are those designated as “Core” or “Qualified” Mental Health Professionals. Many states use QMHP to dictate who can be licensed mental health professionals which has implications for restricting access to groups not named as QMHPs in the public health system. Psychologists, psychiatrists, clinical social workers, licensed marriage and family therapists and psychiatric nurse practitioners currently comprise the Core Mental Health Professions at the federal level and Qualified Mental Health Professionals (QMHP) at the state level. Inclusion into that

group would be a policy and public awareness victory that would help expand the understanding of and access to occupational therapy for people with mental illness.

When occupational therapy practitioners address physical concerns in people with mental illness and are reimbursed for this, they are not seen as a mental health profession or as an essential part of a mental health treatment team.

Understanding the issue of CMHP/QMHP status and knowing the challenges and opportunities the profession face when trying to achieve that goal is an important part of developing a sound and cohesive strategy to expand the role of occupational therapy in mental health practice. A separate work group has been appointed by the President in response to RA Charge 2006C427 to report on barriers and strategies to attaining core and QMHP status for occupational therapy. This group supports the charge of that workgroup, while also recommending that we consider the alternate or additional strategy of boosting our role as a primary discipline in psychiatric rehabilitation. There are significant opportunities in this area as national and regional initiatives support the move towards a recovery orientation. The recovery model is gaining acceptance as evidenced by endorsements from the President's New Freedom Commission on Mental Health (2003) and the National Alliance for the Mentally Ill. The Department of Veteran Affairs and many state mental health systems have developed or are in the process of developing recovery oriented services.

There are many leadership positions within mental health systems that are ideally suited for occupational therapists (e.g. program directors in supported housing or employment programs, clubhouse and other community based psychosocial rehab programs; consultation to consumer operated programs, such as drop-in centers and

housing programs, executive directors of community programs that focus primarily on psychosocial rehabilitation; case management supervisors); however many occupational therapists are either disinterested or ill-prepared to assume these leadership roles.

Education should include the skills required to manage a mental health service such as community living programs, assisted living programs, and to provide consultation and direct services through private practice models. This may encompass such skills as billing – whether through consumer pay or third party payers, personnel management, documentation, business practice, etc. Some of these skills could be developed at the entry-level. However, there are other leadership skills that would be more appropriate for advanced practice and could be developed through doctoral level occupational therapy education or collaborations with degree programs in other disciplines (e.g. MBA).

Moreover, there may be other methods of developing leadership skills such as mentorship, leadership training institutes at face to face meetings, such as annual conference, other AOTA continuing education products and/or the Specialty Certification Process.

Despite occupational therapy's limited presence in mental health practice, occupational therapy has a vital contribution to make in preventing mental health problems, in providing habilitation services, and in rehabilitating individuals with mental health problems. Simply put, the profession's central contribution is its emphasis on occupation, on the everyday function of human beings.

Among the important skills that occupational therapy practitioners bring to the table in mental health is their understanding of activity analysis. Occupational therapy practitioners assist consumers and their families with meeting role responsibilities

through a process of assessment and intervention that considers both the person (e.g. cognition, sensory processing) and the environment and the complex interaction of person/environment. It is the totality of our expertise in the person, environment and occupation and our emphasis on directly addressing functional performance through engagement in activities that makes occupational therapy unique in the field of mental health practice. Our expertise is such that we can provide services not only to the individual, but populations. In addition, we have skills that allow us to train and supervise direct care staff across all areas of mental health practice.

Payment/reimbursement sources for occupational therapy in mental health

There can be a large pay differential for occupational therapy practitioners practicing in mental health settings as compared to other areas of occupational therapy practice. Lower salaries in some areas of mental health practice present a major barrier towards increasing our presence in mental health systems. Data from AOTA surveys in 1997, 2000 & 2006 indicate that mental health practitioners are making lower salaries than occupational therapy practitioners in other practice areas. This is particularly true in community based practice where salaries for direct service staff tend to be low.

Unfortunately, community based practice is an area where the potential for mental health occupational therapy to have an impact is great.

Medicare and Medicaid reimbursement in mental health contribute to low salaries and more generally a lack of access to occupational therapy services for consumers with mental health needs. In addition, the lack of mental health parity in private insurance means that occupational therapy is typically not covered from this funding stream as well. One way to address Medicare may be to advocate at the federal level to broaden local

coverage determinations on occupational therapy coverage to include major mental illness diagnoses. Likewise, at the state level, advocacy efforts could focus on broadening mental health occupational therapy through Medicaid. Private insurance could be addressed as well. In addition advocacy efforts should be directed at including occupational therapy as an individual service rather than being part of the day rate.

Evidence to support occupational therapy practice in mental health

To address any of the issues above (core competencies, role in mental health, payment/reimbursement) occupational therapy must improve our outcomes data and practice evidence. We must make a serious effort to conduct research that shows administrators, payers and consumers that occupational therapy is an efficient and effective service for people with mental illness.

Occupational therapy practitioners have made only a modest contribution to the research literature in mental health. However, the number of researchers in occupational therapy is increasing, and there is a cadre of mental health occupational therapists conducting relevant research. Much of the occupational therapy research in mental health is coming out of countries outside of the United States (e.g. Canada & Australia), yet most of this research is still very relevant to practice in the United States. Moreover, there is a significant body of research conducted by other disciplines that provides evidence to support occupational therapy practices.

There are windows of opportunity where occupational therapy can have a significant impact on the field of mental health research. It is now acknowledged that in the area of research and practice for people with serious mental illness, there is a dearth of valid and reliable measures of functional performance (McKibben et al, 2004). The

National Institutes of Mental Health currently has a Program Announcement (PA -05-037) on Functional Assessment of People with Mental Disorders. Another NIMH program announcement of particular relevance to occupational therapy is PA-06-427 – Research on Community Integration for People with Psychiatric Disabilities. These program announcements indicate an increasing interest in applied behavioral research in serious mental illness. Relevant program announcements for mental health issues for children/adolescents and older adults should also be explored.

AOTA is also designated as a National Outreach Partner for NIMH giving us access to program announcements and access to the NIMH leadership to influence the direction of mental health research. AOTA should take advantage of this relationship to the extent possible to help support the profession’s mental health initiatives.

In addition to a weakness in contributing to the research literature, mental health occupational therapy practitioners are not making use of existing research evidence to support their practice. AOTA's evidence briefs provide one easily accessible source of research evidence for students and practitioners. The evidence briefs are organized primarily by diagnosis and there are mental health diagnoses that are already included (substance abuse, mental health and psychosocial disorders in children and adolescents) and others that are under development (e.g. dementia and autism). However some important literature gets missed with this organization strategy and additional diagnoses should be addressed (e.g. schizophrenia, mood disorders).

AOTA is currently supporting a systematic review using the research question:
“What occupational therapy interventions are effective for improving and maintaining participation and performance in paid and unpaid employment (volunteer opportunities, home management, child care) and education with severe mental illness?”

This will provide another useful resource for evidence based practice. Further systematic reviews should be conducted in the areas of depression in older adults and additional focused questions should focus on recovery oriented outcomes for children, adults and older adults. Examples for focusing review questions have been mentioned previously in our discussion of the recovery model.

Although systematic reviews provide a practical method for analyzing areas in which a significant body of research exists, there are many areas of mental health practice in which only a limited body of research exists. Yet there are important studies that could have significant implications for occupational therapy practice and suggest areas where we might contribute our expertise. For example, there is a small but growing evidence base related to interpersonal and social rhythm therapy which focuses on helping people with bipolar disorder establish routines in their daily life (Frank et al, 2005). In addition there are seminal articles that may not fit in a particular review or evidence brief that are influencing the field of mental health, but may be unknown to occupational therapy practitioners. For example, Michael Green and colleagues (1996, 2000) have widely cited review papers discussing the relationship of cognition and functional performance in schizophrenia. A selected list of important research is included in Appendix B.

In summary, the issue of evidence based practice in mental health has two important components. There needs to be substantial efforts towards increasing the evidence base that supports the efficacy of occupational therapy in mental health. In addition, occupational therapy practitioners need to be aware of existing research that is vital for best practice in mental health.

All four of the issues identified by the 2006 Ad Hoc Group on Mental Health can best be addressed through knowledge of and in some cases in collaboration with other agencies and partners with similar concerns. Appendix C provides an initial draft (formulated by this committee) of a list of agencies, their purpose, and their contact information. In terms of working with other agencies the following suggestions are provided –

- Over-arching agencies that provide services or resources across the broadest spectrum of needs or practice areas are most important partners, as these relationships can accomplish more with a single investment of time and resources. These agencies generally include federal-level government agencies and broad-based organizations.
- Projects where regional/local interests are of primary concern may best be researched and initiated on a regional/local agency level. This also provides a foundation for broader networking if larger projects are anticipated for future development. Most of the organizations noted will have regional/local branches which may be able to facilitate relationships with their national offices.
- Legislative bodies and members are critical partners toward not only policy change, but also funding and community awareness/recognition of needs, services, and initiatives.
- It is important to consider existing relationships between occupational therapy and these organizations and those that can be facilitated through further collaboration. Clarification of occupational therapy's mental health foundations and role is critical toward the development of equity in professional partnerships.

These agencies can be used as resources in addressing the recommendations that follow.

Many of the priorities listed below can be undertaken simultaneously and the profession can build upon the victories achieved, but these priorities represent not only areas where we can make initial progress but where the need is greatest. To achieve our ultimate goal of making occupational therapy a typical and necessary part of mental health treatment requires a coordinated effort involving changes in advocacy, educational preparation, licensing/certification, creating a body of research evidence, establishing a system of post-degree supervision and educating the public, policy makers, payers and other providers about what occupational therapy can bring to mental health practice and how rehabilitation in mental health is equally as important as it is for physical illnesses and developmental disabilities.

1. Establish core competencies for mental health occupational therapy practice and the educational methods to obtain them.

1.1 Bring together experts in a face to face meeting to further delineate and specify the scope of practice in mental health occupational therapy. This group would also identify the knowledge and skills necessary to carry out these practices.

1.2. Create a model curriculum for entry level mental health occupational therapy. It is suggested that representatives from COE, MHSIS, EDSIS and other mental health educators make up the group that develops this curriculum. The model curriculum should be based on the scope of practice identified in recommendation 1.1. Furthermore, the model curriculum should provide general guidelines regarding the amount of time/emphasis on a particular topic (e.g. suggesting credit hours).

2. Expand the role of occupational therapy in mental health systems

2.1. Explore the Association's position on the use of Advanced or Specialty Certification related to advocacy in the area of mental health. AOTA's Certification programs could be used to address challenges and concerns when competing with other non-entry level professional designations of QMHP status. Explore establishing a system of post graduate supervision that is consistent with other QMHP professionals.

2.2. Explore methods for developing leaders in mental health occupational therapy (e.g. combined OT-MBA programs or mentorship programs, hosting leadership institutes at conferences, supporting the development of OTD leadership tracts, mentorship programs, on-line education programs, recruiting students with business skills and interests).

2.3 Explore collaborations with other mental health professional and consumer organizations to determine how we could become partners (e.g. presentations at conferences, booths at exhibit halls) and how those partnerships can advance our goals.

3. Expand the reimbursement resources for mental health practice.

3.1. Advocate broadening reimbursement for occupational therapy in mental health under Medicare local coverage determinations.

3.2 Advocate broadening reimbursement for occupational therapy in mental health under Medicaid at the state level in collaboration with AOTA State Affiliates (e.g. develop resources for states to use, track potential changes to the Medication rehabilitation option at the Federal level to oppose narrowing of the definition and to support the use of the distinct occupational therapy benefit to offset any restrictions on the rehab option).

3.3. Advocate with managed care companies to broaden reimbursement for occupational therapy in mental health.

4. Create and disseminate evidence that supports occupational therapy in mental health.

- 4.1 Identify outcomes that are meaningful to consumers and payors that can be addressed by mental health occupational therapy practitioners.
- 4.2. Invite program directors from NIMH, NIDRR and/or NARSAD) to present an institute at AOTA on relevant research initiatives at their institutions, and tips for successful grant writing.
- 4.3. AOTA to facilitate the attendance of mental health OT researchers at advisory councils or other appropriate meetings of granting agencies.
- 4.3. Expand the evidence based reviews to explore focused questions related to recovery oriented outcomes in schizophrenia and mood disorder. These reviews should be consistent with the core competencies identified in 1.1.
- 4.4. Conduct evidence based reviews related to core competencies of mental health occupational therapy for elders with depression.
- 4.5. Publish a compendium of already published research articles and systematic reviews that are either critical to the knowledge base of mental health occupational therapy practitioners and/or support mental health occupational therapy practices.

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APPENDIX A

Foundational Knowledge: In order for occupational therapy students to gain successful understanding of occupational therapy practice in the mental health area, the 2006 ACOTE standards provide us with guidelines to consider. There are also other factors that become critical for occupational therapy students to adopt for work in this practice area, including (items with * come directly from ACOTE standards 2006 – the standard code is provided):

- Be prepared to articulate and apply occupational therapy theory, evidenced-based evaluations, and interventions to achieve expected outcome as related to occupation.*
- Be prepared to advocate as a professional for the occupational therapy services offered and for the recipients of those services.*
- Demonstrate knowledge and understanding of human development throughout the life span.* (B.1.5)
- Demonstrate knowledge and understanding of concept of human behavior to include behavioral and social sciences (Introductory Psychology, abnormal psychology, and Intro to Sociology or Anthropology.) * (B.1.6)
- Demonstrate knowledge and appreciation of the role of sociocultural, socioeconomic, and diversity factors and lifestyle choices in contemporary society. * (B.1.7)
- Understand and be able to apply the Occupational Therapy Practice Framework (OTPF) in this area of practice.
- Appreciate the basic tenets of activity analysis.

- Appreciate the role of occupational therapy in this practice areas and the history of occupational therapy.

Occupational Therapy Specific Knowledge:

- Articulate the importance of balancing areas of occupations with the achievement of health and wellness. * (B.2.4)
- Analyze the effects of physical and mental health, heritable disease.....within the cultural context of family and society on occupational performance. * (B.2.6)
- Select appropriate assessment tools based on client needs, contextual factors, and psychometric properties of tests. * (B.4.2)
- Select and provide direct occupational therapy interventions and procedures to enhance safety, wellness, and performance in ADL, IADL, education, work, play, leisure, and social participation. * (B.5.2)
- Provide therapeutic use of self... * (B.5.6)
- Modify environments. * (B.5.8)
- Differentiate among the contexts of health care, education, community, and social systems are they relate to the practice of occupational therapy. * (B.6.1.)
- Thorough understanding of the role of occupational therapy in this area versus other professional services.
- Clear understanding of group protocols and group dynamics.
- Demonstrate awareness of the various frames of references used in this area of practice (including cognitive, recovery model, community-based considerations, etc.)
- Develop and implement occupational therapy interventions based on the occupational profile, assessment and the OTPF.
- Understand local, state, federal, national laws that affect the practice of occupational therapy in this area (especially parity laws, 201 vs. 302, etc).

Practice Skills

- Develop and promote the use of appropriate home and community programming to support performance in the client's natural environment and participation in all contexts relevant to the client. * (B.5.15)
- Apply the principles of the teaching-learning process using educational methods to design educational experiences to address the needs of client, family, significant others, colleagues, other health providers, and the public. * (B.5.17)
- Integrating fieldwork sites that are reflective of newer areas of practice (community based, work with homeless, work in alternative school transition service with at-risk youth, etc).
- Ensure that somewhere throughout an occupational therapy student's educational career, they are exposed to working with clients in a mental health setting, whether through a level I fieldwork, class field trip experiences, etc.

Additional Skills for Emerging Areas of Practice

- Advocate for services to meet the needs of individuals, groups and clients;
- Work collaboratively with community organizations, social service agencies, and other partners in design of supportive environments and services;

- Develop and implement public education programs and other mechanisms for providing information about client needs;
- Read and understand research literature and evaluate findings;
- Evaluate effectiveness of programs and use evaluation data to revise programs;
- Develop business plans to establish new forms of service provision;
- Identify sources of funding and secure grants to provide needed services

Appendix B

SAMHSA has developed free toolkits for implementing five evidence based practices - <http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/about.asp>

1. Illness management and recovery
2. Assertive Community Treatment
3. Family Psychoeducation
4. Supported Employment
5. Integrated Dual Diagnosis Treatment

Psychiatric Rehabilitation Journal special issue on Evidence Based Practice – Spring 2004

Reviews of cognition and functional outcomes in schizophrenia

Green, M.F. (1996). What are the functional consequences of neurocognitive deficits in schizophrenia? *American Journal of Psychiatry*, 153, 321-330.

Green, M.F., Kern, R.S., Braff, D.L. & Mintz, J. (2000). Neurocognitive deficits and functional outcome in schizophrenia: Are we measuring the "right stuff"? *Schizophrenia Bulletin*, 26, 119-136.

Functional assessment

McKibbin, C.L., Brekke, J.S., Sires, D., Jeste, D.V. & Patterson, T.L. (2004). Direct assessment of functional abilities: Relevance to persons with schizophrenia. *Schizophrenia Research*, 72, 53-67.

Interpersonal and social rhythm therapy for bipolar disorder (helps people identify disruptions in daily routines and develop a regular schedule)

Frank, E., Kupfer, D. J., Thase, M.E., Mallinger, A.G., Swartz, H.A., Eagiolini, A. M., Grochocinski, V., Houck, P., Scott, J., Thompson, W., & Monk, T. (2005) Two-Year Outcomes for Interpersonal and Social Rhythm Therapy in Individuals With Bipolar I Disorder. *Archives of General Psychiatry*. 62, 996-1004.

Efficacy of psychosocial intervention in schizophrenia (includes skills training, cognitive remediation, family psychoeducation, cognitive behavioral therapy for positive symptoms)

Pfammater, M., Junghan, U.M., & Brenner, H. D. (2006). Efficacy of psychological therapy in schizophrenia: Conclusions from meta-analyses. *Schizophrenia Bulletin*, 32 suppl. 1, S64 – S-80.

Cognitive adaptive therapy – modifying the environment to support ADL/IADL performance

Velligan, D.I., Prihoda, T.J., Ritch, J.L., Maples, N., Bow-Thomas, C.C., & Dassori, A. (2002). A randomized single-blind pilot study of compensatory strategies in schizophrenia outpatients. *Schizophrenia Bulletin*, 28, 283-292.

The skills training component of dialectical behavior therapy

Robins C.J. & Chapman A.L. (2004) Dialectical behavior therapy: current status, recent developments, and future directions. *Journal of Personality Disorders*. 18, 73-89.

Koerner K. & Linehan M.M. (2000) Research on dialectical behavior therapy for patients with borderline personality disorder. *Psychiatric Clinics of North America*. 23, 151-67, 2000 Mar.

Meta-analysis indicating social skills most effective when done across real environments (e.g. classroom, playground, home)

Magee, Q. M., Kavale, K.A, Mathur, S.R., Rutherford, R.G., Forness, S.R. (1999) A meta-analysis of social skill interventions for students with emotional or behavioral disorders. *Journal of Emotional and Behavioral Disorders*. 7(1), 54-64.

Review of sensory motor interventions and autism

Baranek, G.T. (2002). Efficacy of sensory motor interventions for children with autism. *Journal of Autism and Developmental Disorders*, 32, 397-422.

Impact of participation on health in older adults

Glass, T. A., Mendes de Leon, C., Marottoli, R.A., & Berkman, L. F. (1999). Population based study of social and productive activities as predictors of survival among elderly Americans. *British Medical Journal*, 319, 478-483.

Dementia caregiver intervention

Gitlin, L. N; Winter, L.; Corcoran, M.; Dennis, M. P; Schinfeld, S.; Hauck, W. W. (2003) Effects of the Home Environmental Skill-Building Program on the caregiver-care recipient dyad: 6-Month outcomes from the Philadelphia REACH initiative. *Gerontologist*, 43, 532-546.

APPENDIX C

CRITICAL PARTNERS IN MENTAL HEALTH

Networking Key Points

- Over-arching agencies that provide services or resources across the broadest spectrum of needs or practice areas are most important partners, as these relationships can accomplish more with a single investment of time and resources. These agencies generally include federal-level government agencies and broad-based organizations.
- Projects where regional/local interests are of primary concern may best be researched and initiated on a regional/local agency level. This also provides a foundation for broader networking if larger projects are anticipated for future development. Most of the organizations noted will have regional/local branches which may be able to facilitate relationships with their national offices.
- Legislative bodies and members are critical partners toward not only policy change, but also funding and community awareness/recognition of needs, services, and initiatives.
- It is important to consider existing relationships between occupational therapy and these organizations and those that can be facilitated through further collaboration. Clarification of occupational therapy's mental health foundations and role is critical toward the development of equity in professional partnerships.
- Issue of Core or Qualified Mental Health Professions:
 - Mental health practice is looked at largely as talk therapy and pharmaceutical intervention for people with mental illness and the groups most broadly accepted as mental health professions by both consumers and payers are those designated as "Core" or "Qualified" Mental Health Professionals. Many states use QMHP to dictate who can be licensed mental health professionals which has implications for restricting access to groups not named as QMHPs in the public health system.
 - Psychologists, psychiatrists, clinical social workers, licensed marriage and family therapists and psychiatric nurse practitioners currently comprise the Core Mental Health Professions at the federal level and Qualified Mental Health Professionals (QMHP) at the state level. Inclusion into that group would be a policy and public awareness victory that would help expand the understanding of and access to occupational therapy for people with mental illness.

- It is possible for occupational therapy practitioners to work with and be reimbursed for their services for people with mental illness but not seen as a mental health profession or as an essential part of a mental health treatment team when services are primarily referred and/or provided for physical concerns.
- Understanding the issue of CMHP/QMHP status and knowing the challenges and opportunities the profession face when trying to achieve that goal is an important part of developing a sound and cohesive strategy to expand the role of occupational therapy in mental health practice.
- This first chart provides an overview of partnerships that are critical to clarification and expansion of occupational therapy’s role in mental health across areas of practice. It is important to note that the over-arching partners cover all areas of practice. The second chart provides contact information for each agency and/or its parent agency with a general description included of the site, agency or partner’s relevance to OT.

Critical Partners Across Areas of Practice				
	Government	Private	Consumer	Organization
Over-arching	HHS SAMHSA NIH NIMH CDC Nat’l Council on Disability			AMA APA (psychology) APA (psychiatry) AMHCA (counselors) CMHA (Canadian) Nat’l Assoc Social Workers Assoc. for Behavioral and Cognitive Therapy NCCBH AHEC Mental Health Liaison Group (coalition of gov’t, consumer and professional groups) Bazelon Center for Mental Health Law National Association for Rights Protection and Advocacy (NARPA)
Acute	Veterans Administration State/Local Mental Health boards; County & Local Health Dept.	National Association of Research on Schizophrenia and Affective Disorders	National Alliance for the Mentally Ill	National Association of Psychiatric Health Systems
Community	Rural Assistance Center;	Ben and Jerry's	National Alliance for the	APHA

	<p>State/Local Mental Health boards; County & Local Health Dept.</p> <p>WHO</p> <p>NIDR</p> <p>Veterans Administration</p>	<p>Foundation</p> <p>Ittleson Foundation</p> <p>MacArthur Foundation</p> <p>Robert Wood Johnson Foundation</p> <p>Ways to Work</p> <p>National Association of Research on Schizophrenia and Affective Disorders</p>	<p>Mentally Ill</p> <p>National Empowerment Agency</p> <p>AA, ALANON, ALATEEN, NA</p> <p>Recovery Inc.</p>	<p>USPRA</p> <p>Provider Councils</p> <p>State Local Consumer Organizations</p> <p>Association of School Psychologists</p> <p>ASHA</p> <p>Council for Exceptional Children</p> <p>National Assoc. of County Behavioral Health and Developmental Disability Directors</p> <p>National County Behavioral Health and Developmental Disability Directors</p> <p>National Association of State Mental Health Program Directors (NASMHPD)</p> <p>Regional Health Program Directors</p>
Schools	<p>Head Start</p> <p>DOE</p> <p>Institute for Educational Science</p>	<p>Garth Brooks' Teammates</p> <p>For Kids Foundation</p> <p>Hasbro Children's Foundation</p> <p>Gifts In Kind</p> <p>Andrus Family Fund</p>	<p>NEA: State/Regional Education Assoc</p> <p>Parent to Parent</p> <p>PTA</p> <p>Parents as Educators</p> <p>National Home Education Network</p> <p>Autism/PDD Assoc.</p> <p>Alliance for Children and Families</p>	<p>Am Academy Child & Adolescent Psychiatry;</p>
Long Term Care	<p>Long-term care ombudsman</p> <p>Area Agencies on Aging</p> <p>Veteran's Administration</p> <p>National Council on Aging</p> <p>Nursing Home/Long-Term/ Assisted Living Directors</p>	<p>Geriatric Mental Health Foundation</p> <p>Andrus Foundation</p> <p>AARP</p> <p>National Association of Home Care and Hospice</p>	<p>Alzheimer's Assoc.</p> <p>National Alliance of the Mentally Ill</p> <p>Caregivers' Assoc.</p>	<p>APT</p> <p>AAGP/geriatric psychiatrist</p> <p>NARPA</p>

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Contact Information and Relevance for Critical Partners in Mental Health

<p>United States Government Agencies: As a source of policy regulation and major source of funding for many health initiatives, these agencies provide the foundation for many of our programs in mental health. Each division or agency addresses unique aspects of the mental health system, but there is always inter-agency regulation or oversight of programs, funding and services.</p>		
Agency	Online	Information Available
Centers for Disease Control (CDC) and Prevention Mental Health Work Group 4770 Buford Hwy, NE MS K-51 Atlanta, GA 30341-3717	http://www.cdc.gov/mentalhealth/index.htm	Health statistics, current research and related data, multi-agency links.
Mental Health Liaison Group	http://www.mhlg.org/	Policy, appropriations, and networking work group which includes national organizations representing consumer, family members, advocates, professionals and providers and representatives of federal agencies.
Institute of Educational Sciences 555 New Jersey Ave, NW, Washington, DC	http://ies.ed.gov/	Government agency charged to provide rigorous evidence on which to ground education practice and policy.
US Department of Health and Human Services Substance Abuse and Mental Health Administration (SAMSHA) P.O. Box 42557 Washington, DC 20015	http://mentalhealth.samhsa.gov/	Regulatory information, administrative contact information, statistical data, and inter-agency links.
National Association of County Behavioral Health and Developmental Disability Directors (NACBHD) c/o NACo	http://www.nacbhd.org/	Nationwide representative group focusing on unified policy and funding concerns related to behavioral health and developmental disability

440 First St. NW Suite 800 Washington, DC 20001		
National Association of State Mental Health Program Directors (NASMHPD) 66 Canal Center Plaza, Suite 302 Alexandria, VA 22314	http://www.nasmhpd.org/	Works under National Governors Association to address concerns regarding states' issues relating to mental health policy and administration. Also provides training support and technical assistance to members.
National Center for Health Statistics 3311 Toledo Road Hyattsville, MD 20782	http://www.cdc.gov/nchs/	Division of the Centers for Disease Control (CDC) providing statistics related to all areas of health and linkages to other agencies.
National Alliance for the Mentally Ill (NAMI) 2107 Wilson Blvd., Suite 300 Arlington, VA 22201-3042	http://www.nami.org/	Important consumer information network connection. Information regarding policy, advocacy and broad range of mental health topics and initiatives relevant to OT practice.
US Department of Education (USDE) U.S. Department of Education 400 Maryland Avenue, SW Washington, DC 20202	http://www.ed.gov	Significant source of information regarding educational policy and grant/funding initiatives
National Council on Disability (NCD) 1331 F Street, NW, Suite 850 Washington, DC 20004	http://www.ncd.gov/	Agency appointed by and advisor to the President and Congress regarding quality of life for all Americans with disabilities and their families. Links to legislative issues and individuals.
National Institutes of Health (NIH) 9000 Rockville Pike Bethesda, Maryland 20892	http://www.nih.gov/	General health grants information, research information, training, and links to broad areas of health policy and services.
National Institute of Mental Health (NIMH) Public Information and Communications Branch 6001 Executive Boulevard, Room 8184, MSC 9663 Bethesda, MD 20892-9663	http://www.nimh.nih.gov/	Division of NIH dedicated to mental health providing in-depth information and resources – important network for evidence-based practice concerns and advancement.
Rural Assistance Center School of Medicine and Health Sciences Room 4520	http://www.raconline.org	Rural health information and services “portal” Valuable site for all areas of rural health development including funding sources, policy information, and

501 North Columbia Road Stop 9037 Grand Forks, ND 58202-9037		contacts.
US Department of Veterans Affairs	http://www.va.gov/	Agency responsible for coordination and provision of primary care, specialized care, and related medical and social support services for veterans.
State and Local Government Agencies are also a source of information and resources. While information will vary from state to state, more extensive sites may be used as a template for recommendations to other jurisdictions or for other development purposes.		
Non-government Membership Organizations and Service Agencies provide professional and community partners toward research and development in areas of mental health service. Significant relationships when pursuing funding for grants or program development. List could be incorporate additional organizations depending on setting and needs.		
American Medical Association (AMA) 515 N. State Street Chicago, IL 60610 (800) 621-8335	http://www.ama-assn.org/	Source of information regarding medical trends, data and issues – potential networking resource for common initiatives.
American Academy of Child and Adolescent Psychiatry 3615 Wisconsin Avenue, N.W. Washington, D.C.20016-3007	http://www.aacap.org	Source of information and networking regarding medical trends, data and issues specific to child/adolescent concerns. Extensive clinician and family/consumer resource information and links.
American Mental Health Counselors Association 801 N. Fairfax Street, Suite 304 Alexandria, VA 22314	http://www.amhca.org/	Professional organization of mental health counselors may partner toward research or program development.
American Psychiatric Nurses Association 1555 Wilson Blvd., Suite 602 Arlington, VA 22209	http://www.apna.org/	Professional organization of psychiatric nurses and nurse practitioners
Andrus Family Fund	http://www.affund.org	Philanthropic organization focusing on social change – grantees include both adult and children’s programs.
Judge David L. Bazelon Center for Mental Health Law 1101 15th Street, NW, Suite 1212 Washington, DC 20005	www.bazelon.org	Agency providing legal services and advocacy for all areas of mental health/disability. Provides legislative alerts are information regarding current policy concerns.
Alliance for Children and Families	http://www.alliance1.org/	Interagency support organization for family and child service organizations.
Canadian Mental Health	http://www.cmha.ca	Closely related North American System with links to

Association 8 King Street East, Suite 810 Toronto ON M5C 1B5		programs and research.
County for Exceptional Children 1110 North Glebe Road, Suite 300, Arlington, VA 22201	http://www.ccc.sped.org	International professional organization focusing on issues surrounding all exceptional children including gifted/talented and those with developmental disabilities/needs.
Association for Behavioral and Cognitive Therapies 305 7th Avenue, 16th Fl., New York, NY 10001	http://www.aabt.org/	Primary organization site with links to resources and specialty areas related to cognitive and behavioral therapy application.
NARSAD: The Mental Health Research Association 60 Cutter Mill Road, Suite 404, Great Neck, New York 11021	http://www.narsad.org	Organization supporting scientific research toward development of treatment and solutions to mental illness.
National Association of Home Care and Hospice (NAHC) 228 Seventh Street, SE Washington, DC 20003	http://www.nahc.org/	Organization of home care agencies, hospices, home care aide organizations, and medical equipment suppliers.
National Association Directors of Nursing Administration in (NADONA/LTC) 10101 Alliance Rd., #140, Cincinnati OH 45242	http://www.nadona.org/	Educational organization for nursing and administration professionals in the Long Term Care and Assisted Living professions.
National Association of Psychiatric Health Systems (NAPHS) 701 13th Street, NW, Suite 950 Washington, DC 20005-3903	http://www.naphs.org/	Network of agencies and information regarding all areas of mental health services and policy. Significant relationship to OT applications across all areas of mental health practice.
National Council for Community Behavioral Healthcare (NCCBH) 12300 Twinbrook Parkway Suite 320 Rockville, MD 20852	http://www.nccbh.org/	Membership organization of organizational and individual mental health, substance abuse and developmental disability services providers. Organizational members include community mental health centers, hospitals, state associations of providers, and local behavioral health authorities.
American Speech Language Hearing Association 10801 Rockville Pike Rockville, Maryland 20852	http://www.asha.org/default.htm	Primary organization site with links to resources and specialty areas.
National Association of School	http://www.nasponline.org/	Primary organization site with links to resources and

Psychologists (NASP) 4340 East West Highway, Suite 402, Bethesda, MD 20814		specialty areas.
National Association of Social Workers 750 First Street, NE • Suite 700 • Washington, DC 20002-4241	http://www.socialworkers.org/	Primary site with links for specialty areas addressing mental health issues and services.
American Public Health Association (APHA) 800 I Street, NW Washington, DC 20001	http://www.apha.org/	Community health partner agency. Information and networking related to community health, advocacy, and services.
American Psychiatric Association 1000 Wilson Boulevard, Suite 1825, Arlington, Va. 22209-3901	http://www.psych.org/	Critical mental health partner in all areas of policy, program/service, funding, and research development. Extensive professional and community network potential
American Psychological Association 750 First Street, NE, Washington, DC 20002-4242	http://www.apa.org/	Professional organization with informational resources and potential partnerships toward research and publication.
American Physical Therapy Association (APTA) 1111 North Fairfax Street, Alexandria, VA 22314-1488	https://www.apta.org	Share policy, funding, program concerns especially in areas of rehabilitative service and public health.
World Health Organization (WHO) Regional Office for the Americas 525, 23rd Street, N.W. Washington, DC 20037 USA	http://www.who.int/en/	Global healthcare partner. Resource network regarding, conditions, policies, programs.
National Association on Mentally Illness (NAMI) Colonial Place Three 2107 Wilson Blvd., Suite 300 Arlington, VA 22201-3042	http://www.nami.org/	Consumer, professional, family/community advocacy and information agency. Important partnership toward national, state, local initiatives. Strongly community and consumer focused with links to resources and networking.
US Psychiatric Rehabilitation Association (USPRA) 601 Global Way Suite 106 Linthicum, MD 21090	http://www.uspra.org	Association of agencies, professionals, individuals, focused toward a community-based model of care – Important partner toward development of community- focused policies and OT services
National Alliance for Research on	http://www.narsad.org	Research focused agency providing information,

Schizophrenia and Depression (NARSAD) 60 Cutter Mill Road, Suite 404, Great Neck, New York 11021		resources, and grant potential.
National Family Caregivers Association 10400 Connecticut Avenue, Suite 500 Kensington, MD 20895-3944	http://www.nfcacares.org/	Support organization for families caring for chronically ill, aged, or disabled loved ones. Links to educational and support information/resources.
Parent to Parent [Best to search regional listings and note that there are sites using “parent to parent” that are not special needs related and may be commercial in nature]		Regional organizations providing peer support for families of children with special needs – agency names may differ from state to state or region to region.
National Empowerment Agency National Empowerment Center 599 Canal Street Lawrence, MA 01840	http://www.power2u.org/	Advocacy agency providing information, programming, and networking toward empowerment of those with mental illness.
National Association for Rights, Protection, and Advocacy (NARPA) P.O. Box 40585 Tuscaloosa, AL 35404	http://www.narpa.org/	Advocacy agency focusing on social policy change related to the rights and choices of those diagnosed with mental illness. Potential partner toward development of independent living/community support programs.
National Mental Health Association 2000 N. Beauregard Street, 6th Floor Alexandria, Virginia 22311	http://www.nmha.org/	Advocacy, education and research organization with extensive links and resources.
National Education Association (NEA) 1201 16th Street, NW Washington, DC 20036-3290	http://www.nea.org	Networking resources related to educational advocacy, policy, practice, and research. Important source for educational partnership development.
Parents as Teachers National Center, Inc. Attn: Public Information Specialist 2228 Ball Drive	http://www.parentsasteachers.org	Parent support organization linking parents to resources including special needs services. Includes parent and professional site resources.

St. Louis, Mo. 63146		
National Home Education Network P.O. Box 1652 Hobe Sound, FL 33475-1652	http://www.nhen.org/	Networking organization and resources site for home-school families. Families with special needs children may select to home school for various reasons including concerns over appropriateness of traditional school placements.
Recovery Inc. 802 N. Dearborn Street Chicago, Illinois 60610	http://www.recovery-inc.org/	Consumer organization providing broad based support and networking services.
Diagnosis-specific Associations/Agencies. Provide varying levels of resources and networks related to specific diagnostic categories. List is not inclusive and should be used as a template for local/regional information searches.		
Alcoholics Anonymous A.A. World Services, Inc., P.O. Box 459, New York, NY 10163 ALANON 1600 Corporate Landing Parkway Virginia Beach, VA 23454-5617 Narcotics Anonymous World Service Office PO Box 9999 Van Nuys, California 91409	http://www.alcoholics-anonymous.org/ http://www.al-anon.alateen.org/ http://www.na.org/	Each of these agencies provides varying levels of peer and/or family support around specific diagnoses or diagnostic categories. Networking potential exists toward development, programming, and research.
Alzheimer's Association National Office 225 N. Michigan Ave., Fl. 17, Chicago, IL 60601	http://www.alz.org/	
National Autism Association 1330 W. Schatz Road, Nixa, MO 65714	http://www.nationalautismassociation.org/	
National Depression and Bipolar Support Alliance 730 N. Franklin Street, Suite 501, Chicago, Illinois 60610-7224	http://www.dbsalliance.org	
International Foundation for Research and Education on Depression	http://www.ifred.org/	

(iFred) 2017-D Renard Ct. Annapolis, MD 21401 USA		
Anxiety Disorders Association of America 8730 Georgia Ave., Suite 600 Silver Spring, MD 20910	http://www.adaa.org/	
National Attention Deficit Disorder Association (ADDA) 15000 Commerce Parkway, Suite C Mount Laurel, NJ 08054	http://www.add.org/	
Potential Funding Sources/Foundations		
Hasbro Children's Foundation Hasbro Children Foundation 32 West 23rd Street New York, NY 10010	http://www.hasbro.org/	Sample list of private organizations or individuals that may provide seed money/grants toward program development, research, etc. Try the following link for more options: http://www.grantsalerts.com
Gifts in Kind International 333 North Fairfax Street Alexandria, VA 22314	http://www.giftsinkind.org	
Teammates for Kids Foundation • 7851 South Elati Street - Suite 200 - Littleton, CO 80120	http://www.touchemall.com	
MacArthur Foundation 140 S. Dearborn Street, Chicago, IL 60603-5285	http://www.macfound.org	
Robert Wood Johnson Foundation P.O. Box 2316 College Road East and Route 1 Princeton, NJ 08543	http://www.rwjf.org/	

