

October 12, 2005

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TO: AOTA Board of Directors

SUBJECT: Request for Board Action

TOPIC: Promotion of OT in Mental Health Systems

Executive Summary

Despite occupational therapy's genesis in mental health settings (Quiroga, 1995), the profession has not kept pace with other mental health professionals (i.e., social work, psychology), nor with our international occupational therapy colleagues in Canada, Australia, New Zealand, or the United Kingdom (British College of Occupational Therapists, 2004; New Zealand Association of Occupational Therapy, 2004 and 2005; Canadian Association of Occupational Therapists, 2005), in preserving and promoting occupational therapy presence in existing mental health systems. Although there is some presence of occupational therapists and occupational therapy assistants in public and private mental health service systems, other mental health professionals, including nurses, social workers, psychologists and psychiatrists, far outnumber them, particularly in public mental health settings. The sheer numbers of other mental health practitioners in these settings means that occupational therapy is most often having to 'advocate' or 'fight' for its presence, rather than it being an expected and accepted part of the behavioral health workforce.

A workgroup was formed at the request of AOTA President, Dr. Carolyn Baum, to address the following objective: "Assess the needs for positioning OT in mental health systems and make recommendations to the Board. Review the RA resolution; review policy statement; outline a strategy." Three broad areas were identified by the workgroup as representing sets of threats and opportunities to the promotion of occupational therapy within mental health systems, (1) the readiness of occupational therapists and occupational therapy assistants to practice in the current environment informed by evidenced-based mental health practices, particularly in leadership roles; (2) public policy and regulatory issues regarding mental health practice, particularly for adults and children at-risk for or labeled with serious and persistent mental illnesses; and, (3) payment/reimbursement sources for occupational therapy and mental health services.

Threats/Opportunities regarding the readiness of occupational therapy practitioners to practice in mental health systems. A national shortage of mental health professionals exists in many parts of the United States, particularly in rural areas and for bi-lingual practitioners in urban areas (National Health

Service Corps, 2005). In addition, concerns have been identified regarding the degree to which all mental health professional groups have readied their members to practice in the current environment, particularly preparing them with the competencies for evidenced-based mental health practices (Hoge, M.A., Paris, Jr., M., Adger, Jr., H., Collins, Jr., F.L., Finn, C.V., Fricks, L., Gill, K.J., Haber, J., Hansen, D., Ida, D.J., Kaplan, L., Northey, Jr., W.F., O'Connell, M.J., Rosen, A.L., Zebulon Taintor, Tondora, J. & Young, A.S., 2004). To compound this shortage with regards to occupational therapy, the workgroup expressed concern regarding the paucity of occupational therapy practitioners serving as mental health system leaders and their readiness to do so.

Threats/Opportunities related to public policy. Federal and state statutes define who can provide publicly funded mental health service, i.e., be identified as a qualified mental health provider (QMHP). As noted in a recent report prepared by the AOTA State Affairs Group, there is significant variability in state regulations regarding who can be a qualified mental health provider (AOTA State Affairs Group, 2004). Eligibility to be a QMHP generally requires masters-level education and licensure, and most typically includes licensed clinical social workers (LCSW), licensed psychologists, nurse practitioners, licensed marriage and family therapists (LMFT), and/or licensed mental health/professional counselors (LMHC/LPC). In most states occupational therapists are not identified as qualified mental health providers.

Threats/opportunities related to payment sources. There appears to be both a perceived and real cost differential between occupational therapy practitioners and other mental health providers in public mental health settings. Individual occupational therapy practitioners seeking to obtain positions in mental health settings, particularly publicly (i.e., Medicaid or state block grant) funded non-profit organizations, are often told by the organization that although the contribution that occupational therapy can make is clear, it is too expensive. When occupational therapists are not included in the QMPH provider listing for a given state, they are then forced to either 'advocate' for the creation of an occupational therapy position or must look for job titles that match their academic education and fieldwork experience. At the current time, occupational therapy is not a covered service under the mental health benefit for most insurance and

behavioral health MCO plans. In those states where a mental health parity law is in effect, occupational therapy may be covered for parity diagnoses (generally schizophrenia, major depression, bipolar disorders), when that health plan covers occupational therapy for medical conditions.

Although it is possible that individual occupational therapy practitioners will continue to establish themselves in mental health practice and may have some success in expanding the presence of occupational therapy in their local community, failure on the part of the profession to promote occupational therapy in mental health systems at the national level will result in the loss of an historically important area of practice. Further, it will derail what Reilly (1969) argued was “one of the greatest ideas of the twentieth century” and prevent occupational therapy from contributing to one of the major public health concerns of the future—depression. Depression has been identified as only second to cardiovascular disease as a major contributing factor to disability worldwide in the next decade (Murray & Lopez, 1996). In addition, the prevalence of mental health disorders in the United States (Narrow, 1998) and the relative number of untreated individuals (New Freedom Commission on Mental Health, 2003) emphasizes the importance of occupational therapy training and provision of services for mental disorders.

Action Item

The workgroup retained the three strategic domains/directions identified in their initial environmental scan and identified activities targeted to specific dimensions of each domain. It is the workgroup’s belief that the AOTA Board will need to pursue these domains and activities simultaneously as they are interconnected, and to only target one of the areas would result in a further erosion of occupational therapy presence in mental health systems.

1. Influence the readiness of occupational therapy practitioners to participate in mental health systems.
 - 1.1. Develop, fund and implement a national initiative that would actively recruit, prepare and support advanced practice occupational therapy practitioners to take on targeted leadership roles in mental health systems.

- 1.2. Conduct evidenced-based reviews of occupational therapy practice consistent with outcomes that are meaningful to mental health systems, i.e., increased days in community placements, reduction in staff hours, reduction in crisis calls, decreased number of community complaints, sustained work, academic achievements, and decrease in substance misuse in older adults.
- 1.3. Develop, fund and implement a national initiative in partnership with occupational therapy mental health educators, their educational institutions and the Annapolis Coalition for the Behavioral Health Workforce to insure that current and future entry-level occupational therapy practitioners are prepared to implement evidenced-based mental health practices.
2. Influence public policy at state and federal level to promote participation of occupational therapy as a core mental health professional.
 - 2.1. Track and analyze public policy issues related to mental health systems for which occupational therapy practitioners are well suited to be responsive.
 - 2.2. Advocate for occupational therapy to be identified as a core mental health profession in all federal documents.
 - 2.3. Encourage and take a proactive stance with state occupational therapy associations to assist them in their legislative efforts to have occupational therapists identified as qualified mental health providers.
3. Influence payment streams for occupational therapy for persons at-risk or diagnosed with psychiatric disorders (i.e., behavioral health managed care organization (MCOs), insurance companies, Medicaid/Medicare).
 - 3.1. Advocate with behavioral health MCOs to pay for occupational therapy for psychiatric disorders.

Relation to Strategic Plan

Overall, the strategic directions and the activities proposed to position occupational therapy practitioners in mental health systems are primarily consistent with Strategic Goal II “to represent and advocate for the organization’s members, the profession and the needs of those the profession serves.” Specifically, “to promote greater public understanding of occupational therapy and its unique

contributions in meeting the health and social needs of those served by its practitioners” (II-A); “to heighten AOTA’s influence with both public and private sector policymakers” (II-B); “to monitor and be proactive on emerging public policy, professional issues, economic and demographic trends affecting the profession, and inform and promote members to action on issues that require their attention” (II-C); “to engage in strategic alliances with stakeholders, and partner with agencies and associations that are working to achieve participation of all members of society” (II-D); “to publicize the profession’s positions on regulations and policies that affect participation of all members of society” (II-G); and, “to encourage member involvement in community and national advocacy activities to remove barriers to the participation of the populations served by occupational therapy” (II-H). In addition, selected activities are consistent with Strategic Goal III “to foster the discovery, integration, application and dissemination of occupational therapy knowledge to advance practice, education and research.”

Resources Needed

With regards to the resources needed, it is the workgroup’s assessment that none of the activities proposed here can be accomplished solely through the efforts of the volunteer mental health workgroup (i.e., Mental Health Special Interest Section Committee) or the AOTA staff currently tasked with attending to mental health practice concerns. Both funding and staff resources will need to be dedicated to these activities or it is unlikely that they will be completed, either in sufficient time or with sufficient quality to be of any value. Specifically, the activities associated with the readiness of occupational therapy practitioners to practice in mental health systems will require a pooling of various funding streams, including AOTA investment, to properly capitalize. In addition, access to persons with knowledge and experience in seeking foundation and other grant sources for such activities will be necessary as well. The activities proposed addressing the public policy will require staff resources to insure that sufficient expertise and attention is available. The activities proposed for addressing mental health payment streams will require less resources than those proposed for the other two strategic directions. Indeed, some of the work that would be done in completing the activities related to the first

two could be accessed to complete the activities in this domain as well (i.e., evidenced-based reviews, QMHP status, etc.).

Full Report

Statement of the Problem

Despite occupational therapy's genesis in mental health settings (Quiroga, 1995), the profession has not kept pace with other mental health professionals (i.e., social work, psychology), nor with our international occupational therapy colleagues in Canada, Australia, New Zealand, or the United Kingdom (British College of Occupational Therapy, 2004; New Zealand Association of Occupational Therapists, 2004 and 2005; Canadian Association of Occupational Therapists, 2005), in preserving and promoting occupational therapy presence in existing mental health systems. Although, there are scattered oases of practitioners, educators and researchers who have sustained and expanded occupational therapy participation in mental health practice, it has not been sufficient to position occupational therapy as a major player in either the public or private mental health systems in the United States. Occupational therapy is not mentioned in federal legislation as a core mental health profession, and many states do not consider graduation from an occupational therapy program as qualifying preparation for a QMHP (Qualified Mental Health Professional)(AOTA State Affairs Group, 2004). As a result, occupational therapists and occupational therapy assistants are not the mental health practitioners of choice for mental health organizations seeking to meet their workforce needs, even when these needs are consistent with occupational therapy competencies.

In national discussions, the USPRA (United States Psychiatric Rehabilitation Association) is seen as the national organization representing psychosocial rehabilitation services in mental health. Social workers, psychologists, rehabilitation counselors, occupational therapy practitioners and paraprofessionals make up the membership of the USPRA, which has a certification program for psychosocial rehabilitation providers. Occupational therapy educational programs vary in the degree to which their curriculum addresses mental health and psychosocial issues, and most do not specify or require fieldwork experience in mental health. In addition, occupational therapy practitioners are not well represented in local, state or national leadership positions within mental health systems in the United States and therefore have limited influence on public policy and reimbursement. Medicare

reimbursement of services for persons diagnosed with psychiatric disorders is often problematic unless an additional medical diagnosis is co-occurring.

Despite some presence of occupational therapists and occupational therapy assistants in public and private mental health service systems, other mental health professionals, including nurses, social workers, psychologists and psychiatrists, far outnumber them, particularly in public mental health settings. Those occupational therapy practitioners who are in mental health settings are most commonly working in inpatient psychiatric settings, particularly state hospitals, and Medicare reimbursed partial hospitalization programs. Even here however, there has been ongoing pattern of reduction of occupational therapy positions over the last several decades. In these instances, the replacement workforce has most often been recreational therapists or some other type of creative expressive therapist. It does appear that this may be changing, with an occupational therapy presence increasingly being found in programs for persons at-risk of mental disorders, like homeless shelters (Schultz-Krohn, 2004) and welfare-to-work programs (Wilson, 2000). However, the sheer numbers of other mental health practitioners in these settings means that occupational therapy is most often having to ‘advocate’ or ‘fight’ for its presence, rather than it being an expected and accepted part of the behavioral health workforce.

Background Information

Three broad areas were identified by the workgroup as representing sets of threats and opportunities to the promotion of occupational therapy within mental health systems. Specifically, they are: the readiness of occupational therapists and occupational therapy assistants to practice in the current environment informed by evidenced-based mental health practices; public policy and regulatory issues regarding mental health practice particularly for adults and children at-risk for or labeled with serious and persist mental illnesses; and payment/reimbursement sources for occupational therapy and mental health services.

Readiness of occupational therapists to practice in current environment.

Role blending and transdisciplinary practice have long been a part of occupational therapy practice in both inpatient and community-based mental health service settings. In institutional settings like state hospitals, occupational therapy practitioners have collaborated, cross-practiced, and at times conflicted, with the practice of other ‘activity’ based/rehabilitation professionals, including recreational therapists, art therapists, music therapists, movement/dance therapists and creative arts therapists. With the rise of psychiatric rehabilitation as an intervention approach, some occupational therapy practitioners have struggled to identify ways in which their practice can be distinguished from that of other practitioners of psychiatric rehabilitation approaches. In those community-based, psychiatric rehabilitation oriented service settings where functional job titles (i.e., case manager) and generalist practices (i.e., clubhouses, ACT/PACT programs) are used, some occupational therapy practitioners have found it difficult to practice because they feel that their specialist knowledge is not valued (Parker, 2001). For other occupational therapy practitioners, the occupation-based and natural environment focus of many of the psychiatric rehabilitation interventions has been essential to their practice of authentic occupational therapy (Yerxa, 1967). Our profession’s move to promoting occupation-based practice across all practice areas may help to mediate this situation to some degree.

As noted above, the emergence of recovery as a guiding philosophy for adult mental health services, both at the national level in the Surgeon General’s Report on Mental Health and the President’s New Freedom Commission Report on Mental Health (U.S. Department of Health and Human Services, 1999; New Freedom Commission on Mental Health, 2003) and at state levels (Jacobson, 2004), is a wonderful opportunity for occupational therapy. Psychiatric rehabilitation approaches, along with consumer-operated services, have become the preferred approach to service delivery for persons with serious and persistent mental illness. Occupational therapy practitioners are more ready, than other mental health practitioners, to practice from this perspective given our long standing base in rehabilitation. This is the case even when considering the consumer/survivor communities criticism of rehabilitation (Fisher, nd). In addition, our deep appreciation and understanding of the biopsychosocial

complexity of occupational functioning and the way in which psychiatric disorders can disrupt that functioning is critical to the success of psychiatric rehabilitation interventions. Individual practitioners have been able to demonstrate this to individual organizations and in some instances this has resulted in an increase in the number of occupational therapy practitioners hired by those organizations. However, as a profession we have not been successful in making this evident to other professional groups, state and local mental health authorities or mental health payer sources.

A national shortage of mental health professionals exists in many parts of the United States, particularly in rural areas and for bi-lingual practitioners in urban areas (National Health Service Corps, 2005). In addition, concerns have been identified regarding the degree to which all mental health professional groups have readied their members to practice in the current environment, particularly preparing them with the competencies for evidenced-based mental health practices (Hoge, M.A., Paris, Jr., M., Adger, Jr., H., Collins, Jr., F.L., Finn, C.V., Fricks, L., Gill, K.J., Haber, J., Hansen, D., Ida, D.J., Kaplan, L., Northey, Jr., W.F., O'Connell, M.J., Rosen, A.L., Zebulon Taintor, Tondora, J. & Young, A.S., 2004). AOTA's initiative to develop evidenced-based practice briefs is important in this regard and expanding the number of mental health practice briefs would be beneficial. AOTA's response to a recent request from the Oregon Department of Mental Health request regarding occupational therapy practitioner's training in and use of evidenced-based mental health practices underscores the importance of this issue (AOTA State Affairs Group, 2005). The Annapolis Coalition for the Behavioral Health Workforce was founded by the Substance Abuse and Mental Health Services Administration (SAMHSA) in response to the findings of the New Freedom Commission on Mental Health (2003) that the mental health workforce at large was not sufficiently prepared to meet the complex needs of persons at-risk of or labeled with psychiatric disorders. Concern was expressed both with regards to entry-level academic and fieldwork education, as well as continuing education, particularly with regards to the use of evidence-based mental health practices. Occupational therapy practitioners have not been involved in, nor were they considered in the initial mix of mental health providers of concern identified by the Coalition according to Ann McManis, Project Director (personal communication, September, 2005). Participation

in the Coalition may provide occupational therapy with an opportunity to educate the mental health provider community at large about the readiness for occupational therapy practitioners to function in mental health settings. The Chairperson of the Mental Health SIS has been in recent communication with Coalition representatives regarding the role of occupational therapy in mental health and AOTA's interest in working with them in their task of developing a quality mental health workforce. The effort of the Commission on Education, Education SIS, and the Mental Health SIS, as per RA Resolution 2004C126 to survey educational programs regarding their mental health content, will be of considerable help in addressing one of the strategic activities of the Coalition which is to survey the educational content of various mental health professional educational programs.

Public Policy/Regulatory Issues

Federal and state statutes define who can provide publicly funded mental health service, i.e., be identified as a qualified mental health provider (QMHP). As noted in a recent report prepared by AOTA State Policy Department, there is significant variability in state regulations regarding who can be a qualified mental health provider (AOTA State Policy Department, 2004). Eligibility to be a QMHP generally requires masters-level education and licensure, and most typically includes licensed clinical social workers (LCSW), licensed psychologists, nurse practitioners, licensed marriage and family therapists (LMFT), and/or licensed mental health/professional counselors (LMHC/LPC).

In some states a two-tier approach has been utilized, identifying a *licensed* practitioner of the healing arts (LPHA) AND the QMHP. In those states, the QMHP represents a lower-tier professional and eligibility may be a bachelor's degree or work-equivalent. In these instances, no license is required to practice, but there may be a certification (e.g., USPRA's Certified Psychiatric Rehabilitation Practitioner) or documentation of practice experience. In those states with this two-tier approach, occupational therapists qualify as a QMHP (i.e., California). The LPHA on the other hand must be licensed and often serves in an oversight role regarding the practice of the QMHP. In states where QMHPs are required to have master's level education and be licensed, some occupational therapists have obtained credentials through master's level programs in another profession (e.g., licensed professional counselor or licensed

clinical social worker) in order to be eligible for QMHP status. This may be the only way for occupational therapists to pursue leadership positions in mental health organizations.

In light of the master's level education required for the QMHP/LPHA, the profession's move to a required post-baccalaureate entry level degree will place occupational therapy at an equivalent education level as some of those professions who are identified as "core mental health professionals" (i.e., LMFT, LCSW, LMHC/LPC). However, lack of extensive mental health curriculum content in occupational therapy programs may still present a barrier to recognition in states as QMHP. The mental health curriculum survey that is currently being conducted by the Commission on Education, Mental Health SIS, and the Education SIS in response to a 2004 Representative Assembly motion will provide a better understanding of the significance of this barrier. In addition, the introduction of AOTA's Board Certification in Mental Health (BCMh) may also provide an additional method for occupational therapists to demonstrate their mental health practice qualifications. It should be noted that AOTA's State Affairs Group staff recommend against using the BCMh to position occupational therapists as QMHPs since the certification represents advanced practice. State Affairs Group staff argues that occupational therapists should be identified as QMHPs based on their entry-level education and fieldwork preparation alone (Personal communication, C. Willmarth, November 12, 2004). However, current requirements for entry level practice (education and fieldwork) may not provide sufficient readiness in light of state QMHP regulations to permit occupational therapists to provide mental health services. This is evident when comparing the 480 hour supervised practice hours post degree for occupational therapists to that for LCSWs, LMFTs and LPCs (i.e., 3200 hours in California) before they can sit for their professional license exam. In addition, advanced practice nurses who are considered LPHAs are required to complete additional preparatory coursework and fieldwork beyond their master's degree in nursing in order to sit for the national advanced practice nursing exam.

Scope of practice barriers exist, in addition to the educational and fieldwork barriers. In most mental health settings, the scope of practice of the QMHP or LPHA includes diagnosing psychiatric disorders and the provision of psychotherapy, neither of which are currently within the scope of the

occupational therapy. One effort to address the role of occupational therapists in psychiatric diagnosis was put forth by the New Zealand Association of Occupational Therapists (NZAOT) in response to the practice demands of occupational therapists on community mental health teams in that country (New Zealand Association of Occupational Therapists, 1999). In this position paper, NZAOT argued that occupational therapists could contribute to the development of a provisional diagnosis, but could only do so when they had ongoing access to psychiatric consultation. In the United States, although there are psychiatrists in most mental health practice settings, the QMHP or LPHA serves as a physician surrogate with regards to the diagnostic function. In considering the psychotherapy scope of practice, it should be remembered that occupational therapy has at least since the 1960's, along with other rehabilitation or activities therapies (i.e., recreational therapy) been seen as “adjunctive” to psychotherapy. Although psychotherapy is not a prominent service of most public mental health systems, it does remain available in the private mental health market. This legacy of being “adjunctive” again positions occupational therapy alongside, rather than central to mental health services. This is the case despite the emergence of the rehabilitation and recovery perspective in which engagement in occupation is seen as a necessary transformative experience in reclaiming the self (Anthony, Cohen & Farkas, 2002).

Despite the limited number of occupational therapy practitioners working in mental health in comparison to other mental health professional groups, a pool of advanced practice occupational therapy practitioners in mental health, with links to and relationships with important stakeholders in mental health systems has emerged. These stakeholder groups include behavioral health managed care companies (e.g., Value Options, Pacific Behavioral Healthcare), state mental health departments (Illinois), statewide/multi-state mental health service organizations (i.e. Sheppard Pratt Healthcare Systems, Telecare, Inc.) and other mental health professional organizations (e.g., United States Psychiatric Rehabilitation Association [USPRA], American Ambulatory Behavioral Healthcare Association [AABHA]). The Mental Health SIS was recently mandated to identify mental health professional organizations with which it would be strategically valuable for AOTA to establish working relationships.

The Mental Health SIS began talks with USPRA last year and has begun to identify issues of mutual concern, particularly related to public policy, between the two organizations.

A small number of occupational therapy researchers have also established themselves within the mental health research community and are collaborating with other mental health researchers on exploring issues critical to persons at-risk of and labeled with psychiatric disorders, many that have public policy implications. Occupational therapy associations in the Canada, United Kingdom, New Zealand, and Australia in response to similar challenges to occupational therapy practice have taken more active approaches that can serve as guides for US efforts (British College of Occupational Therapy, 2005; New Zealand Association of Occupational Therapists, 2004 and 2005; Canadian Association of Occupational Therapists, 2005). In these countries professional OT associations have been involved, in national mental health public policy initiatives (Canadian Association of Occupational Therapists, 2005; British College of Occupational Therapy, 2004; Australian Government. Department of Health and Aging, 2005).

Payment/Reimbursement Streams

There appears to be both a perceived and real cost differential between occupational therapy practitioners and other mental health providers in public mental health settings. Individual occupational therapy practitioners seeking to obtain positions in mental health settings, particularly publicly (i.e., Medicaid or state block grant) funded non-profit organizations, are often told by the organization that although the contribution that occupational therapy can make is clear, it is too expensive. When occupational therapists are not included in the QMPH provider listing for a given state, they are then forced to either 'advocate' for the creation of an occupational therapy position or must look for job titles that match their academic education and fieldwork experience. In the first instance, the practitioner is likely to use locally available occupational therapy salary schedules in their proposal to the organization. In these instances, they will likely price themselves too high given the salary levels for occupational therapy in other practice specialties. In the second instance, the occupational therapy practitioner may meet the qualifications for the job title, the organization is eager to hire them, but most often the practitioner considers the salary to be too low. Although they may take the job initially, because it their

area of interest and passion, the salary may not be sufficient to sustain them in the field without the opportunity of leadership positions, which may be thwarted because they are not eligible for QMHP/LPHA status.

The situation is generally better for directly operated government programs, where salaries for occupational therapy job titles may still be higher than job titles for which LMFTs, LMHC/LPC, and LCSWs are eligible. For example, in Los Angeles County, the starting salary for an Occupational Therapist I is \$5615.82/month, while the starting salary for a Psychiatric Social Worker 1 is \$3,929.27 to \$4,622.18/month. This moves the system at large to be highly selective in including occupational therapy practitioners into the mix, unless they are required by state and federal statutes. This has been the case for Medicare reimbursed inpatient and partial hospitalization programs (PHPs), where occupational therapy practitioners have been able to retain a presence despite the practice challenges common to those settings and the fact that occupational therapy is not a required service for PHPs. Historically, reimbursement rates under Medicare have been better than those under Medicaid, for any type healthcare service. In addition, salaries in directly operated government services have been better than in mental health service organizations that state and local governments contract for services.

This is likely a contributing factor to the current situation, along with AOTA's long standing commitment to advocate for Medicare reimbursement for occupational therapy to the exclusion of advocacy for Medicaid reimbursed occupational therapy and mental health services. Given that many individuals diagnosed with psychiatric disorders are not eligible for Medicare and rely on Medicaid or state block grants to cover their mental health services, they may not have access to occupational therapy. In contrast to adult mental health services, Medicaid reimbursement for occupational therapy for children and adolescents has been increasing. Youth violence programs, infant mental health services and other services targeting the mental health needs of children and adolescent are proliferating and in many states occupational therapy practitioners are meeting these needs. In addition, with the Olmstead Act the needs of older adults are also being met through the development of Medicaid funded Adult Day Care/Adult

Day Health Center services. Occupational therapists are one of the required providers in these program models.

At the current time, occupational therapy is not a covered service under the mental health benefit for most insurance and behavioral health MCO plans. In those states where a mental health parity law is in effect, OT may be covered for parity diagnoses (generally schizophrenia, major depression, bipolar disorders), when that health plan covers occupational therapy for medical conditions. Although there are only a few mental health occupational therapists in private practice, they are generally limited to out-of-pocket payments for services or to specialized contracts negotiated at the local level. It is important to note, that with regards to this threat, psychotherapy benefits are also limited under many insurance and behavioral health MCO plans as well, particularly for persons at-risk of psychiatric disorders, for adults with serious and persistent mental illness, for children with serious emotional disorders or for older adults with mental disorders (particularly in skilled nursing facilities). This is the case even in those states that have enacted mental health parity legislation.

Behavioral health MCOs and insurance companies frequently maintain a roster of specialty providers that they utilize for their beneficiaries who have particular needs, such as adults with serious and persistent mental illnesses and complex functional disabilities. These types of beneficiaries are often not referred for psychotherapy, but do receive medication management, limited case management and in some instances residential treatment or other supported living assistance. The specialty provider option may provide an opportunity for occupational therapy if we can demonstrate our ability to improve the person's functional abilities and reduce the need for more intensive levels of care. In addition, disability management services for persons experiencing work disruptions due to mental illness may also present an opportunity for occupational therapy. Work days lost to depression and other psychiatric disorders is considerable (Mental Health Liaison Group, 2004). Although psychologists are providing the bulk of these services in the United States, the Canadian Occupational Therapy Association has launched a national campaign to promote the role of occupational therapy in partnership with psychologists as the team of choice for return to work interventions (Canadian Occupational Therapy Association, 2005).

Implications for the Profession

Although it is possible that individual occupational therapists will continue to establish themselves in mental health practice and may have some success in expanding the presence of occupational therapy in their local community, failure on the part of the profession to promote occupational therapy in mental health systems at the national level will result in the loss of an historically important area of practice. Further, it will derail what Reilly (1969) argued was “one of the greatest ideas of the twentieth century” and prevent occupational therapy from contributing to one of the major public health concerns of the future—depression. Depression has been identified as only second to cardiovascular disease as a major contributing factor to disability worldwide in the next decade (Murray & Lopez, 1996). In addition, the prevalence of mental health disorders in the United States (Narrow, 1998) and the relative number of untreated individuals (New Freedom Commission on Mental Health, 2003) emphasizes the importance of occupational therapy training and provision of services for mental disorders.

Recommendations Considered

The recommendations developed by the workgroup are consistent with the three strategic domains generated during the environmental scan and the development of the statement of the problem. These domains seemed to resonate well with AOTA’s Strategic Plan, therefore they are used to frame the recommended actions by the workgroup. We urge the Board to address all three domains *simultaneously*, as they are interconnected, and to target only one of the areas will result in a further erosion of occupational therapy presence in mental health systems. However, in an effort to respond to our charge for prioritizing, we have presented them here in their order of importance. In addition, within each strategic domain, we have also presented the specific activities that we identified in their order of importance.

1. *Influence readiness of occupational therapists to participate in mental health systems.* This activity is consistent with Strategic Goal II “to represent and advocate for the organization’s members, the profession, and the needs of those the profession serves.” This particular domain generated significant discussion amongst the workgroup members. Our members were represented by an advanced practice direct services provider, a senior manager within a regional mental healthcare organization and a researcher/co-developer of evidenced-based occupational therapy intervention—all expressed concerns about the readiness of OT’s to practice in their contexts. Concerns arose regarding the quality of the professional education, as well as the lack of the opportunity for mental health fieldwork. These are not new concerns and to some degree have prompted AOTA’s recent efforts to prioritize mental health practice, particularly through a number of RA motions over the last several years. As noted in the statement of the problem, organizations trying to recruit occupational therapy practitioners have reported positions being unfilled for several months at a time. As a result, some organizations abandon recruitment of occupational therapy practitioners all together. Unlike previous decades where positions in mental health were being lost, it appears that in the current market, the availability for qualified occupational therapy practitioners is not meeting the demand.

1.1. *Develop, fund and implement a national initiative that would actively recruit, prepare and support advanced practice occupational therapy practitioners to take on targeted leadership roles in mental health systems.* This activity is consistent with Strategic Goal II-C “to monitor and be proactive on emerging public policy, professional issues, economic and demographic trends affecting the profession, and inform and promote members to action on issues that require their attention.”

One area of great need regarding the readiness of occupational therapy practitioners to practice in current mental health systems identified by the workgroup, was to develop their leadership capacity. Concern was expressed that occupational therapy practitioners are not sufficiently represented in the leadership of current mental health systems. It was noted that even when

leadership opportunities are available, no qualified occupational therapy practitioners are available to meet the organizations needs. Despite AOTA's previous efforts at promoting mental health leadership and collaboration (i.e., Mental Health Partnership Project) and the emergence of the OTD, it appears that occupational therapy practitioners have not acquired the credentials or intentionally pursued mental health leadership as a career trajectory. As noted in the statement of the problem, there are oases of advanced practitioners, as well as a growing cadre of OTDs, who might be well-suited to take on these roles if given the support and the preparation to do so. The activity proposed here could be developed in collaboration with the educational institutions, particularly those with OTD programs that require a practice residency. In addition public mental health systems, as well as large mental health organizations, could be recruited as partners and as host for advanced practice fellowships/residencies. Leadership initiatives are not a new approach to meeting workforce needs and possible funding sources could include AOTF, Robert Wood Johnson Foundation, and other foundations, government or university sources. The need for qualified occupational therapy practitioners to take on leadership in mental health systems cannot be emphasized enough. The workgroup's assessment of the current mental health practice environment was that without occupational therapy practitioners in leadership positions, existing direct provider positions may be lost over time and the presence of occupational therapy in mental health may erode further.

- 1.2. Conduct evidenced-based reviews of occupational therapy practice consistent with outcomes that are meaningful to mental health systems, i.e., increased days in community placements, reduction in staff hours, reduction in crisis calls, decreased number of community complaints, sustained work, academic achievement and decrease in substance misuse in older adults This activity is consistent with Strategic Goal III "to foster the discovery, integration, application and dissemination of occupational therapy knowledge to advance practice, education and research."

This activity is proposed as targeting two areas of concern identified by the workgroup. First is the attention and understanding that occupational therapy practitioners have regarding the connection between their interventions and the targeted outcomes of value to the mental health system. Failure to target occupational therapy interventions to these outcomes will result in a further erosion of occupational therapy in mental health systems of care. Second is to provide tools to both occupational therapy practitioners and the mental health system in which they work regarding the contribution that occupational therapy can make to recovery and the prevention of disability.

- 1.3. *Develop, fund and implement a national initiative in partnership with occupational therapy mental health educators, their educational institutions and the Annapolis Coalition to insure that current and future entry-level occupational therapists are prepared for in evidenced-based mental health practices.* This activity is consistent with Strategic Goal(s) II-C, D and H. Specifically, “to monitor and be proactive on emerging public policy, professional issues, economic and demographic trends affecting the profession, and inform and promote members to action on issues that require their attention” (II-C); “to engage in strategic alliances with stakeholders, and partner with agencies and associations that are working to achieve participation of all members of society” (II-D) and “to encourage member involvement in community and national advocacy activities to remove barriers to the participation of the populations served by occupational therapy” (II-H).

In concert with activity 1.1 and 1.2 above, this activity is intended to insure that entry-level practitioners are positioned to practice in current and future mental health systems of care. As noted in the statement of the problem, national concern has arisen regarding the readiness of all entry-level practitioners to provide evidenced-based mental health interventions. This national concern resulted in the formation of the Annapolis Coalition for the Behavioral Health Workforce. Members of our workgroup expressed concern that many new graduates are not even prepared to use longstanding mental health occupational therapy practices (i.e., activity

analysis, cognitive models), without considerable supervision on fieldwork. The survey regarding mental health curriculum content in entry-level occupational therapy education survey, concurrently being conducted by the Commission on Education, Education SIS, and the Mental Health SIS, can contribute greatly to this activity, as it will provide us with a better understanding of the current curriculum for entry-level professional education. One potential outcome of this activity could be the development of a model curriculum for occupational therapy in mental health. Such a curriculum could be used by educational institutions to inform the development and refinement of their courses that target mental health practice. Partnering with the Annapolis Coalition on this activity will help position occupational therapy within the core mental health profession cadre. The USPRA is currently in discussion with the Coalition regarding psychiatric rehabilitation providers, some of who are occupational therapy practitioners. Partnering with USPRA in their efforts to work with the Coalition might also make sense given the mutual concerns of occupational therapy and PSR practitioners for success and satisfaction in living, learning and working environments of choice for persons labeled with psychiatric disabilities. It should be noted however, that there are practice areas beyond psychiatric rehabilitation in which AOTA's collaboration with the Coalition would be valuable, particularly the mental health needs of children, adolescents and older adults.

2. *Influence public policy at state and federal level to promote participation of occupational therapists as a core mental health professional.* The following recommended activities are consistent with AOTA's Strategic Goal II "to represent and advocate for the organization member's, the profession and the needs of those the profession serves." In addition, this recommendation supports work that AOTA has already initiated, i.e., State Affairs Group report regarding occupational therapists as qualified mental health providers in state statutes.

- 2.1. *Track and analyze public policy issues related to mental health systems for which occupational therapy practitioners are well suited to be responsive.* This activity is consistent with Strategic Goal II-C "to monitor and be proactive on emerging public policy professional

issues, economic and demographic trends affecting the profession, and inform and promote members to action on issues that require their attention.”

Although AOTA has kept its eye on the prize for selected areas of practice, AOTA’s attention to public policy issues regarding mental health practice has waxed and waned over the years.

More recent attention by AOTA to the impact of Medicaid regulations and budget cuts on occupational therapy practice, including mental health practice is greatly appreciated.

However, in combination with the failure on the part of state occupational therapy associations to aggressively track and take action on changes in Medicaid and other state

regulations/reimbursement streams regarding mental health services, occupational therapy has not been protected from downsizing and other cost containment activities (i.e., where

occupational therapy practitioners are seen as more expensive providers than recreational therapists, etc), or from the identification of other mental health practitioners as preferred

providers of choice (i.e., identification of LCSWs, etc. as core mental health professionals). This activity would require that public policy concerns regarding mental health practice be

prioritized within the appropriate AOTA group, at the same level of attention and resource investment that Medicare and IDEA has had over the last several years. In addition, the

Mental Health SIS should identify this activity as its first priority as well and be charged to work with the appropriate AOTA group in crafting AOTA’s responses and in mobilizing state

occupational therapy associations to these areas of concern.

2.2. *Advocate for occupational therapy to be identified as a core mental health profession in all*

federal documents. This activity is consistent with Strategic Goal II-C “to monitor and be proactive on emerging public policy, professional issues, economic and demographic trends

affecting the profession, and inform and promote members to action on issues that require their attention.”

As regulations for mental health practice have evolved over the last three decades,

occupational therapy practitioners have not been identified as core mental health professionals

along with social workers, psychologists and other mental health professionals. This has likely been influenced by our historical position as adjunctive to psychotherapy, as well as our failure as a profession to anticipate the long term impact of such a position. By not being a core mental health professional, individual practitioners are thwarted in their efforts to participate in some roles, particularly those with leadership responsibilities, within the mental health delivery system. In addition, persons labeled with psychiatric disabilities and children and adolescents who are Medicaid-dependent are prevented access to occupational therapy services to support their recovery and participation in context. To accomplish this would require a long term strategy and has implications for professional education and for our collaborative relationships with the professional associations of those mental health professions that are identified as “core”. Much like the ongoing tension with the American Physical Therapy Association over their strategic goal to have physical therapists identified “as autonomous practitioners to whom patients/clients have unrestricted direct access as an entry point into the healthcare delivery system and who are paid for all elements of patient/client management in all practice environments” (American Physical Therapy Association, 2005), the activity proposed here could garner considerable resistance from the other mental health professional groups. It is likely, as noted above, that this would be considered a broadening of our scope of practice and challenges would be mounted regarding our education and fieldwork readiness to perform the functions of a core mental health professional. Despite these risks, given that states typically utilize federal documents when framing their regulations regarding healthcare practices, it is felt that this national initiative would result in expanding and securing opportunities for occupational therapy practitioners in mental health practice in the future.

- 2.3. Encourage and take a proactive stance with state occupational therapy associations to assist them in their legislative efforts to have occupational therapists identified as qualified mental health providers. This activity is consistent with Strategic Goal II-F “to strengthen relationships with occupational therapy state or election area affiliates”, and complements the

activity identified above, but focuses specifically on the state regulations regarding qualified mental health providers (QMHP). These are the state regulations, primarily related to Medicaid reimbursed mental health services, the primary funding source for public mental health services. As noted in the statement of the problem, in many states occupational therapists are not identified in the list of professionals who can be a QMHP. Like AOTA, state associations have often focused on their advocacy efforts towards practice barriers that have high impact, particularly with regards to the number of occupational therapy practitioners that may benefit from the advocacy effort. Since mental health practice has fewer practitioners in comparison to other practice areas, state associations may not prioritize barriers to that practice given their limited advocacy/lobbying resources. This activity would be much like the work that AOTA has done to help states develop practice acts, and more recently its collaboration with California to protect the practice of occupational therapy in the worker's compensation reimbursement system. The importance of this activity is represented by the ongoing dialogue on the Mental Health SIS listserv from individual practitioners seeking guidance from their peers regarding access to practice opportunities in those states where occupational therapists are not identified as a QMHP. As at the national level, it is likely that these advocacy efforts would garner resistance from the state associations for the representative mental health professions. In addition, depending on the state-specific regulations regarding the scope of practice of a QMHP, may require modifications of state occupational therapy practice acts.

3. *Influence payment streams for occupational therapy for persons at-risk or diagnosed with psychiatric disorders (i.e., behavioral health MCOs, insurance, Medicaid/Medicare).* As with the first set of recommended activities, the following activities are consistent with AOTA's Strategic Goal II "to represent and advocate for the organization member's, the profession and the needs of those the profession serves."

As noted in the statement of the problem, despite AOTA's long tradition of advocating for reimbursement of occupational therapy services and the growth of occupational therapy presence in

the community mental health service sector over the last 20 years, only recently has Medicaid reimbursement for public mental health services become a focus for AOTA. In addition, there has been little to no effort to insure MCO or insurance coverage for OT services for persons at risk or diagnosed with psychiatric disorders.

3.1 Develop marketing campaign for public mental health authorities on contribution re role of occupational therapy in mental health. This activity is consistent with Strategic Goal II-A, “to promote greater public understanding of occupational therapy and its unique contributions in meeting the health and social needs of those served by its practitioners.”

The expected outcome of this activity would be an increased recruitment, hiring and retention of occupational therapy practitioners in publicly funded mental health services. As noted in the statement of the problem, more non-occupational therapy mental health providers are recruited in this area than are occupational therapy practitioners. State and local mental health authorities would be the target of this campaign, with particular attention to those states where occupational therapists are already identified as qualified mental health providers. Although initially considered by the workgroup, after thoughtful discussion this activity was not identified as a priority at this time. Given that the target of such a campaign would be state mental health authorities, it was felt that this was an activity more appropriately taken up by state associations, as opposed to AOTA. In addition, work group members reflected on their experiences in which already available opportunities for occupational therapy practitioners to work in the public mental health sector had gone unfilled, suggesting that the target of a marketing campaign might more appropriately be to the practitioners themselves.

3.2 Advocate with behavioral health MCOs to pay for occupational therapy for psychiatric disorders. This activity is consistent with Strategic Goal II-B “to heighten AOTA’s influence with both public and private sector policymakers.” Although currently only a small number of mental health occupational therapy practitioners are in private practice, this is a practice sector that could grow if an adequate funding source was available. Those occupational therapy

practitioners who have been successful in establishing private practices could be consulted regarding what has worked and what has not. In addition, AOTA could take advantage of already existing relationships between individual occupational therapists that have been active in volunteer leadership roles and behavioral health MCOs (i.e. Pacific Behavioral Healthcare and Value Options). Such an activity could be a collaborative effort between the AOTA Practice Group and the Mental Health SIS.

Resources Needed

With regards to the various activities proposed for each of the strategic directions identified, the workgroup understands some are very labor intensive. However, the workgroup believes that unless appropriate resources are dedicated to these activities they will not be successful. None of the activities proposed here can be accomplished solely through the efforts of volunteer mental health workgroup (i.e., Mental Health SIS) or the AOTA staff currently tasked with attending to mental health practice concerns.

- Specifically, the activities associated with the readiness of occupational therapists and occupational therapy assistants to practice in mental health systems will require a pooling of various funding streams, including AOTA investment, to properly capitalize. In addition, access to persons with knowledge and experience in seeking foundation and other grant sources for such activities will be necessary as well.
- The activities proposed to target the public policy threats and opportunities, may tax an already burdened Practice Group and Public Policy Group staff. That being said, staff resources will need to be dedicated to these activities or it is unlikely that they will be completed, either in sufficient time or with sufficient quality to be of any value.
- The activities proposed for addressing mental health payment streams may require less resources than those proposed for the other two strategic directions. In deed, some of the work that would be done in completing the activities related to the first two could be accessed to complete the activities in this domain as well (i.e., evidenced-based reviews, QMHP status, etc.).

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